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Original Article

The Experience of Speech-Language Pathologists in Hospitals and Community Rehabilitation Centers: Do the care practices change?

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ABSTRACT

This work seeks to characterize speech therapy practices in two public health care contexts in Chile (hospitals and primary care - community rehabilitation centers). It is a qualitative study with a micro-sociological approach, in which in-depth interviews and non-participatory observations were performed on two speech-language pathologists working in Community Rehabilitation Centers (CCR), and two who work in public hospitals. The data obtained were analyzed using tools from Grounded Theory, and a conceptualization was proposed based on similarities and differences between speech therapy practices, using the ATLAS-ti software. The following categories emerged from the analysis: role of the professional, subject of care, therapist-user relationship, physical space and organization of the session, and participants. The main finding is that all the professionals mention the relevance of considering psychosocial aspects in the approach they use for therapy. However, such incorporation was not evidenced in the practice of any of the speech therapists during participant observation. The results allow us to conclude that the conceptualization of speech therapy is built mostly from the work context. Furthermore, the models of care that are at the base (biomedical-biopsychosocial) are currently in a process of hybridization, the practice of speech-language pathologists being inserted and also influenced by the work context.

Keywords:
Speech Therapy; Rehabilitation; Public hospitals; Primary health care; Scope of Practice

Experiencias de fonoaudiólogos/as en hospitales y Centros Comunitarios de Rehabilitación: ¿se modifica la práctica de atención?

RESUMEN

El presente trabajo busca caracterizar las prácticas fonoaudiológicas en dos contextos de atención de la salud pública chilena (hospitalario y atención primaria - centros comunitarios de rehabilitación). Es un estudio cualitativo con enfoque micro-sociológico, que implicó la realización de entrevistas en profundidad y observaciones no participantes a dos fonoaudiólogos/as insertos en Centros Comunitarios de Rehabilitación (CCR) y dos fonoaudiólogos/as insertos en hospitales públicos. Los datos obtenidos se analizaron con herramientas de la Teoría Fundamentada y se propuso una conceptualización basada en semejanzas y diferencias de las prácticas fonoaudiológicas utilizando el software computacional ATLAS-ti. Del análisis surgen las siguientes categorías: rol del profesional, sujeto de atención, relación terapeuta-usuario/a, espacio físico y organización de la sesión, los/las participantes. Además, el principal hallazgo refiere a que todos/as los/las profesionales mencionan la relevancia de incorporar matices psicosociales en el abordaje que realizan. Sin embargo, en la práctica de todos/as los/las fonoaudiólogos/as durante la observación participante no se evidencia dicha incorporación. Los resultados permiten concluir que la conceptualización del quehacer fonoaudiológico se construye mayormente a partir del contexto laboral. Asimismo, los modelos de atención a la base (biomédico-biopsicosocial) se encuentran actualmente en un proceso de hibridación, siendo la práctica de los/las fonoaudiólogos/as situada y también influida por el contexto laboral.

Palabras clave:
Fonoaudiología; Rehabilitación; Hospitales públicos; Atención primaria de salud; Alcance de la Práctica

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INTRODUCTION

The training and activities of Speech-Language Pathologists (SLPs) are diverse when it comes to the contexts of care for the adult population in Chile (Espinosa et al., 2014). This means that it is conceived in a myriad of forms, and it is exercised in diverse territories, contexts, and realities. Moreover, several models are used that provide a rationale and structure to health care, among which we can find the biomedical and biopsychosocial models (Juárez, 2011).

Speech therapy in Chile has been developed mainly according to the biomedical model. Due to this, the discipline has had a focus on disorders until now, relegating the person, their family, and their context to the background (Brahm, 2014; Simmons-Mackie & Kagan, 2007). In this model, the professional is seen as superior in their knowledge, since they provide answers in a unidirectional manner without necessarily establishing a bond with the person or family with whom they work (Baeta, 2015; Tapia Saavedra, 2013).

The biopsychosocial model has been integrated in the International Classification of Functioning, Disability, and Health (ICF), proposed by the World Health Organization (WHO) and approved by the World Health Assembly in 2001 (Vergara, 2010). This model proposes that the subject (patient-user) is the one who identifies the problem and actively involves their family context in the therapy process, thus being seen as an active entity whose shaping as a person is determined by psychosocial factors (Brahm, 2014; Ibarra Peso et al., 2012). Due to the above, it is relevant that the professional acquires and handles strategies to work with service users, their families, and communities, focusing on their quality of life.

Community-Based Rehabilitation (CBR) proposes that the user and their family are active agents in the therapy process. Thus, it brings rehabilitation closer to some territories and equalizes access to it, not just considering health but also the other components of the CBR matrix. Said components are: education, livelihood, social, and empowerment (World Health Organization [WHO], 2012).

In Chile, CBR has been incorporated as a requirement into primary health care, mainly in Community Rehabilitation Centers (*Centros Comunitarios de Rehabilitación*, CCR) (Baeta, 2015). In recent years, SLPs have attempted to facilitate the promotion, prevention, and education in communication, in all the contexts in which they perform their role (Silva Ríos et al., 2020). This is reflected in their work in primary health care, where they position themselves mainly as communication rehabilitators (Silva Ríos, Escudero, et al., 2018). However, the context, labor structures, and national policies have hindered this progress. This is observed in the fact that the professionals working in primary health care continue to apply the biomedical model (Silva Ríos, Escudero, et al., 2018; Tapia & Carreño, 2018).

The aforementioned is related to the unquestionable link between speech therapy and the biomedical model during the academic training of said professionals. According to Serra (2008), the health situations presented during academic training are distorted, that is to say, a technical perspective with specialized language is used, alienating the therapist from the user. This is based on the fact that undergraduate education does not provide the students with sufficient skills nor knowledge to intervene actively and efficiently in complex social contexts. Such contexts demand that the professional carry out fieldwork, understanding all the social barriers and facilitators that surround the user during the evaluation and therapy processes (Ithurralde et al., 2019).

Undergraduate training is a fundamental pillar of the SLP's work. However, in order to translate the knowledge into concrete actions in the workplace, it is essential to consider the organizational structure and the public policies associated with the role of SLPs in the center where they work. It has been observed that while the professionals show soft skills and knowledge about social issues, the organizational structures are imposed on professional action, overshadowing their ideals, interests, or knowledge (Silva Ríos, Escudero, et al., 2018).

During the past years, there has been an attempt to use academic training to enhance humanistic and social aspects, where the identity and profile of the future professional are oriented towards working on communicative wellbeing. According to Romero (2012), communicative wellbeing is understood as an "adequate adaptation and integration of the physical, psychological, social, spiritual, and emotional dimensions to any level of health need" (p. 102). Based on this description, speech therapy is conceived as a support process that involves "therapeutically acting in a comprehensive way in cooperation with other relevant actors, considering context, diversity, and human rights …" (p. 105).

In our current health care system, the speech therapy practice is different depending on the context where it is carried out. Despite recognizing the existence of differences between practices, there is not a characterization that provides evidence of this fact. To achieve such characterization, it is necessary to analyze and compare speech therapy practices between different health care contexts, considering the actions as well as the underlying theoretical model. This would provide the material to allow a

discussion about the pillars on which the work of an SLP is built (Vega Rodríguez et al., 2017). Furthermore, knowing the approaches, modes of action, and practices developed by SLPs in their work context makes it possible to exhibit facts, and to contrast what the professionals do with what they should be carrying out, based on the theoretical models that guide their practice.

Based on the aforementioned, the objective of this research is to characterize the work experiences of speech-language pathologists who work in CCRs and public hospitals of the Metropolitan region of Chile. To achieve this objective, the following research questions are proposed: 'What are the characteristics of speech therapy practices in two hospitals and two primary care centers (CCR)?' and 'Which health care models respond to those practices?'

METHODOLOGY

This work was carried out using a qualitative methodology, which involves inquiring and describing social actions or behaviors, attempting to obtain answers in a micro-sociological context. That is to say, knowing how certain day-to-day behaviors are developed through ethnographic resources (Sosa, 2019). The epistemological perspective that supports this research is the hermeneutic-interpretative tradition, where social issues are built on a set of shared and related meanings. Said meanings provide sense and belonging to a social context, known as everydayness (spaces where the process of understanding happens). In addition, meanings deliver guidelines and models to interpret individual and collective action (Vasilachis, 2006).

The sample was obtained by convenience and it was intentional. According to this, the researcher selects the participants according to strategic personal criteria, mainly based on knowledge of the situation, and willingness (Andréu, 2000). Thus, the theoretical sample was formed by 4 professionals from different districts of Santiago. Two were SLPs inserted in CCRs, with experience in CBR, and the other 2 worked in public hospitals. All the participants had kept direct contact with their users for at least a year. The size of the sample is given by the information gathered and the duration of the research.

The data were collected during 4 months using in-depth interpretative interviews, as well as 3 non-participatory observations. The interviews addressed the research topic through non-standardized and non-predetermined questions, in order for the interviewee to be able to express their knowledge, motivation, feelings, and beliefs (Scribano, 2008; Varguillas Carmona & Ribot de Flores, 2007). The interviews had a duration of approximately 2 hours and were recorded and transcribed for analysis. The non-participatory observations lasted approximately 1 hour. These were recorded on logbooks and field notes, to obtain data in a context in which the researcher does not take part (Nieto, 2001).

The result analysis was carried out using tools from Grounded Theory (open coding and comparative analysis of the concepts), which allowed generating categories (conceptualization process). The categories were obtained using the ATLAS-ti software (Hwang, 2008; Strauss & Corbin, 2002).

This study was approved by the ethics committee for research on human beings of *Universidad de Chile* (050-2014). Furthermore, it complies with the postulates in the Helsinki declaration, the CIOMS 1992 international ethics guideline for biomedical research involving human beings, and the ICH 1996 good clinical practice guidelines. Finally, informed consent was obtained from each one of the participants.

RESULTS

The results were organized into categories according to the information most frequently observed in the interviews and non-participatory observations:

a. Categories obtained from the interviews: Role of the Professional, Subject of Intervention, and User-Therapist Relationship.
b. Categories obtained from the observations: Physical Space and Organization of the Session.

The categories mentioned above are explained and developed, quoting comments from the interviews and indicating the interviewee with a number (e.g. I1).

Interviews

Professional Role

In the context of hospitals, the SLPs mention that educating the family and the health care team is a core activity, for example:

> *"according to the needs…communicative, relating to feeding or swallowing" (I4).*

In contrast, the SLPs inserted in CCR describe their role as a guide, which involves negotiating objectives and actions together with the user:

> *"…to orient and educate them about how to rehabilitate their different abilities…I do not pretend to change anything about the person, I am orienting them in their rehabilitation" (I1).*

Regarding the objective of speech therapy, the professionals working in hospitals consider it to be the compensation or restitution of functions,

> *"…the role of the speech-language pathologist is to evaluate and determine the type of treatment for swallowing, speech, language, and for improving the quality of life in relation to the patient's deficiencies…" (I3).*

On their part, those who work in CCRs proposed a role directed at knowing the social reality of the subjects:

> *"On some occasions, the home visits are made as a team, on others as pairs or individually…Knowing the psychosocial reality, the context of the person, not just arriving and intervening […]an environmental management, maybe detecting barriers that affect communication, feeding…barriers or factors that make the person have a bad performance at home…" (I3).*

This implies that the SLPs from CCRs participate in multidisciplinary team meetings, to review and propose joint objectives. Moreover, contents and activities addressed by other professionals are shared, in order to include them in speech therapy sessions and support the generalization of skills,

> *"Discussing cases and reinforcing interdisciplinary work is a constant" (I2).*

Subject of Intervention

The professionals who use the CBR strategy expect the subjects to be empowered in their health situation:

> *"The vision we have of the people, to begin with, they are not patients …" (I1)*

> *"We try to promote this change of paradigm in people, so they are active agents of change…a determining factor for achieving this objective is that the person participates in groups" (I2).*

User -Therapist Relationship

SLPs inserted in hospitals have a rather hierarchical relationship (they are responsible for the intervention). They report communicative or space-related strategies that allow them to be closer to the subject of intervention. For example:

> *"I intervene with the patient on the wheelchair, which means I step out of my desk..." (I4).*

The professionals working in CCR are presented as guides or partners, working alongside the service user:

> *"Here we are all equal in general, the users do not call us in any particular way, by our names…", "they tell me, for example, Ummm, 'ok, tell me what to do', and I tell them 'I cannot tell you what to do, I am guiding you…' […] I am going to help you solve your problem, guiding you because I know about the topic'…the diagnosis is participatory" (I2).*

This practice relates to the belief that the service user has an active role because they have the abilities to contribute to their therapy.

Non-Participatory Observations

Physical Space

The SLPs from hospitals work in spaces related to the modality of intervention. This means that they work with hospitalized people as well as carry out outpatient sessions in an office supplied with chairs, table, desk, and sink.

The SLPs in CCRs work in an individual space similar to the one described above. However, they also share spaces with other professionals such as physical and occupational therapists (which include implements such as mats and machinery for physical activity), in addition to an area for team meetings.

Organization of the Session

In the context of hospitals, the time of intervention varies according to the objective. For example, for hospitalized patients, the intervention fluctuates between 25 minutes and 1 hour. The functions of the professional are oriented towards patient intervention and communication with the family. In contrast, outpatient intervention is between 25 and 45 minutes and in some cases, a family member could participate if the professional considers it relevant.

For their part, the CCR speech therapists spend between 45 minutes and 1 hour in the evaluation and intervention. The SLP, the family member, and the user participate in these processes, in

spaces shared with other professionals. It is noteworthy that the participation of family is recognized as important during the interviews, nevertheless during the study the active participation of family members was not observed.

The foregoing provides characteristics of the professional performance of each SLP in a specific therapeutic context. In particular, it is observed that the biopsychosocial model is more present in CCRs. On the other hand, the biomedical model stands out in the context of hospitals.

DISCUSSION

These results provide elements that allow characterizing the experience of 4 speech-language pathologists. This means that what is observed is not necessarily generalizable to other realities. Nevertheless, their experiences are a contribution to the knowledge of two realities of work, allowing answering the research questions.

Regarding the characterization of practices in hospitals and CCRs, the influence of work context on the experiences arises as a topic during the interviews. This relates to the objectives in public services and the difference between primary and tertiary care. In hospitals, a common objective is to achieve medical stability and early discharge of the users, while in CCRs the insertion of the user in their community is a central objective.

The aforementioned makes it possible to differentiate the interventions and approaches used by speech therapists in these services. Thus, hospital professionals direct their approach mainly to body structures and functions, while CCR professionals focus on activity (individual functionality) and participation (social functionality) of the users (Duarte et al., 2017). The latter is also pointed out by professionals who work in other regions of the country in a CBR context. This is manifested in the fact that they work as guides for users and their families within an inter-transdisciplinary team, where it is sought to improve the quality of life of people with a focus on participation (Silva Ríos, Rojas, et al., 2018).

The speech therapy practice has historically been based on the biomedical model, which has had an impact on professional training. Furthermore, public policies and institutional frameworks have influenced professional actions, by defining achievement goals and health care formats that restrict the full expression of the biopsychosocial model (Tapia Saavedra, 2013).

Another aspect that emerges from the work of the CCR participants is the user-therapist relationship, where all the interviewees emphasize an active role of the service user, consistent with the CBR strategy *(Instituto Nacional de Rehabilitación* Pedro Aguirre Cerda, 2005). This approach encourages the education and participation of users, their families, and the community (Besoain-Saldaña et al., 2020). However, it is important to point out that an "active participation" of the users is not enough to achieve inclusion, but that real work is required within the person's context, with their support network, and in the intervention, in coordination with other institutions, which represents an even greater challenge for speech therapy.

In addition to the above, the interviewees believe that the therapy planning process should be shared between the professional and the user, and they specifically mention the relevance of collective construction of therapy plans, the need to consider community participation of the users, and the requirement to agree on the therapy objectives. However, the information obtained from the interviews was not evidenced during the observation of therapy sessions. The role of the guide pointed out by the participants was limited to providing indications, which were accepted without generating an agreement dialogue. Similarly, in most of the situations, it was the therapist who directed the sessions and activities. This reflects the fact, according to Tapia Saavedra, (2013), that in our health system the guidelines of the community model are observed in the discourse of professionals, but in the context of work a hierarchical relationship is maintained.

According to the Pan American Health Organization (PAHO) and the WHO, the biopsychosocial approach contemplates the interaction between the person in a situation of disability (PeSD) and their family, community, and social environment, being a function of the CCRs to favor this participation and community inclusion (Besoain-Saldaña et al., 2020). During the interviews, all the participants highlighted the importance of context and community in rehabilitation. This shows that hospital professionals have notions of the biopsychosocial model and are aware of the cultural, psychological, social, and biological factors that surround the user (Tapia et al., 2016). However, including the family in the care provided in hospitals is complicated due to the context of such spaces. This is because there is an institutional framework that regulates health care and a lack of autonomy in the decision-making process. Family inclusion is also negatively influenced by the circumstances of the population the therapists care for (Tapia & Carreño, 2018). The latter might also happen in primary care, where SLPs working in CCRs have to consider CBR as a model of work, which implies, for example, home visits, work insertion of the users, etc. Nonetheless, the theoretical model on

occasions is confronted with a health care structure that measures the number of services provided (monthly statistic record, [*registro estadístico mensual, REM*]), thus limiting the types of practices that can be carried out in this context (Silva Ríos, Escudero, et al., 2018).

Lastly, the participants state that performance in the current context is dynamic, in terms of the knowledge necessary for the practice, and depends on the institutional structure of their workplace, showing that the practice is modified by experience. The role is re-signified through contact and bonding with the users, the conception of "subject of care", beliefs about the illness, condition, or health situation, among other factors. According to Goffman (2006), a good apprenticeship about a context implies being inserted in it and experiencing the habitual routines of their members. Within this experience, as mentioned by Silva Ríos, Rojas, et al. (2018), the professionals' undergraduate training becomes relevant, as well as a capacity for critical thinking, since they need to adapt and make their actions flexible in diverse environments and circumstances.

As a synthesis, it is observed that the practice of the SLPs has been shaped by their interactions with others, having to necessarily include the history of the space and institutional regulations. Each context is different and the interactions that take place within it are owned and accepted by the group, that is, context and experience constitute a collective reality. In that sense, the professional carries out actions that allow them to fulfill their task in the best possible way within their context, which in most of them translates into training and gaining relevant knowledge for the activities they carry out. Each professional "seeks to adapt to their immediate conditions, interpreting their context to develop behaviors that will either be confirmed or rejected in the future" (Mercado & Zaragoza, 2011).

CONCLUSIONS

It is observed that the interviewees share knowledge and competencies that belong to the discipline, independently of the context. However, their action is different according to the structure and objectives of the service in which they are inserted. The context of work directly influences the professional activities of SLPs, due to the influence of other professionals, personal beliefs, and emotions concerning the users. Furthermore, the intervention models and strategies of the work context have an influence as well.

Concerning the view that SLPs working in CCRs have of their professional practice, they consider themselves to be guides that provide orientation to users, their families, and community. They are aware of the sociocultural reality in which they are inserted and propose an interdisciplinary work, expecting that the users have an active and participatory role in their intervention. The professionals recognize the importance of lowering the barrier between therapists and users. Nevertheless, differences were observed between discourse and action; the interviews show a theoretical mastery of the CBR strategy, but in the observations only one professional generated a space of equality and horizontality of the relationship (based on the language used, proxemic, time disposition, type of activities, level of participation of the user and their family, etc.).

Regarding the participants who work in hospitals, it is noteworthy that their perspective of rehabilitation is oriented primarily towards restoration or compensation of functions, without a distinct use of biopsychosocial elements. Their action is related to their knowledge and beliefs of what their function is in their context of work.

In both contexts, the design and execution of professional activities are determined by the institution, regulations, and the protocolization of assessment and intervention procedures. They are also determined by the fact that the public system, on which said institutions depend on, establishes the efficiency and effectiveness of the processes. Therefore, the regulations that the professionals must follow in their institution influence many of their daily activities, which means that each SLP builds their practice according to this institutional framework.

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REFERENCES

Andréu, J. (2000). *Técnicas de Análisis de Contenido: Una revisión actualizada*. Fundación Centro de Estudios Andaluces.

Baeta, M. (2015). Cultura y modelo biomédico: Reflexiones en el proceso de salud enfermedad. *Comunidad y Salud*, *13*(2), 81–84. http://ve.scielo.org/scielo.php?script=sci_abstract&pid=S1690-32932015000200011&lng=es&nrm=iso&tlng=es

Besoain-Saldaña, Á., Sanhueza, J. R., Hizaut, M. M., Rojas, V. C., Ortega, G. H., & Aliaga-Castillo, V. (2020). Rehabilitación Basada en la Comunidad (RBC) en centros de atención primaria en Chile. *Revista de Saúde Pública*, *54*.

https://doi.org/10.11606/s1518-8787.2020054001999

Brahm, S. (Ed.). (2014). Fortalecimiento de la atención primaria de salud: Propuestas para mejorar el sistema sanitario chileno [Review of *Fortalecimiento de la atención primaria de salud: Propuestas para mejorar el sistema sanitario chileno*, por E. Arancibia, J. Contreras, R. Fábrega, A. Infante, I. Irarrázaval, M. Inostroza, S. Íñiguez, J. Montero, K. Puschel, E. Santelices, I. Segovia, Á. Téllez, C. Tello, & P. Villaseca]. *Temas de la agenda pública*, *9*(67), 1–19. https://politicaspublicas.uc.cl/wp-content/uploads/2015/02/fortalecimiento-de-la-atencion-primaria-de-salud-propuestas-para-mejorar-el-sistema-sanitario.pdf

Duarte, L., Peña, M., & Piragua, L. (2017). Rol del fonoaudiólogo en el primer nivel de atención en salud dentro del Sistema General de Seguridad Social en Salud en Colombia. *Areté*, *7*, 173–178. https://arete.ibero.edu.co/article/view/525

Espinosa, F., Herrera, P., & Venegas, D. (2014). *Caracterización del quehacer fonoaudiológico en dos contextos de atención: Centros comunitarios de rehabilitación y hospitales de salud pública* [Tesis de Licenciatura, Universidad de Chile]. http://repositorio.uchile.cl/handle/2250/130738

Goffman, E. (2006). *Frame Analysis. Los marcos de referencia* (1ª ed.). Centro de Investigaciones Sociológicas.

Hwang, S. (2008). Utilizing Qualitative Data Analysis Software: A Review of Atlas.ti. *Social Science Computer Review*, *26*(4), 519–527. https://doi.org/10.1177/0894439307312485

Ibarra Peso, J., Hernández Castro, A., & Meza Vásquez, S. (2012). Percepción de la transición del modelo biomédico al modelo biopsicosocial en usuarios internos del CESFAM Pinares, comuna de Chiguayante. *Medwave*. http://www.medwave.cl/link.cgi/Medwave/Estudios/Investigacion/5290

Instituto Nacional de Rehabilitación Pedro Aguirre Cerda. (2005). *Sistematización Rehabilitación con Base Comunitaria INRPAC*. https://www.senadis.gob.cl/descarga/i/236/documento

Ithurralde, C., Campra, C., Felice, F., & Ginghini, M. F. (2019). Formación académica y práctica profesional en Fonoaudiología Social y Comunitaria. *Escenarios*, *30*, Article 30. https://revistas.unlp.edu.ar/escenarios/article/view/10034

Juárez, F. (2011). El concepto de salud: Una explicación sobre su unicidad, multiplicidad y los modelos de salud. *International Journal of Psychological Research*, *4*(1), 70–79. https://dialnet.unirioja.es/servlet/articulo?codigo=5134644

Mercado, A., & Zaragoza, L. (2011). La interacción social en el pensamiento sociológico de Erving Goffman. *Espacios Públicos*, *14*(31), 158–175. https://www.redalyc.org/articulo.oa?id=67621192009

Nieto, C. (2001). *Sociología*. Editorial Club Universitario.

Organización Mundial de la Salud [OMS]. (2012). *Guía para la Rehabilitación Basada en la Comunidad*. https://apps.who.int/iris/bitstream/handle/10665/44809/9789243548050_Salud_spa.pdf;jsessionid=2854E8C58FCEAF35C1C223B9CDC0A0C9?sequence=3

Romero, L. (2012). Desplazamiento respecto de los saberes disciplinares de la Fonoaudiología. *Revista Chilena de Fonoaudiología*, *11*, 99–106. https://doi.org/10.5354/0719-4692.2012.24520

Scribano, A. O. (2008). *El proceso de investigación social cualitativo*. Prometeo Libros Editorial.

Serra, S. (2008). *Fonoaudiológicamente: Nociones básicas y práctica profesional* (1a ed.). Editorial Brujas.

Silva Ríos, A., del Campos Rivas, M., & Pérez, R. (2020). Conocimiento de la Rehabilitación Basada en la Comunidad por parte de fonoaudiólogos de la región de Valparaíso, Chile. *REVISTA CUHSO*, *30*(2), 189–202. https://doi.org/10.7770/cuhso.v30i2.1949

Silva Ríos, A., Escudero, P., Hidalgo, R., & del Campo, M. (2018). Estudio Cualitativo de la Práctica Fonoaudiológica en el Contexto de la Atención Primaria de la Salud, en la Quinta Región de Valparaíso. *Ciencia & Trabajo*, *20*(62), 103–106. https://doi.org/10.4067/S0718-24492018000200103

Silva Ríos, A., Rojas, G., Vásquez, K., & del Campo, M. (2018). Estudio Cualitativo de la Práctica Fonoaudiológica en el Contexto de Rehabilitación Basada en la Comunidad, en la Quinta Región de Valparaíso. *Ciencia & Trabajo*, *20*(63), 126–130. https://doi.org/10.4067/S0718-24492018000300126

Simmons-Mackie, N., & Kagan, A. (2007). Application of the ICF in aphasia. *Seminars in Speech and Language*, *28*(4), 244–253. https://doi.org/10.1055/s-2007-986521

Sosa, A. (2019). La inducción analítica como método sociológico desde una perspectiva histórica. *Cinta moebio*, *64*, 11–30. https://doi.org/10.4067/s0717-554x2019000100011

Strauss, A., & Corbin, J. (2002). *Bases de la investigación cualitativa: Técnicas y procedimientos para desarrollar la teoría fundamentada*. Universidad de Antioquia.

Tapia, S., & Carreño, A. (2018). ¿Es posible la integración del modelo comunitario en la atención de rehabilitación en Chile? Barreras para su real expresión desde los interventores. *Revista del Instituto de Salud Pública de Chile*, *2*(1), 1–8. https://doi.org/10.34052/rispch.v2i1.43

Tapia, S., Espinoza, F., Herrera, P., & Venegas, D. (2016). Caracterización de fonoaudiólogos/as insertos/as en Centros Comunitarios de Rehabilitación. *Revista Chilena de Fonoaudiología*, *15*, 1–13. https://doi.org/10.5354/rcdf.v15i0.44186

Tapia Saavedra, S. (2013). *Modelo comunitario versus modelo biomedico un acercamiento desde la atención primaria*. http://repositorio.uchile.cl/handle/2250/130684

Varguillas Carmona, C., & Ribot de Flores, S. (2007). Implicaciones conceptuales y metodológicas en la aplicación de la entrevista en profundidad. *Laurus Revista de Educación*, *13*(23), 249–262.

Vasilachis (Ed.). (2006). *Estrategias de investigación cualitativa* (1ª ed.). Editorial Gedisa. http://investigacionsocial.sociales.uba.ar/wp-content/uploads/sites/103/2013/03/Estrategias-de-la-investigacin-cualitativa-1.pdf

Vega Rodríguez, Y. E., Torres Rodríguez, A. M., & del Campo Rivas, M. N. (2017). Análisis del Rol del Fonoaudiólogo(a) en el Sector Salud en Chile. *Ciencia & Trabajo*, *19*(59), 76–80. https://doi.org/10.4067/S0718-24492017000200076

Vergara, L. (2010). Desarrollo de la medicina física y rehabilitación como especialidad médica. *Revista Hospital Clínico Universidad de Chile*, *21*(4), 281–288. http://repositorio.uchile.cl/handle/2250/124197