Voice disorders: social representations by teachers in speech therapy

Distúrbios da voz: representações sociais por professores em tratamento fonoaudiológico

Trastornos de la voz: representaciones sociales por los profesores en el tratamiento fonoaudiologico

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Abstract

The voice is fundamental for teaching, given the intense muscle processing that needs to be properly implemented in order to meet classroom demands. High prevalence of voice disorders and absence from work due to voice problems among teachers have been confirmed. The objective of this study was to compare the social representations regarding voice disorders and coping strategies that teachers undergoing speech therapy describe. Eighteen semi-structured interviews were conducted by means of focus groups, and the content was subjected to thematic analysis. In a general manner, the social representations regarding voice disorders and the institutional actions that are associated with these disorders (management and assistance) influence how the problem is announced, recognized and coped with, seen now as occupational dysphonia or as individual illness. A paradox between on the one hand, surveillance of vocal symptoms and incapacity for work; and on the other, denial of such problems, was identified. Converging to literature contribution, the symptom statement is not immediate to its clinical

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expression, or in spite of declared or assumed such symptoms are relegated to the background by teachers themselves. The disease and symptoms influence the teacher's ability to respond to the demands of education and the requirements of management. The development of prevention programs and for promotion of voice health will benefit if considered the social representations of dysphonia.

Keywords: *Voice disorders; Faculty; Focus groups; Speech therapy*

Resumo

A voz é fundamental para o exercício da docência, requerendo intenso e adequado processamento muscular para atender à demanda em sala de aula. Elevadas prevalências de distúrbio vocal e falta ao trabalho por causa da voz entre professores têm sido confirmados. O objetivo deste estudo foi comparar as representações sociais sobre o distúrbio vocal e o enfrentamento do problema, elaboradas por professores em tratamento fonoaudiológico. Realizaram-se dezoito entrevistas semi-estruturadas por meio de grupos focais, as quais foram submetidas à análise temática. De modo geral, as representações sociais sobre os distúrbios da voz e as ações institucionais a ele associadas (gestão e assistência) influenciam a declaração, o reconhecimento e o enfrentamento do problema, visto, ora como disfonia ocupacional, ora como doença individual. Identificou-se um paradoxo entre a vigência tanto de sintomas vocais quanto de incapacidade para o trabalho e a negação de tais problemas. Convergente ao aporte da literatura, a declaração do sintoma não é imediata à sua expressão clínica, ou, apesar de declarados ou assumidos, tais sintomas são relegados a segundo plano pelos próprios professores. O adoecimento e os sintomas influenciam na capacidade do professor em responder às demandas do ensino e às exigências da gestão. A elaboração de programas de prevenção e promoção da saúde vocal será beneficiada se consideradas as representações sociais da disfonia.

Palavras-chave: *Distúrbios da voz; Docentes; Grupos focais; Fonoterapia*

Resumen

La voz es fundamental para el ejercicio de la docencia, requiriendo un intenso y adecuado procesamiento muscular para atender la demanda de la sala de aula. Se han confirmado entre los profesores elevadas prevalencias de disturbio vocal y faltas al trabajo por problemas en la voz. El objetivo de este estudio fue comparar las representaciones sociales que se tienen de los trastornos de la voz y como se enfrenta el problema, a partir del tratamiento fonoaudiológico de profesores. Se realizaron dieciocho entrevistas semi-estructuradas por medio de grupos focales, las cuales fueron sometidas al análisis temático. De forma general, las representaciones sociales sobre el disturbio vocal y las acciones institucionales a ella asociadas (gestión y asistencia) influenciaron la declaración, el reconocimiento y el enfrentamiento del problema, visto ahora como disfonía ocupacional o enfermedad individual. Se identificó también una incongruencia entre la vigencia de síntomas vocales y de incapacidad para el trabajo, y la negación de estos problemas. Convergiendo a la contribución de la literatura, la declaración de los síntomas no es inmediata para su manifestación clínica, oa pesar de estos síntomas declarados o asumidos son relegados a un segundo plano por los propios maestros. La enfermedad y los síntomas influyen en la capacidad del maestro para responder a las exigencias de la educación y los requisitos de gestión. El elaboración de programas de prevención y de promoción de la salud vocal se beneficiará si se consideran las representaciones sociales de la disfonía.

Palabras claves: *Trastornos de la voz; Docentes; Grupos focales; Logoterapia*

Introduction

The voice is critical to the practice of teaching, requiring intense and proper muscle processing to meet classroom demands. High voice disorder prevalence and absence from work among teachers due to the voice has already been confirmed[1-2]. The presence of voice problem among teachers increases by 70% the probability of absenteeism report[3]. The voice disorder manifests itself in various forms and degrees of severity. There is not a indisputable criterion for defining the voice as normal or altered,

because the perception of "alteration" depends on the sender and on the receiver. For specialists, vocal assessment includes different levels; such as: social acceptance, speech intelligibility, comfort in its production, transmission of emotional content of speech and efficiency of the vocal mechanism, which is dependent on environmental requirements[4]. From the occupational point of view, the impact of voice problem is articulated to social representations, and not only to the severity assigned by clinicians to dysphonia[5].

Social representation is a form of particular knowledge related to common sense which structures a way to capture and interpret a given unfamiliar reality[6], including the facts related to the body and to the processes of becoming ill. The same author states that the social representation results from a psychic activity, linked to values, norms and social rules, whose function is to develop knowledge, behaviors and communication among individuals.

The representation of bodily reality, in this case the voice, is imbued with the explanations and statements produced, in a structured way, in the individuals' daily life in relation to the community to which they belong. Studying social representations of symptoms and illnesses is a way to address how the experiences of the individuals, ways of being, feeling or acting in such situations are constitutively referred to society[7].

The same "disease" or the same symptom as defined in the clinic, can be interpreted completely differently by two individuals affected by the same problems. Such an interpretation is influenced by the socio-cultural heritage and personality, and, in turn, is also reflected in subsequent behaviors, such as the search of therapeutic plans and adherence to these[8]. In short, the way the individuals explicit or not their complaints, seek or not resources to mitigate their problems, join or not to institutional plans is influenced by social representations.

As for the context, it is identified a discrepancy between the needs of individuals with voice disorders and the guarantees provided for in the Brazilian legislation and at the school system policies. The law does not recognize the voice disorder as being work-related[9], but still advocates therapeutic and periodic workshops of speech therapy for teachers. As for the school system policies, they develop prevention and care actions to mitigate the vocal illness, besides institutional practices that explicitly restrain absenteeism[10], such as a financial bonus for those who were not absent during a certain period, including absences for illness reason.

The aim of this study was to compare the social representations of the vocal disorder and the problem confrontation, developed by teachers in speech therapy.

Methods

In the methodological approach, we opted for the qualitative study to understand a reality that cannot be quantified. Qualitative research delves into the universe of meanings, reasons, aspirations, beliefs, values and attitudes[11].

There were eighteen semi-structured interviews with focus groups. The groups met municipal teachers diagnosed with voice disorders confirmed by the municipal occupational health service, under the program "Teacher Vocal Health", which includes periodic evaluations, workshops on voice, support of teachers on work leave and on functional rehabilitation and referral to treatment[12]. According to the protocol, the municipal teacher called by the occupational health service for otorhinolaryngological evaluation and speech therapy, when needed, is forwarded to voice treatment. The Speech Therapy Clinic of a university hospital is a reference to the public service of that population. Teachers recruited for the focus group were being assisted in this clinic at the time of the survey.

The university hospital authorized the research in the speech therapy clinic, issuing a statement that was sent to the Research Ethics Committee of the institution. The research project was approved (ETIC nº. 482/08), having complied with all the rules of Resolution CNS446 / 2011 of the National Health Council.

Information on the target population was obtained from clinical records. Of the 38 teachers recruited to the study, 20 refused to participate claiming time constraints. Finally, the intentional sample consisted of 18 teachers aged between 27 and 62 years, working in teaching between one year and returning to teaching after retirement, as well as different profiles of gender, education, vocal[13] deviation degree, adhesion or not the referral of medical expertise, number of shifts and positions at school.

All teachers were enrolled in therapy for vocal disorder, with weekly attendance, always at the same time and day of the week. Three participants

were male, six worked in a shift at school and three studied until high school completion. Most worked in two shifts as teachers (n = 12) and had higher education level (n = 6) and graduate studies (n = 9). At the time of research, the teachers worked in various levels of education such as early childhood education (n = 6), elementary (n = 12), high school (n = 3) and teaching youth and adults (n = 1). Three of these teachers also worked at the school coordination. In auditory perceptual voice assessment the following degrees of vocal deviation were found: a teacher with a neutral voice, nine with mild and five moderate. Three subjects were not considered because they did not attend on the date scheduled to start the treatment.

The selection and number of participants sought to reflect the universe identified in epidemiological survey conducted earlier[14]. Among the criteria for the composition of the sample, it was attempted not to be restricted to permanent workers of elementary school and to include male teachers.

To ensure the anonymity of the participants in the description of the results, it was assigned a number preceded by the letter F (female) or M (male) to each individual.

The recording of interviews produced through focus groups took place in 2009. The number of focus group was set after previous exploration of the field and its organization as well as the duration of sessions followed the literature information on the subject. Three groups were formed with an average of six participants. two meetings were held in each group, lasting about 60 minutes. The heterogeneity of participants and their opinions sometimes conflicting, a third meeting was scheduled with subjects from all groups for discussion and exploration of issues generated in the analysis of the material collected in previous meetings[15].

The interviews by means of the focus groups took place near the university hospital in a comfortable room, with privacy guaranteed and snacks were offered. The organization of the chairs, arranged in a circle, provided the visibility of those present, participation and group interaction. The sessions were recorded with the consent of participants.

The orientation script of the semi-structured interviews of the focus group, previously prepared, covered the following topics: a) voice change during the teaching career; b) definition and consequence of vocal disorder in personal and professional life; c) Interpersonal relationships at work as an effect of voice disorder; d) voice care experienced by the group; e) relations with the health service and with voice experts.

All the material was transcribed and analyzed based on the content analysis technique, more precisely the thematic analysis[16]. Thematic analysis is the best way to qualitatively investigate the health related material, since the theme of the concept refers to a statement about a certain subject. The theme is the meaning unit that naturally emerges from an analyzed text, respecting the criteria of theory that serves as a guide for this reading[17].

The stages of content analysis were organized in three stages: 1.Pre-analysis; 2. Material exploration; and finally 3. Result treatment: inference and interpreting[17].

Results

In the interviews, attention was drawn to the teacher's behavior of assuming the vocal symptoms after the confirmation of expert or clinical diagnosis, without considering the symptoms manifested and perceived earlier.

> [...] The only thing that bothered me is that I have allergic rhinitis and in the winter time I was hoarse ... during the examination I had nothing [...] (F5).
> [...] at some point of the day my voice become hoarse and I would attributed it to a cold [...] (M1)
> [...] I was already feeling I was tired [...] but now yes, at this time now, a year and a bit, I'm feeling that the voice has worsened [...] (F11)
> [...] I had never realized any change [...] after the medical examiner told me, I began to realize [...] (M3)

The teacher M2 spontaneously sought medical expertise, complaining of vocal alteration, but the diagnosis of dysphonia was not confirmed. Returning later for that service, the diagnosis was declared and the treatment was instituted.

> [...] I realized that for six years I have this change of voice, but two years ago it became more clear to me [...] she (the speech therapist) said my problem was psychological [...] (M2).

The representations of vocal disorder are manifested primarily in notions concerning *voice alteration* or *change*, which refer to the symptoms with specific auditory marker. However, the appropriate

manifestations of biomedical model were observed, such as *allergy, hearing loss* or *cold*, although more general notions of *problem* or *fatigue* have been identified. It is plausible that the difficulties of the teacher to notice the symptoms express barriers with regard to self-care, since the vocal symptoms are perceived as sporadic and transient.

The speeches of the teachers show that the perception of vocal disorder is anchored in both representations of the disease process and voice alterations not preventable at work, but the emphasis on the proper stance towards it occurs when this process is represented as a deterrent or prejudice to the professional practice.

> [...] it caught my attention in the sense of having to stop [teaching] to search for an expert (M2).
> [...] I had noticed it, I became more worried now that I really lost my voice, it's horrible, you try to communicate and you can't [...] Yes, I had noticed it, but it is that thing, you let it go [...] (F8)

Before the onset of vocal symptoms, all respondents expressed annoyance and concern when identified limitations in the use of voice. The appropriation of the biomedical model does not seem to be sufficient for the explanation of the problem, because it takes objective impediments for the confront, as seen in:

> [...] you begin to appreciate after you see the table with the physical issues [...] (M2)

M1 and F13 sought therapeutic use only when it was detected lesion on the vocal fold, despite the earlier perception of hoarseness and advice from colleagues about the need for treatment.

> [...] it is difficult to know when you are with a cold or with voice problem. (F13).
> [...] as my voice is louder I thought I would never have a problem [...] some people began to notice it. (M1)

Attention was drawn to the speech of a teacher who denied the presence of voice disorder, despite being set in a vocal rehabilitation: [...] they (speech therapists) noticed it... [...] I have no problem ... I think I'm getting deaf (F4).

It is noted that M1 assigns hoarseness to a cold, despite the warnings from co-workers for wear caused by heavy use of voice. The following statements explain ways to anchor the social representations of voice problem as losses in the course of conducting or other labor and social activities. In [...] not having a voice to maintain discipline (F2), what means for teachers "having no voice"? The speech alludes to the difficulties to develop the didactic and pedagogical strategies, as seen in:

> [...] She's losing the class management, she can't maintain discipline in the class because no one can understand what she says (F2);
> [...] You do not have command voice ... The voice problem has hampered me in this sense (F13);
> [...] We keep talking a lot, we have to explain the same thing all the time and anxious in want to make the boy understand it [...] (F5);
> [...] You do not do what you used to do before, to imitate three or four different voices in a story, not today, it's that reading [...] (F14);
> [...] I do not sing in the classroom, so the quality of the class is impaired [...] (F15).

The reports [...] I try not to talk, but there's no way out [...] (F3); [...] When it's recess time I'm almost dying [...] (F7); [...] Suddenly my voice disappears and I start talking weakly. Then I have to stop for a while [...] (F11), make it visible that teachers start to face the vocal problems when they anchor its representations in losses to the labor function, entailed by the failure to produce the voice on the required power.

Criticism of the occupational health service is also anchored in the notion of injury:

> [...] they do not go to schools [...] (F2),
> [...] it's very superficial ... so much that at the end of year, there are a number of teachers on medical leave [...] (F12).
> The losses to the career and the disadvantages of the medical leaves are cited:
> [...] suddenly do not take another job position, anyway, other legal problems that the City Council lays [...] (F8).

If, on the one hand, the benefits provided by the programs and voice workshops are mentioned - [...] I read the booklet ... I will reeducate myself [...] (F1) -; and for the vocal rehabilitation - [...] now the voice has greatly improved [...] (F1) -; barriers, on the other hand, indicate restrictions for declaration and recognition of the medical condition - [...] I have to go up there [...] (F2) - referring to the distance between the school and the periodic evaluation of the occupational health service; fear of

restrictions in the career due to medical certificate and leave - [...] there's no point in trying another tender (F14) -; and fear of being in the stage that requires speech therapy - [...] I took care of myself excessively so that I wouldn't be sent to the speech therapy ... distance, cost, out of the routine (F2).

As for the school management, the problem of replacing the sick teacher spontaneously emerged. Situations evoked in the teachers' discourse represent the institutional weaknesses to deal with the problem, generating an overload for teacher who will cover the absence of his colleague:

> [...] there are some teachers who have already arrived in the class for a replacement, cried and was no longer able to work on that day (F2).

The objectives of the school system are threatened because there is disturbance in the teaching-learning process when the teacher is replaced by another [...] The student loses the rhythm of classes, he feels that the school environment is always confusing (F5). All this generates school dropout: [...] we began to lose students due to lack of teacher, there is a shortage of teachers in all shifts [...] (M1).

Such replacement situations explain conflicts between colleagues:

> [...] So you see a lot, not enough to fight though, but that one colleague gossips against another colleague because one took leave and I was overloaded (M3);
> [...] I've already heard: [if I have to go to the classroom so that she can take a leave every day, I'll complain] (F13).

On the account of other teachers, referring to conflicts between co-workers, M3 was adamant: [...] the City Council stays cool and send the problem forward, they hand in the fight to the school [...].

In the other direction, F8 realizes the solidarity of colleagues: [...] because they know that the problem can happen to anyone, it's ok ... I opted to do speech therapy in the morning, not to hinder the work from school [...].

Teachers represent divergently the management position that focuses its actions on devices such as textbooks, tests, etc. For them there is lack of support when treatment requires removal because [...] there is no one to replace you [...] (F9).

The sick teacher goes on to rely on colleagues, expresses representations of the experiences of relationship problems in school and lives with the threat of reprimand before the failure to comply with the requirement of the managers.

> [...] it is as if we were guilty for having fallen ill, we are guilty of not knowing how to use the voice(F2).
> [...] it's not possible to change ... no one offers themselves to help, not even when the voice is worse [...] (F3).
> [...] they've already said it: change your profession [...] (F12)
> [...] only if you have a close friend, one helps the other (F13);
> [...] There's no additional for overtime work, there's no thanks, there's pressure and the threat of sending you to comptroller, if you do not do the substitution (F9).

The teachers feel blamed on the one hand, but are aware of the precariousness of working conditions on the other [...] it is really noisy (F1); [...] Many students per class (F7); [...] You have to pay for the microphone if you want one (F8); [...] I have a washcloth to pass on my desk [...] (F11). Teachers, even in the face of poor working conditions, develop strategies and adapt the demands of the classroom in view of the objectives of the education system. However, this situation can deteriorate to the point of exacerbating the disease state, generating successive work leaves.

The situation of students was mentioned [...] drug trafficking, the child may be drugged [...]. (F5); [...] Basic education comes from the family, but they are coming to us to be educated [...] (F6); [...] we have to win our shout [...] (M2). In this last comment, it is observed that the cause of vocal disorder is objectified in the concrete image of the shout, as an icon that gives visibility to the reality of power struggles in the interaction in the classroom.

Several representations of fear marked the suffering in the face of the declaration or the institutional recognition of illness: fear of leaving the profession, fear of losing the double shifts, fear of not passing the probation time successfully, fear of not knowing how to work, afraid of receiving the clinical diagnosis, afraid of not being able to recover the voices.

> [...] I went to work even when hoarse, I could not go to the doctor to get the certificate, there was the fear of losing the job (F1);
> [...] on my view, I had nothing, I was afraid [...] (F3)

> [...] when I lost my voice I said: I'm screwed. I'm lost, what will I do? [...] (F8)
> [...] I'm afraid I won't be able, I graduated to be a teacher. (F7)
> [...] and I was afraid because I had just started… to lose the double shift, they will dismiss me [...] (M2)

Sick and before generating situations of suffering, teachers reported the routine character of antidepressant self-medication in schools [...] By the way, who does not take it? [...] (F12). It is noted that the phrase was uttered in a low voice and by exchange of silent glances between teachers, revealing therefore the protection of their public image, to the extent that such disclosure jeopardizes their line of ethical conduct across the medical prerogative of medication prescription.

When the revelations broke out in groups, the emotions and the expression tone became clear in an environment with sharp discomfort marked by attempts at deterrence through jest or jokes like:

> [...] Teachers will be a luxury item [...] (F8)
> [...] depending on where I'm going to substitute I close my eyes, and if anything happens I call the coordination, which calls the direction, I call the SAMU (emergency mobile service), I call 190 (police)[...] (F2)

Discussion

The results bring clarification of the influence of the vocal representations about dysphonia confrontation, as postponing the declaration of the vocal problem. The strategy of focus groups does not allow the generalization of such relations, implying the need to conduct more comprehensive studies, with different methodologies. It is likely that the recruitment of subjects for focus groups in strictly institutional framework has caused selection bias, because at the Speech Therapy Clinic only teachers exclusively sent by the municipal occupational health service are seen.

Social representations of the voice disorder show a difficulty in perceiving or assuming the need to address the problem. Accepting the voice problem as natural or as sole consequence of a circumstance is frequent and may result in delay or absence of approach to the problem[18].

Study in Children's school context found no association between vocal alteration in clinical assessment and self-evaluation of educators[19]. It was found that the teachers do not refer only to voice quality in self-assessment, but also aspects such as difficulty in speaking loud or in the presence of noise, corroborating the present study. Reports in groups suggest the perception of the subject about their difficulty in communicating. The diagnosis was not always interpreted by the subject as confirmation of a disease. Personal experience and the finding of an impediment in the use of voice seem to have greater weight than the medical diagnosis.

The vocal symptoms are perceived by the teachers in the study as related to the use of voice at work, as well as a result of respiratory and hearing diseases. Postponing the search for assistance seems to be associated with representations of the symptom as episodic and due to illness. Such diseases, such as allergic rhinitis and deafness that were cited by participants, may be related to the work resulting from biological, chemical and physical risks in the working environment. It can also be cited as environmental risk factors present at schools noise in the classroom[20-21], as well as poor hygiene in the rooms, presence of contaminants in the work area, among others. Other factors such as psycho-emotional changes, anxiety and stress can also influence voice production, resulting in inadequate vocal adjustments[21], perceived by teachers in voice usage situation in the classroom.

Teachers use high vocal demand strategies in the classroom to meet the educational goals such as transmitting and memorizing the content, enhancing understanding of the topic, stimulating or restraining the participation of students, controlling indiscipline[22]. At the moment the use of voice hindered didactic and pedagogical strategies, the teachers participating in the began to recognize the disorder. In self-reports, descriptions of symptoms were not directly related to the disease process. The perception of the load of the work as the origin and evolution of the illness is not always apparent[23].

The impact of vocal disorders on quality of life seems to depend more on self-assessment of the subject on his vocal condition that on the conclusions of the examination of experts. There are reports on the actions of occupational health services of control and restrictions on work activities due to vocal illness with loss in the career, as well as the disorder generated in the school routine due to the need for occasional substitutions. Impediments and stressful situations perceived by teachers on identifying vocal symptoms can contribute to the denial

of voice disorder and treatment delay. The pressure suffered by the school board and by colleagues not to leave the unit, the priority in treating other health problems, and the dedication of care to another at the expense of their own health was mentioned in a qualitative study with teachers[24]. The authors identified a rigid and inflexible management structure still marked by weak social support devices, in addition to intense overload and wear.

Both education managers and health professionals doubt the veracity of the reasons that generate medical leaves in the group of teachers, assigning them to a sort of hysteria or irresponsibility[25]. Such attribution of causality shows possible anchor explanatory schemes of the biomedical model (hysteria) linked to a common sense of their own moral perspective (irresponsibility). It reproduces the worker's culpability with reflections on the social representation of the disease, which makes the subject responsible for his own illness.

Social problems situations experienced in school routine were mentioned by teachers. It is known that stressful situations at work are strongly implicated in the disease process and absence by voice problem[3], such as high demand associated with low control at work[26] and the experience of episodes of violence committed by students or parents of students[2]. The high wear at work to deal with stressful situations leads effort to control and not show fatigue, irritation, anger, compromising the physical and mental health of the teacher[26].

Extracurricular factors also modulate the teaching activity. According to teachers, parents have valued education more and are more demanding. Paradoxically, however, they value less the teachers and have less time to educate and monitor the children[27]. The devaluation of teachers and lack of social support to sustain its actions in dealing with students and their families in vulnerable situations (poverty, violence, drugs), help to strengthen the fear of teachers with health effects[28].

The barriers to the perception of voice problem by the teacher with consequent worsening of the clinical condition increase the injury at work[29]. The costs of health care, absence at the work due to voice problem and loss of productivity appears to be more frequent among teachers with more intense vocal symptoms and longer duration when compared to those with mild clinical picture[30].

Recognition of voice disorder as a grievance related to work becomes essential to give subsidies to actions for primary health care at schools aimed at vocal health of teachers. Educational activities and spaces with groups of teachers to disseminate knowledge about the conditions of vocal production in relation to aspects of the environment and work organization are expected[24].

The institutional recognition of vocal disorder is represented in terms of social and affective losses for teachers, making indefinite future life projects. Judging by the results, it would be reasonable to ask whether the social consequences following the confirmation of the diagnosis do more harm than the actual dysphonia.

The reports of the 18 teachers show social representations that undervalue vocal symptoms. Such undervaluation is associated with anchoring of the concepts related to vocal disorder from two different discursive fields: the domain of the institutional model, which, although developing positive actions, restrains absenteeism and does not equip the management to reverse the induced disturbances in face of disability to the work; and the medical discourse of the field, which emphasizes the biological aspect, individual, in the process of falling ill.

Conclusion

We identified a paradox between the presence of vocal symptoms and the inability to work and the denial or avoidance of voice problem statement. Converging to literature contribution, the symptom statement is not immediate to its clinical expression, or in spite of declared or assumed such symptoms are relegated to the background by the teachers themselves.

The disease and symptoms influence the teacher's ability to respond to the demands of education and the requirements of the administration. The development of actions to prevent and to promote vocal health will benefit if the social representations of dysphonia is considered.

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