CoDAS
ISSN 2317-1782 (Online version)

Original Article
Artigo Original

Quality of life of aphasia subjects participating in an interdisciplinary group

Qualidade de vida de sujeitos com afasia participantes de um grupo interdisciplinar de convivência

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Keywords

Quality of Life
Aphasia
Interdisciplinary Placement
Health Care
Social Participation
Health Equity

ABSTRACT

Purpose: To analyze the Quality of Life of subjects with aphasia participating in an Interdisciplinary Living Group. **Methods:** cross-sectional and quantitative study. Convenience sample submitted to two questionnaires: a semi-structured one, developed exclusively for the characterization of the subjects and the World Health Organization Quality of Life Scale - Bref (WHOQOL-Bref) to identify their Quality of Life (QOL). Data analysis was descriptive. **Results:** Eight subjects were interviewed, aged between 35 and 78 years and schooling between Incomplete Elementary School and Incomplete Higher Education. The predominant occupation was that of a clerk and the income varied between one and four minimum wages. The time of brain injury was from three to 10 years, caused predominantly by Stroke caused by Systemic Arterial Hypertension. As for WHOQOL, there was an important variation between the subjects in the four domains (physical, psychological, social and environmental). However, most scored above 70 points. For all subjects, the Living Group was identified as a space for the production of life and health, motivating them to seek other services. **Conclusion:** The subjects were adults and elderly people belonging to the lower-middle class; presented chronic health conditions, impaired verbal expression and long monitoring time to their health needs. The WHOQOL-Bref revealed that five subjects perceived their favorable living/health conditions, however, they highlighted reduced social contact. The Living Group became an important space for improving QOL.

Descritores

Qualidade de Vida
Afasia
Práticas Interdisciplinares
Atenção à Saúde
Participação Social
Equidade em Saúde

RESUMO

Objetivo: Analisar a Qualidade de Vida de sujeitos com afasia participantes de um Grupo Interdisciplinar de Convivência. **Método:** estudo transversal e quantitativo. Os participantes foram submetidos a dois questionários: um semiestruturado, desenvolvido para a caracterização dos sujeitos e o outro o *World Health Organization Quality of Life Scale – Bref* (WHOQOL-*Bref*) para identificação da Qualidade de Vida (QV) dos mesmos. A análise dos dados foi realizada de modo descritivo. **Resultados:** Foram entrevistados oito sujeitos com idade entre 35 e 78 anos e escolaridade variando entre Ensino Fundamental Incompleto e Superior Incompleto. A ocupação predominante na amostra foi a de balconista e a renda variou entre um e quatro salários mínimos. O tempo de lesão cerebral variou de três a 10 anos, causada predominantemente por Acidentes Vasculares Cerebrais decorrentes de Hipertensão Arterial Sistêmica. Quanto ao WHOQOL houve importante variação entre os sujeitos nos quatro domínios (físico, psicológico, social e ambiental). No entanto, a maioria pontuou acima de 70 pontos. Para todos os sujeitos, o Grupo de Convivência foi identificado como espaço de produção de vida e saúde sendo motivador para a busca de outros atendimentos. **Conclusão:** Os sujeitos eram adultos e idosos pertencentes à classe econômica média baixa; apresentavam condições crônicas de saúde, comprometimento da expressão verbal e longo período de acompanhamento das necessidades de saúde. O WHOQOL-*Bref* revelou que cinco sujeitos perceberam suas condições de vida/saúde favoráveis, no entanto, destacaram convívio social reduzido. O Grupo de Convivência configurou-se como importante espaço para melhoria de QV.

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Received: January 29, 2020

Accepted: October 30, 2020

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Financial support: nothing to declare.

Conflict of interests: nothing to declare.

INTRODUCTION

Quality of Life (QOL) can be understood, among several definitions, as the perception of the human being in relation to his position within the context in which he lives, including culture and values that guide his goals, standards and expectations. In the last century, it has steadily improved and supported, in most countries, political, economic, social and environmental advances, as well as advances in public health in general(1-3).

Therefore, it is a concept related to the subjective perception of aspects of life and it interacts with the physical, functional, psychological and social dimensions(3) of each and every person. Many authors(1-5) emphasize that studies on QOL need to consider, necessarily, the individual perception of the subject himself, thus allowing subjective aspects to reveal the states or the life/health needs of those ones submitted to QOL assessment.

There are numerous ways to assess QOL in the context of health impairments and the instruments vary according to the theoretical approaches and the objectives of the studies(6). For example, the Medical Outcomes Study Questionaire 36-Item Short Form Health Survey (SF-36)(7), the Health-Related Quality of Life (HRQoL)(8), the Stroke Specific Quality of Life (SS-QOL)(9), the Stroke and Aphasia Quality of Life Scale-39 (SAQOL-39)(10). Including, there are even some studies(11-13) that used these instruments in aphasic populations, in order to produce comparative scales and, also, analyzed QOL in caregivers and/or family members of subjects who present aphasia.

Although there are countless determinations, there is no definition of QOL that is widely accepted(14) due to the fact that analyzing QOL does not only include factors related to health, such as physical, functional, emotional and mental well-being, but also other information that are important to people, such as work, family, friends, and other everyday circumstances, always considering that the personal perception of whom is intended to investigate is essential(6).

However, the World Health Organization Quality of Life Assessment Instrument (WHOQOL)(15) stands out, as it was developed by the World Health Organization (WHO), after a long period of discussion among researchers from all over the world, who were engaged in producing an instrument that could assess the QOL of subjects from the most varied cultures and living/health conditions. Such effort resulted in an instrument with 100 questions that, subsequently, enabled the production of a reduced version - The World Health Organization Quality of Life Assessment Instrument Bref (WHOQOL-Bref)(16) - widely used today and, therefore, adopted in our study.

Considering the attested validity and psychometric quality, as well as the universality of the WHOQOL-Bref(16), it is recommended that such questionnaire would be used to assess QOL of any and all people, regardless of their condition or health needs. In this sense, it was considered pertinent to use it in the case of aphasias, historically characterized as language disorders that bring impossibilities or communicative difficulties associated with motor and/or sensory impairments. According to a discursive perspective(17), regarding afasias, the different linguistic levels are affected in their productive aspects, (production of speech and/or writing) and/or interpretive aspects (understanding/ recognition of oral and/or written meanings), being caused by some type of acquired injury, usually resulting from Stroke, Traumatic Brain Injury (TBI) and even tumors.

It is believed that subjects with aphasia need speech therapy and, also, other health professionals help, respecting their linguistic-cognitive, psycho-emotional, social and physiological characteristics. This understanding comes from the fact that each person with aphasia is considered to deal with their deficits in a unique way and, as a consequence, the need to listen attentively to the singularity and beyond the symptoms(18). It is noteworthy that the health care of individuals with aphasia can be at the individual and/or group level. Therapeutic and/or coexistence groups tend to be opportune to be developed with such subjects(19,20), aiming at an attention that responds to the multiple factors that influence the leading of their lives; among these, the comorbidities resulting from brain injury and their impacts on QOL.

Therefore, the objective of this study, in the same perspective as described above, was to analyze the QOL of subjects with aphasia who were participating in the Interdisciplinary Living Group (ILG).

METHODS

It is a cross-sectional study, of a quantitative character and analysis by proportionality. This study is one of the results of a research approved by the Research Ethics Committee of the University where it is developed, under the number 2.732.475. The sample was composed by convenience, being characterized by a sampling method in which the possibility of choosing a certain element of the population is unknown, that is, the sample items are selected because they are more accessible(21), having been invited subjects with aphasia, participants in the Interdisciplinary Living Group (ILG). Currently, ILG has 12 subjects (adults and elderly people) with aphasia, but only eight subjects participated, considering, as an inclusion criterion, attendance in the group.

It is important to clarify that the ILG is an Extension Program for the Speech, Hearing and Language Sciences Major, from a Federal University, being this program created in 2010 and, since then, it has followed, through weekly sessions of three hours, people affected by brain injury who present aphasias, among neurological sequelae. The activities developed are interdisciplinary (with undergraduate students and professionals of Speech, Hearing and Language Sciences, Psychology and Occupational Therapy, for example), and they were guided by three moments: 1st) Wheel of novelty (when all participants tell something that happened during the week, which can be personal or covered in written, television and/or digital media); 2nd) Snack (space for food and more conversation between the participants) and 3rd) Interdisciplinary activities, which were chosen by the participants at the beginning of each semester, among them: writing, reading, interpretation and dramatization of poetry or other discursive genres; singing and dancing; motor circuits, mathematical calculations, among other cognitive games and craft activities. The objective of ILG is, therefore, to act on the multiple aspects involved in health, based on social interaction and the “living exercise of language”(17).

Data collection occured between May 2019 and June 2019, after the completion of ILG activities, in an undisturbed location, on average, lasting 30 minutes. The subjects received guidance on the objectives and procedures of the research, as well as consented to their participation by signing the Informed Consent Form (ICF). All subjects presented comprehension, clarity, motor and cognitive conditions to answer the questions, read by the applicators.

Initially, and individually, the subjects answered a semi-structured questionnaire, containing the following information: age, sex, marital status, education, occupation, family income, if they were the main provider of the family, number of residents in the house and if they received some kind of social benefit.

In addition, the questionnaire asked about health impairments: cause, type and time of brain injury, post-injury impairment and need for help with activities of daily living. At the same meeting, WHOQOL-Bref(16) was applied. Such application occurred without the collaboration of the caregiver and/or family member, precisely to give evidence to the perception of the subjects with aphasia, following the theoretical and methodological assumptions that guide ILG meetings.

WHOQOL-Bref(16) has 26 questions that address four domains: physical, psychological, social relationships and the environment. The scores indicate the perception of the subject regarding his QOL, so that the closer to 100, the better his QOL(15,16); is; the desirable reference average is 70. The answers are in Likert Scale and indicate: intensity (“nothing” to “extremely”); capacity (“nothing” to “completely”); frequency (“never” to “always”) and evaluation (“very dissatisfied” to “very satisfied” or “very bad” to “very good”)(22).

The physical domain researches aspects related to physical pain and discomfort, dependence on medication/treatment, mobility, sleep and rest, energy and fatigue, performance in activities of daily living and ability to work. For the psychological domain, there are questions related to: positive and negative feelings, spirituality or personal beliefs, condition of learning, memory, concentration, acceptance of body image/appearance and self-esteem. As for the social domain, the questions are aimed at personal, sexual relationships and social support. The environment domain has issues that research the healthiness of the physical environment, financial and information resources, leisure, home environment, access to health and transportation services(22).

RESULTS

Table 1 shows the sociodemographic characteristics of the subjects with aphasia participating in this study.

It is possible to note that of the eight subjects, four subjects were male; aged between 35 and 78 years (mean age of 58.75 years), half of the subjects was 60 years old or older. Regarding marital status, the majority (5/8) were married, 2/8 single and 1/8 divorced.

Education ranged from Incomplete Elementary School (2/8) to Incomplete Higher Education (1/8); it is emphasized that only one of the subjects had complete elementary school, 2/8 incomplete high school and 2/8 complete high school. The prevalent occupation was that of a clerk (3/8); the condition of job execution varied between employees (5/8, being 3/8 in commerce, one in a private company and the other in the public sector) and self-employed (3/8). Personal income was between one and four minimum wages; only one subject received a salary; 5/8 received approximately two and 2/8 four minimum wages. Regarding the financial benefits received, it was obtained that 3/8 of the subjects were retired due to disability (due to stroke) and 4/8 due to working time/contribution and/or age. The majority (6/8) of the subjects remained the main provider of family support.

Table 2 shows the health conditions and needs of the subjects in this study, according to their own points of view, highlighting the causes and sequelae of the neurological episode.

Note that stroke, caused by Systemic Arterial Hypertension (SAH), was the main cause (7/8) of the injuries that resulted in aphasia; only one subject suffered TBI. All subjects complained of communication difficulties (speaking and/or writing); the majority (6/8) complained of body balance and one reported visual difficulties. The majority (6/8) had independence in ADL.

Table 1. Sociodemographic characterization of subjects with aphasia participating in ILG (n = 8)

Variable	S1	S2	S3	S4	S5	S6	S7	S8
Gender	Female	Female	Male	Male	Male	Female	Female	Male
Age	60	35	56	69	65	49	58	78
Marital status	Married	Single	Married	Divorced	Married	Single	Married	Married
Schooling	CHS	IHE	CHS	IHS	IHS	CES	IES	IES
Occupation	Accountant	Clerk/Student	Driver	Cherk	Bank clerk	Clerk	Homemaker	Truck driver
Social Benefit	No	R/D	R/A+TC	R/A+TC	R/A+TC	R/D	R/D	R/A+TC
Family Income (R$)	2.400.00	Not mentioned	4.000.00	1.500.00	4.000.00	998.00	1.030.00	2.500.00
Main provider	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Number of residents	3	4	3	1	4	1	9	2

Caption: S: Subject; IES: Incomplete Elementary School; CES: Complete Elementary School; IHS: Incomplete High School; CHS: Complete High School; IHE: Incomplete Higher Education; R/D: Retired due to Disability; R/A+TC: Retired by Age and Time of Contribution

Table 2. Characterization of health impairments - general and neurological - and the care accessed by subjects with aphasia according to themselves

	S1	S2	S3	S4	S5	S6	S7	S8
Type of Brain Injury	Stroke.	TBI	Stroke	Stroke	Stroke	Stroke	Stroke	Stroke
Post-injury sequelae	Speaking	Speaking; Eq.	Walking; Eq.	Speaking; Reading; Eq.	Walking; Speaking; Comp.; Reading; Writing; Eq.	Walking; Speaking; Eq; Seeing;	Walking and Speaking	Walking; Speaking, Eq.
Injury time	5 years	10 years	5 years	9 years	9 years	8 years	3 years	10 years
Aid for ADL	No	No	No	No	No	Yes, but little.	No	No
Cause of brain injury	SAH	C.A.	SAH	SAH; DM	SAH	SAH	SAH	SAH

Caption: S: Subject; TBI: Traumatic Brain Injury; Eq.: Equilibrium; Comp.: Comprehend; ADL: Activities of Daily Living; SAH: Systemic Arterial Hypertension; C.A.: Car Accident; DM: Diabetes Melittus

Table 3. Neurological diagnosis, linguistic-cognitive and behavioral conditions (n = 8)

	S1	S2	S3	S4	S5	S6	S7	S8
Diagnóstico Neurológico								
Type of Aphasia	Motor	Conduction	Motor	Sensorial	Sensorial	Conduction	Conduction	Motor
Cognitive Processes								
Oral Language	Hesitations; Anticipations; Self-corrections.	Long breaks; Lapses; Slowdown.	Perseverations; Anticipations; Self-corrections.	Lapses.	Phonetic disintegration.	Long breaks; Lapses.	Long breaks; Lapses.	Perseverations; Anticipations; Self-corrections.
Written language	Erasures; Refractions.	Erasures; Refractions.	Erasures; Refractions.	Preserved copy; Irregular writing.	Preserved copy; Irregular writing.	Erasures; Refractions.	Erasures; Refractions.	Erasures; Refractions.
Sign language	Preserved.	Preserved.	Preserved.	Preserved.	Pouco comprometida	Preserved.	Preserved.	
Attention/ Concentration	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.
Gnosia	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.
Memory	Preserved.	Little compromised	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.	Preserved.
Logical reasoning	Preserved in 3 or 4 digits	P Preserved in 3 or 4 digits	Preserved in 3 or 4 digits	Preserved in 2 digits	Preserved in 2 digits	Preserved in 1 digit	Preserved in digit	Preserved in 3 or 4 digits
Behavior	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate

Caption: S: subject

In addition to the data above, it was verified that all subjects were accompanied by a neurologist, speech therapist and occupational therapist; 3/8 accompanied by a physiotherapist. The lowest index of physical therapy assistance was due to the fact that the subjects had already overcome difficulties in terms of walking.

The time of brain injury ranged from three to ten years (average of 5.5 years) and the time of participation in ILG from two to ten years (average of 5.62 years). It is noteworthy that 4/8 subjects started their participation in the ILG between ten and eight years ago; 3/8 subjects started five years ago and only one started two years ago. For 7/8 subjects (except S2), ILG was the first group where they received care focused on neurological sequelae and, for all, the place that encouraged them to participate in other treatments and therapeutic groups.

Table 3 shows the diagnosis attributed by a neurologist to each subject, the identification of the most striking epilinguistic operations(23) presented by the subjects, as well as the manifestations of other cognitive and behavioral processes, apprehended in the interaction between subjects with aphasia and without aphasia. Therefore, linguistic-cognitive and behavioral aspects apprehended in the social/group interaction are presented, not resulting from formal evaluations.

Note that 3/8 subjects had a neurological diagnosis of motor aphasia, an equal number had conduction aphasia and 2/8 had sensory aphasia. Regarding the linguistic aspects, it was verified that 3/8 subjects presented, in speaking, hesitations, anticipations, phonemic perseverations, as well as self-corrections or cadenced speech to circumvent the phonoarticulatory difficulties. Long pauses and lapses (anomalies or semantic paraphasias), were the most striking characteristics of 4/8 and phonetic disintegration the characteristic of a subject.

Written and reading production was possible for 6/8 subjects, despite their erasures and refractions. Two subjects had many restrictions on copying, writing and reading.

Table 4. Distribution of WHOQOL-Bref scores for each participant, for each domain and total score (n = 8)

SUBJECT	PHYSICAL DOM.	PSICOLOGICAL DOM.	SOCIAL DOM.	ENVIRONMENTAL DOM.	QOL
S1	85.7	79.2	66.7	65.6	74.3
S2	67.9	79.2	58.3	78.1	70.9
S3	96.4	91.7	100.0	93.8	95.5
S4	85.7	79.2	75.0	81.3	80.3
S5	60.7	70.8	83.3	81.3	74.0
S6	35.7	62.5	66.7	59.4	56.1
S7	82.1	66.7	66.7	62.5	69.5
S8	67.9	83.3	58.3	81.3	72.7

Caption: S: subject; DOM.: domain; QOL: Quality of Life

All subjects presented and understood sign language well, which is used as a substitute or a means of accompanying orality. One subject had less significant sign language, requiring more negotiation of meaning.

Attentional and gnostic processes (auditory ones and non-verbal visual ones), as well as mnemonics, were preserved in all subjects, except the last ones in one subject. 4/8 subjects were able to perform basic mathematical operations with three and four digits, 2/8 with two digits and 2/8 with one digit. All subjects presented adequate behaviors in social life.

Table 4 shows WHOQOL-Bref scores(16) achieved by each participant, in each domain and in general.

There was an important variation in the scores of the subjects in different domains and in general. For half of the subjects, the scores in the physical domain were above 80; however, there was a great difference between the score given by S3 (96.4) and by S6 (35.7).

In relation to the psychological domain, the scores were above 70 for the majority (6/8) of the subjects, reaching a mark above 90 in the case of S3 and slightly above 60 in the case of S6. It is noteworthy the fact that 3/8 scored equally in this area.

Regarding the social domain, scores below 60 were obtained in the cases of S2 and S8. S3 indicated maximum satisfaction related to this domain.

On the other hand, for the environment domain, 5/8 presented scores above 70, while 2/8 presented around 60 points and 3/8 with the same score (81.3). S3 stands out, again, maintaining a score above 90 points in this domain.

DISCUSSION

The characteristics related to gender (half men and half women) and age (between 41 and 68 years old at the time of the neurological episode) of the subjects in this study, do not coincide with the data found in a documentary research on the epidemiology of stroke carried out in the database of the Unified Health System - DATASUS - corresponding to 2014(24), which revealed that 56.27% of hospital admissions were due to men with stroke and 43.73% to women. However, it is close to the data of a prospective study carried out in a multicenter hospital in Fortaleza(25) that identified a percentage of 51.8% in females.

It should be noted that stroke was the main cause of aphasias, in particular ischemic stroke, which tends to have a lower mortality rate. This data corroborates those who indicate strokes as important public health problems (national and international) in recent years, alongside TBI, since they produce high expenses with hospital admissions(24,25) and with the disabilities resulting from losses in motor functions, language and other cognitive processes, limitations in activities of daily living, depression and restrictions on social interaction(8-10).

In relation to the education of the subjects affected by stroke, and consequently by aphasias, researches(4,26,27) relate them to low or no education, indicating a strong influence of the lack of information on the basic diseases of stroke (Systemic Arterial Hypertension, Diabetes Mellitus, physical inactivity, for example) and/or health problems caused by them.

The subjects in this sample, except for two who did not complete elementary school, presented average schooling; however, such a condition did not remove them from the risk factors of preventable chronic health conditions that tend to be associated with neurological injuries(26,27). It should be noted that chronic health conditions related to the cardiovascular system, in most cases, can be avoided by adopting healthy habits such as: regular practice of physical activities, a balanced diet and, above all, avoidance of alcohol and tobacco consumption(25).

It is recognized and argued that behavioral change for healthy lifestyles is a major challenge for the prevention of health conditions and it depends on the commitment of people, in general, and, basically, on the performance of health professionals. It is known that to increase the effectiveness of the aforementioned change process,it is important to take into account the cultural context, the motivation of people and the development of autonomy(12,27), facts certainly associated with health determinants and conditions, for example, the access to work and income, aspects which were already discussed.

With regard to the economic conditions exposed by the subjects, it can be mentioned that they are not very precarious: the oldest ones, current providers of their homes, had been employed and were retired (age and time of contribution) with remuneration equal or less. higher than two minimum wages (income per capita between R $ 800.00 and R $ 1,500.00) -, while those of working age were retired due to disability with a minimum wage (considering that they were not the main providers of their homes). However, this situation is not showed in other studies that found an income less than or equal to a minimum wage(11,12,26).

It should also be noted that the situation of young people (retired due to disability), in addition to producing personal and family impacts (to be discussed later) tends to burden the social security system(4). Alongside this, there are higher expenses with health care for people with brain injury. It is worth remembering that the financial income of all participating subjects would not be sufficient for specialized care outside the public health system. A study(28) which indicated a high rate of people with brain injury monitored in the public system stands out, since the costs of therapeutic treatments in the short and long term are high.

In relation to data related to health conditions and needs, as well as the therapeutic treatments of the subjects, it is possible to mention that they are compatible with studies carried out at hospital level(24,25,29), outpatient level(11) or primary care level(29). Listening to the subjects in their complaints, regarding access to therapeutic care essential to deal with neurological sequelae and how they have led their daily lives, through the application of the WHOQOL-Bref(16), it was possible to identify the coping differences regarding the difficulties to communicate (through speech, writing and/or gestures) and to develop their ADLs.

Regarding the general QOL scores of the participating subjects, a great variation was detected - 95 points to 56 points. It can be mentioned that the physical and environmental domains were the ones that most impacted this variation. It is also possible to mention that those who presented the physical domain as the best were those who, even with SAH, difficulties to speak, read, balance, had better access to services and better living conditions (environmental domain). Furthermore, the subjects with the highest scores in the physical domain did not need help to perform the ADLs.

ADL independence was also identified by those with the worst scores in the social domain. Such variation, perhaps, is due to family income, since two subjects who considered the social domain as better, had better incomes. By the way, a study(30) carried out with the population of users of Basic Health Units (BHU), with different health complaints, also had better income associated with better QOL and vice versa.

Even in the case of the worst score in the social domain, one can consider the influence of the time of the brain injury - it can be inferred that the chronicity of the state of health imposed by the brain injury tends to keep subjects away from the extended social life, leaving group therapeutic spaces as the only living options, as found in the speech of S7 about ILG:

> [...] *it is a treatment that I like a lot, they treat me well. They are young, but they understand me, they do not make fun of me when I say wrong, it is another family* [...]. (S7; 06/05/2019).

Such testimony highlights what Santana(19) mentions about group therapeutic practice in aphasias. According to the author, the group is configured as a potential space for the subject to place himself discursively, with space for the expression of his subjectivity and his linguistic conditions. Then, it can be said that group interaction is a privileged place to capture the perception of the subject in relation to his position in life, that is, the cultural context (value system) in which he lives in order to establish his goals, expectations, standards and concerns(17,19,20). Analyzing the QOL of subjects with aphasia can favor analyzes of each domain present in WHOQOL-Bref instrument(16), which can sometimes contribute to the effectiveness of a more humanized and co-responsible care process.

This study revealed that similar health problems - brain injury and its sequelae - were interpreted differently by each participating subject. He stressed the importance of applying and analyzing WHOQOL-Bref scores(16) from time to time, with subjects with aphasia, in order to update and expand health care and, above all, to give the subjects the opportunity to perceive themselves as people who have needs and who can analyze their life contexts (family and therapeutic ones) and act on them in a more active and autonomous way.

CONCLUSION

This study allowed us to make an analysis of the QOL of subjects with aphasia participating in a coexistence group, belonging to the lower-middle class. Such subjects presented chronic health conditions and impaired verbal expression, as well as a long period of monitoring their care needs; also, the majority had favorable QOL indexes.

It can be ensured that the physical, psychological, social and environmental domains that make part of WHOQOL - Bref are potent to effectively reveal the QOL of subjects with aphasia. Then, the convenience of always taking into consideration the subjective perception of subjects with aphasia about their life/health needs was evidenced. It was also evident the importance of offering care to subjects with aphasia who favor social interaction (as in the case of therapeutic and social groups).

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CDM responsible for data collection, data tabulation, statistical analysis, preparation and revision of the manuscript; MB responsible for data collection, data tabulation, statistical analysis and preparation of the manuscript; GRB responsible for data collection and preparation of the manuscript; VAVSF responsible for reviewing the manuscript; EF responsible for preparing and reviewing the manuscript.