

An approach to touching while providing high-quality affective health care to hospitalized elderly patients*

RECONHECIMENTO DOS ASPECTOS TACÊSICOS PARA O CUIDADO AFETIVO E DE QUALIDADE AO IDOSO HOSPITALIZADO

TÍTULO DO ARTIGO EM ESPANHOL, TÍTULO DO ARTIGO EM ESPANHOL, TÍTULO DO ARTIGO EM ESPANHOL, TÍTULO DO ARTIGO EM ESPANHOL

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ABSTRACT

The aim of the present study was to verify the important factors of tacesics that should be observed while touching the elderly. This qualitative and exploratory field of study was developed using 117 undergraduate students and healthcare professionals who participated in a training course regarding nonverbal communication in gerontology. The results revealed that the majority of the participants were able to identify at least one care factor that must be respected when touching the elderly. The discourses allowed for the construction of nine categories indicating the conditions that are necessary for high-quality affective care provided within the tacesics context; these conditions included the authorization for the touch to occur, location of the touch, intensity of the touch, condition of the elderly person, intentionality and type of touch, duration of the touch, gender and age of the person who touches and of the person being touched, frequency of the touch, and characteristics of the hands that touch. Touch is part of the quotidian practice of healthcare professionals and expresses their dedication and its related emotions, thereby revealing the quality of the care that is provided.

DESCRIPTORS

Aged
Hospitalization
Nursing care
Nonverbal communication
Skin
Geriatric nursing

RESUMO

Verificar os aspectos tacênicos importantes para serem observados ao tocar o idoso. Estudo de campo, qualitativo e exploratório desenvolvido com 117 graduandos e profissionais de saúde participantes da capacitação em comunicação não verbal em gerontologia. Os resultados revelam que a maioria conseguiu identificar, pelo menos, um fator de atenção que precisa ser respeitado ao tocar o idoso. Os discursos permitiram a construção de nove categorias apontando condições necessárias ao cuidado afetivo e de qualidade prestado no âmbito da tacêsica; quais sejam: autorização para que o toque ocorra; localização do toque; intensidade do toque; condição do idoso; intencionalidade e tipo de toque; duração do toque; sexo e idade de quem toca e quem é tocado; frequência do toque e características das mãos que tocam. O tocar faz parte do cotidiano dos profissionais da saúde e expressa zelo e sentimentos consequentemente, revela a qualidade da assistência prestada.

DESCRITORES

Idoso
Hospitalização
Cuidados de enfermagem
Comunicação não verbal
Pele
Enfermagem geriátrica

RESUMEN

Verificar aspectos importantes del lenguaje táctil a ser observados al tocar al anciano. Estudio de campo, cualitativo, exploratorio, desarrollado con 117 estudiantes y profesionales de salud participantes de capacitación en comunicación no verbal en gerontología. Los resultados demostraron que la mayoría consiguió identificar al menos un factor de atención a respetarse al tocar al anciano. Los discursos permitieron construir nueve categorías tomando nota de condiciones necesarias para el cuidado afectivo y de calidad brindado en el marco del lenguaje del tacto, que fueron: autorización para que ocurra el toque; localización del toque; intensidad del toque; condición del anciano; intencionalidad y tipo de toque; duración del toque; sexo y edad de quien toca y de quien es tocado; frecuencia del toque y características de las manos que tocan. El tocar forma parte del cotidiano de los profesionales de salud y expresa cuidado y sentimientos; consecuentemente, revela la calidad de atención prestada.

DESCRIPTORES

Anciano
Hospitalización
Atención de enfermería
Comunicación no verbal
Piel
Enfermería geriátrica

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INTRODUCTION

The skin reflects physical and psychological conditions, such as health, age, and ethnic or cultural differences, as well as protects and regulates the body temperature. The skin is a protective, waterproof barrier that prevents fluid loss and the penetration of substances and micro-organisms. This organ protects the body from ultraviolet radiation, is a nidus of immunological and organic defense-related reactions and is the focus of sensory perception and body image⁽¹⁾.

In old age, these functions decay, thereby rendering the person more fragile and subject to the aggressions of the environment⁽¹⁾. Advanced age is accompanied by changes in skin turgor and immunological function. As a person ages, the risk of the appearance of lesions in the integument increases because the skin becomes thinner and more fragile and because losses occur in the subcutaneous fat layer⁽²⁾. These changes require qualified attention to the care and maintenance of health in the elderly. Furthermore, there is a reduction in the sensitivity to touch, pressure, vibration, heat and cold⁽¹⁻²⁾. In the elderly, the skin sensitivity changes; however, the need for the touch does not. Often, this mechanism is the only way for the elderly to feel included and loved because do they want to be not only protected or tolerated but also understood, respected and cared for⁽³⁾.

To touch the human skin is to communicate with the other person, to take care of the other person, and to provide the other person with companionship⁽⁴⁾. In the professional/client interaction, touch is classified into three types: 1) expressive touch, also described in the literature as affective, which occurs spontaneously and is not necessarily part of the performance of procedures; 2) instrumental touch, which is a deliberate, physical contact for performing a pre-determined technique or procedure; and 3) expressive-instrumental touch, which is a combination of the other two types⁽⁵⁾.

An individual who becomes hospitalized experiences a stressful situation, which is often one of suffering. Principles of human relationships, such as compassion, the expression of affection, dedication, attention and showing respect and tolerance qualify the care and, combined with the technical support that is necessary for caring for the elderly, make it differential⁽⁶⁾.

The clients recognize that the affective relationship with the team favors treatment that provides more comfort. The professional-client bond is a facilitator of communication, as it contributes to deeper knowledge of the client, thereby making it possible to effectively observe and comprehend what is being verbally and nonverbally communicated⁽⁷⁾.

The present study confirmed that communication is an aggregate of verbal and nonverbal dimensions: the first refers to spoken or written words, and the second is associated with gestures, facial expressions, intonation, tone of voice, silences, physical appearance, environmental conditions, body postures and the maintenance of personal space and touch. Communication is an interactional process, in which messages, feelings and ideas are shared. This process influences the behavior of people, which is based on their values, beliefs, life history and culture⁽⁴⁾.

Tacesics involves tactile communication and touching and is the study of touch and of the characteristics that are involved, including the gender and age of the communicators, duration, location, action (speed and manner of approach that precede the touch), intensity (pressure exerted), frequency and sensations caused by the touch (degrees of comfort and discomfort generated in the communicating agents)⁽³⁻⁴⁾. Touch is described as one of the most significant forms of contact with the world, through which the sensory system of the individual may be activated⁽⁸⁾. Touch is related to the personal space, culture of the communicators and expectations regarding the relationship⁽⁴⁾.

Physical contact, which is promoted by touch, provokes neural, glandular, muscular and mental alterations and contributes to the recovery of hospitalized clients. Therefore, it is believed that more studies concerning touch should be conducted and that professionals should know how to use touch as a care strategy⁽⁴⁾.

Due to the importance of touch, training was provided for undergraduate students and healthcare professionals regarding nonverbal communication, with the inclusion of tacesics as an essential dimension to be used in caring for the elderly. In this article, we discuss the data referring to this dimension (which was addressed during the training) and the results related to the assimilation of the developed content—aiming to verify the important aspects of tacesics that should be observed while touching the elderly.

METHOD

This present investigation was a qualitative, descriptive and exploratory field study that was developed in two hospitals in the state of São Paulo, in the cities of Assis and Marília, after approval by the Human Research Ethics Committee (CEP/HRA Protocol No. 167/08). In total, 117 people participated, including 33 undergraduate students in their final semester of Nursing, Medicine and Psychology and 84 healthcare professionals (physicians, physical educators, social workers, nurses and nursing technicians), who all participated in the training course held on

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nonverbal communication in gerontology. The duration of the training was twelve hours divided into three weekly meetings of four hours each, with an interval of twenty minutes, and the instruction was provided during the week days, between 14:00 and 18:00.

The inclusion criteria for participation in this training were to be eighteen years of age or over, to be affiliated with the institution (whether by employment or by education), to have applied to participate in the training, and to have the interest and availability to attend on the pre-scheduled training days.

The training program complied with a pedagogical matrix containing the theoretical bases to be developed and with the resources and pedagogical procedures that included poetry readings, displaying images of the elderly with reflective text, discussing hospital experiences and classroom dialogue. The matrix was designed so that, at the end of each meeting, the participants could reveal their degree of assimilation.

Among the aims of this training was comprehension of the factors that are influential when touching the elderly. To obtain the specific data presented in this study, the question *What factors need to be observed by health-care professionals when touching the elderly, in order to provide care with affection and quality?* was used. This question was administered by the first author of this study (who is a specialist in gerontological nursing and who developed the program) immediately after the first four-hour meeting, as previously mentioned, which was conducted in January 2009 and during which this issue was discussed.

To ensure the anonymity of the participants, the answer sheets were collected without making notes that could identify them. The responses were read and corrected according to the gauge theory (based on the theoretical framework of Montagu⁽³⁾ and Silva⁽⁴⁾) that was used in the training. The data analysis was performed via the thematic grouping of the 117 discourses, based on the content analysis method⁽⁹⁾ that allowed for the inference of knowledge relative to the perceptions of care while touching the hospitalized elderly.

RESULTS

The study population consisted of 117 people who were undergoing training in nonverbal communication in gerontology; 71.8% (84) were healthcare professionals (physicians, nurses, physical educators, psychologists and physiotherapists), and 28.2% (33) were undergraduate students in the healthcare area. Regarding gender and age, 80.3% (94) were women with a mean age of 35.7 years, and 19.7% (23) were men with a mean age of 29.6 years. The average age of the participants (independent of gender) was 34.5 years, the youngest being 20 years of age and the oldest being 59 years of age.

Upon questioning regarding the factors that should be observed while touching the elderly, the majority of the participants (96.6%) identified at least one care factor that must be respected. The results allowed for the identification of nine categories that represent the main factors/conditions for quality of touch: authorization for the touch to occur; location of the touch; intensity of the touch; condition of the elderly person; intentionality and type of touch; duration of the touch; gender and age of the person who touches and of the person being touched; frequency of the touch; and characteristics of the hands that touch.

The first category, *authorization for the touch to occur*, comprised the responses in which emphasis was placed on the necessity of asking permission from the client. The professional stated the importance of observing the patients' reactions regarding the receptivity to being touched (responses to the invasion of personal space); validation of the reason for the touch, in which the professional feels the need to reveal the intention for the touch and to explore the limits provided for its continuity or discontinuance. Examples of the discourses are as follows:

I see the expression of how he receives the touch, if he would like to be touched at that moment, if it feels good for him, if it brought good things or not (P 29).

I learned the basics, what is essential and not always done. How I will touch the elderly person without first clearly asking if he allows it, if he wants it. Performing care requires touching his body, but it is his space, and I need to take some time before everything, before you start touching and doing things (P 34).

In the category *location of the touch*, the responses emphasized how the region of the body that is exposed to the touch must be valued, as the acceptance (more or less) of the professional's touch is dependent on this factor. Examples of the discourses are as follows:

To pay attention and to avoid places such as the legs and feet or trunk and neck. The hands and the shoulders should be preferred (...) (P 21).

Depending on who the elderly people are, on their culture, the conditions of judgment that they possess and even on the social status they occupy, it is easier or more difficult to touch them. I am referring, for example, to the place that is touched, an intimate area is very difficult, especially for those who never had a chance to go to professionals, such as a consultation with a gynecologist; we need to discover, valorize and respect (P 88).

There are places that even a professional is constrained to touch, but there are other areas that are easier and should be touched more often, such as the shoulders (P 90).

The third category, *intensity of the touch*, was composed of responses that emphasized the intensity or pressure exerted by the hands of the professional on the various regions of the body, i.e., the manner in which the professional touches the client.

Depending on the force, it can make anyone dislike it, especially the elderly, even if they need it; the hands need the correct weight in the correct place (P 11).

To check the pressure, what you do is essential because the skin of the elderly is different. To say that it is beautiful is too much; however, it has sensitivity, and when touched can stimulate positive or negative things in the person. The elderly know very well if the touch is loving or not. Another important thing is that, depending on what is done (whether it is a technique or a simple greeting), the intensity is different (P 96).

The category *condition of the elderly person* was based on responses that recalled how the professional's observations regarding the previous physical, mental and emotional situation or condition of the client may not only prevent but also regulate the performance of the touch. This category included specific concerns regarding the elderly, regarding the valorization of context and coherence when performing the touch, as well as the desire, will and/or need of the elderly person to be touched and to have respect shown for their culture. Examples are as follows:

The professional carries out the procedure on the body of the elderly person regardless of their mental condition; however, it is important to take greater care when the elderly person has reduced awareness, confusion or other problems that create a situation whereby the touch does not benefit the person (P 14).

Because the person is elderly does not mean they do not want affection and tenderness; the touch provides this, an expression of tenderness and comfort, attention, and dedication to the other. It needs to be linked to the actual conditions of the elderly person as well; otherwise, it is meaningless because the disease brings sadness and memories that make him not want to be manipulated. We have to pay attention to the faces and mouths of the elderly, because this is important (P 78).

Each elderly person has a history and with it a desire or not to be touched. However, there are activities where it is necessary to touch; even if they do not want it, they allow it because it needs to be done. To observe the emotions of the person will be important (P 101).

Intentionality and type of touch is the category that grouped the discourses that valued the availability and concerns of the professional regarding exposing their intentions and feelings to the elderly, as well as the elderly revealing theirs, and the importance of the professional recognizing the different types of touch (instrumental and/or affective). The following is an example:

The physician has an intention, which is to perform an abdominal palpation. This is to touch in a different way than should be done when the patient is leaving the consulting room. You must pay attention to this; the touch is everything (P 44).

The sixth category, *duration of the touch*, brought together the discourses that emphasized the time used and how much this slow or rapid action might facilitate the care and the bond the professional has with the client. The following is an example:

I do not always have the time needed, so I do the procedure quickly, and I know this interferes with the patient liking me, but what can I do? (P 05).

Gender and age of the person who touches and of the person being touched is the category comprising the responses that contemplated the statements regarding the sexual difference between the professional and the client, which may cause greater or lesser ease and acceptance of the touch. The response of one of the participants was as follows:

I'm a young man, so it is easier to touch an older gentleman. Now, to touch and manipulate an older lady is a different thing. For me, it's all the same, but for them, it's not. They die of embarrassment (P 19).

The category *frequency of the touch* grouped the statements about how the professional touches the client without noticing what he or she is doing and how it is necessary to perform numerous touches during the same procedure. One example was as follows:

I bandage a wound, and when I do this, I touch the person often. I do not always do this as it's needed and not always how they need it. It is so routine that I prefer to be honest in saying that I touch a lot without noticing (P 65).

The final category, *characteristics of the hands that touch*, was composed of statements that referred to the importance that is assigned to the type and quality of the hands of professionals when touching the elderly under their responsibility. The example chosen was as follows:

Do you think the elderly do not see whether your hands are well looked after? They see and want a clean, warm hand that is positioned correctly and that is soft (P 98).

DISCUSSION

Humans exist in the world, and in it, they choose a way to live and to exist, conforming to the exercise of their freedom. The possibility of touching and letting oneself be touched is a manner of being in the world, and touch is an existential factor that may express the affection of the human, which is demonstrated as concern, solicitude and relating to others⁽¹⁰⁾. Touch meets the need expressed by the participants for the professional not only to pay attention but also to seek permission to touch the elderly person under their responsibility.

There is no doubt that inpatient units are communication spaces and that both verbal and nonverbal dimensions guide the relationships between the hospitalized elderly and the nursing team, allowing a constellation of

messages that can be consciously or unconsciously received and decoded⁽¹¹⁾.

In the hospital setting, human beings who provide or receive care both touch and are touched in various manners and/or by various techniques, e.g., with the hands, the body, the hair, instruments, clothing or equipment. Touch occurs in a variety of situations and may demonstrate care, affection, devotion, dedication, commitment, responsibility, knowledge, respect, and/or inclusion. The opposite of these characteristics, although not being the target of effective/affective care, are present at certain times and sometimes cause the loss of dignity, independence and autonomy in patients who are being cared for^(3,5,7).

Another aspect that should always be mentioned when studying tacesics is related to where the person is touched because, depending on the region, a greater or lesser degree of embarrassment is generated; this variable is dependent on the context, age, intention and cultural diversity. Although it is desirable for the client to be touched, the manner in which the tactile expression is performed can assume different connotations that may or may not provide satisfaction⁽³⁻⁴⁾.

When the participants mentioned that location was an important factor that might or might not facilitate touch, they associated it with the culture and the region of the body, as has been confirmed in the literature^(3-6,8). When performing a touch, the professional should remember that, at this point, he or she occupies an empowered position and that misinterpretations may occur, causing embarrassment and discomfort. Therefore, personal factors, communication skills, attitudes, beliefs, values and even technical knowledge must be considered; the professionals should also contemplate the forms of acceptable or unacceptable behavior, whether the touch is required and the expectations that exist when performing the touch, combined with an awareness that what they do is important and essential for appropriate care⁽¹²⁾.

In their discourses, the participants stated that, while touching, the professional evokes either positive or negative emotions. Because touch may be instrumental and/or affective⁽³⁾ and is not only subject to the performance of technical/scientific procedures, it may be used as a supportive technique for the display of affection, empathy, safety and proximity.

The healthcare team may perceive that delicate touch is observed and valued by the patients; however, this practice is commonly neglected, as has been revealed by a study of hospitalized elderly people⁽¹¹⁾.

The results revealed the relationship between the intensity and duration of the touch and the quality of the elderly individual's skin. According to the literature⁽¹⁻³⁾, the skin transforms physical stimuli into chemical signals, and these signals are translated into psychological states. At

any time of life, loving and affectionate contact with the skin may generate feelings of support, companionship, comfort, and a friendly presence; conversely, rude and aggressive touch (or even no touch at all), when performed in our culture, makes a person feel rejected, invaded or ignored and may cause a defensive or angry reaction⁽¹³⁾.

The discourses that comprised the category valorizing the requirements of the elderly patient regarding touch highlight how the professional must recognize the existence of two types of touch (instrumental and affective) as quality care resources. When stating that *the faces and mouths of the elderly need to be observed*, the participant corroborated the claims of authors who stated that, for instrumental touch to approximate affective care, the professional must evolve from the simple mechanical execution of the technique to the stage of comprehending the specific emotions that the client experiences while being touched⁽¹³⁻¹⁵⁾. To this end, the professional should acquire knowledge regarding the necessity of decoding the facial and corporal expressions of the client, as these expressions may reveal whether the client is allowing the touch and/or whether he or she wants it to continue^(4,15).

The results confirm the argument that, using tacesics, care may be expressed and information may be provided because there are situations in which words are inappropriate. Furthermore, touch may provide emotional support during crises and may facilitate interactions with patients who are affected by disabilities such as impaired vision and hearing⁽¹⁶⁾.

A study, which was conducted using nurses and investigated affective care, revealed that nurses consider self-knowledge and a sense of well-being to be relevant characteristics for the affectivity of the care, as these factors facilitate empathic behavior that promotes health and the recognition of their own limits. Effective and affective human care goes beyond qualified listening and includes knowing how to touch⁽¹⁷⁾.

Several factors influence touch; a study involving healthcare professionals⁽¹⁴⁾ demonstrated that greater apprehension exists when touching the opposite sex, when the procedure to be performed is very invasive or when an intimate area of the body is being touched, with the touch possibly causing embarrassment to both the client and the professional. The investigation also revealed that the mood of the professionals, their involvement with the clients and with their own profession, and the characteristics of the clients (such as aggressiveness or requiring special attention from the team) influence the quantity and quality of touch.

Touch may represent the manner of being cared for, thereby revealing positive and negative emotions. In experiments that were performed at Depauw University⁽⁷⁾ and that utilized volunteers who attempted to communicate a series of emotions to a blindfolded stranger through touch, an accuracy of 70% was demonstrated in the de-

coding of distinct emotions, such as anger, fear, disgust, love, gratitude and sympathy. The investigation revealed systematic differences in the quality of contact for each of the emotions that are transmitted. Anger, for example, is associated with a strong touch of moderate and short duration, such as pushes; in contrast, a hug is associated with love and involves a longer-lasting touch. Moreover, it was found that the location of touch varies depending on the emotion that is being expressed and on the respective genders of the person who touches and the person who is being touched.

Emotions (positive and/or negative) must be recognized and valorized in the healthcare context. The fact that the hospitalized elderly person has usually experienced multiple hospitalizations does not automatically indicate favorable conditions for the performance of procedures that involve touch as their direct or indirect consequence. Indeed, to be faced with the known versus unknown or with the habitual versus unusual may evoke negative memories, anguish, suffering, pain, embarrassment, and bitterness, among other emotions⁽¹⁴⁾.

When mentioning that *the disease brings sadness and memories*, the participant confirmed the conclusions of authors⁽¹⁸⁾ who claimed that disease usually causes a disruption in the quotidian life of the person being cared for. Often, elderly people find themselves in situations that they never wanted to experience. In routine practice, healthcare professionals sometimes end up performing ritualistic care, thereby touching the patient's body and causing feelings of discomfort, fear, apprehension and dependency. During these circumstances, the elderly person is exposed to the loss of their identity and to a lack of privacy. It is common for professionals to perceive this fragility and to assume the presence of low self-esteem, which may be revealed through passivity and may be translated as permission for unwanted, yet compulsory touching that is deemed necessary to remain *well* in that environment⁽¹⁸⁾.

The condition of infirmity generates feelings such as disability, dependence, insecurity and a sense of loss of control over oneself. Commonly, patients perceive their hospitalization as involving depersonalization because of the difficulty they have maintaining their identity, intimacy and privacy. The hospital is stressful, especially for elderly people, due to losing control of their lives and being in the hands of people on whom they depend for survival⁽¹⁹⁾.

Research conducted in a geriatric unit of a public hospital of São Paulo⁽²⁰⁾, which investigated auxiliary nurses, found that although not agreeing with the phrase *all dependent elderly people should enter into our work routine*, the professionals recognized that it was a reality in routine practice and, moreover, a necessity because they were required to perform the work.

The category that encompassed the characteristics of the hands of the professional who touches the client was

in agreement with a study revealing that the reflections made by clients regarding what constitutes care validated the physical characteristics of the healthcare professional and were also associated with hygiene. When the professional approaches, the clients expect that a message of hygiene is provided⁽²¹⁾. Notably, having a good appearance, including treated hands and clean nails, is a requirement demanded by work institutions because it is believed that this condition transmits the image of an organized, safe and effective company⁽²²⁾.

Awareness of this problem and valorization of the aspects of care and touching are the responsibilities of the healthcare professional. Being well intentioned is not enough to ensure effective and appropriate care; indeed, it is necessary to modify one's behavior when faced with the needs of others, to be willing to learn from them and to be affectionate toward them⁽¹⁸⁾.

However, patient care may acquire an entirely different quality when sensitivity, affection, empathy and comprehension are expressed and transmitted through care that also involves tacesics as a conscious strategy⁽¹¹⁾.

CONCLUSION

For the proposed aim, it was perceived that the aspects cited and recalled that must be observed while touching the elderly were the following: prior authorization, location of the body region where the elderly person will be touched, intensity of the touch, constant monitoring of the conditions of the elderly person to observe the reactions provoked by the touch and whether they are favorable or unfavorable, intentionality and type of touch to be performed, duration and frequency, gender and age of the person who touches and of the person being touched and the characteristics of the hands that touch.

Due to the attempt to preserve the anonymity of the participants, the data were not treated differently between the undergraduate students and the professionals. This fact constitutes a limitation of the study, as the latter group most likely had more experience in care and might have found it easier to reflect on the issues that were presented.

It is worthwhile that the professional pay attention to the characteristics inherent to tacesics. Patient care should involve a moment of presence with the other person, during which the communication is meaningful and focused on the human and on the integrality of the person; furthermore, the limits and fragilities of the elderly person should be respected in their entirety, thereby yielding effectiveness of the care that is provided. Touch is part of the quotidian working reality of healthcare professionals and, in certain circumstances, should be considered with great awareness. These conditions include situations in which difficult news that causes much anguish is delivered, where the self-esteem and self-image are

compromised, or any other situation in which the client is being submitted to a harsh reality. It is recommended that healthcare professionals touch people consciously, knowing the types of touch and their emotional potential.

The National Health Agenda must increasingly incorporate resolute policies and actions directed toward the elderly population. To improve the care of these patients, greater investment in the education of geriatric care professionals is necessary, including increasing the length of healthcare courses to include this content.

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