

Replication of the training program in nonverbal communication in gerontology

Replicação de programa de capacitação em comunicação não verbal em gerontologia
Reproducción del programa de capacitación en comunicación no verbal en gerontología

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ABSTRACT

Objective: to measure the rate of assimilation of applied content at immediate and subsequent moments after a nonverbal communication in gerontology training program. **Method:** descriptive and exploratory field study developed in three state administered hospitals, which attend Brazilian National Health Service (SUS) clients. The duration of the training was twelve hours, applied with 102 healthcare professionals. **Results:** the results revealed that the rate of assimilation of the content immediately after the program was satisfactory, as well as being satisfactory in the aspects concept of aging; strategies to foster the independence and autonomy of the elderly person; communication interferences linked to the elderly and the professional; recognition of non-verbal functions and dimensions. The exception was the professional perception faced with aspects that influence the success of communication. **Conclusion:** it was concluded that the replication of this program was relevant and current for the hospital context, remaining efficient for healthcare professionals.

Key words: Nonverbal Communication; Gerontology; Education.

RESUMO

Objetivo: replicar um programa de capacitação em comunicação não verbal em gerontologia para verificar a pertinência do seu conteúdo na atualidade e o índice de assimilação imediata. **Método:** estudo de campo descritivo e exploratório desenvolvido em três hospitais de administração direta do Estado de São Paulo, que atendem exclusivamente clientes do Sistema Único de Saúde (SUS). A capacitação teve duração de 12 horas e foi aplicada com 102 profissionais de saúde. **Resultados:** foram identificados índice de assimilação imediato satisfatório nos aspectos de conceito de envelhecimento; estratégias de favorecimento de independência e autonomia do idoso; interferências comunicacionais ligadas ao idoso e ao profissional; reconhecimento das funções e dimensões não verbais. Como exceção foi verificada a percepção do profissional frente às influências para o sucesso comunicacional, que foi insatisfatória. **Conclusão:** a replicação do programa revelou-se pertinente e atualizada ao cenário dos serviços hospitalares, mantendo-se eficiente aos profissionais de saúde.

Descritores: Comunicação Não Verbal; Gerontologia; Educação.

RESUMEN

Objetivo: reproducir el programa de capacitación en comunicación no verbal en Gerontología para verificar la pertinencia de su contenido en la actualidad y el índice de asimilación inmediata. **Método:** estudio de campo, descriptivo y exploratorio desarrollado en tres hospitales bajo administración directa del Estado de São Paulo, que atienden exclusivamente clientes del Sistema Único de Salud (SUS). La capacitación tuvo una duración de 12 horas y fue aplicada a 102 profesionales de salud. **Resultados:** el índice de asimilación inmediato es satisfactorio en los aspectos de conceptos de envejecimiento; estrategias en favor de la y autonomía del anciano; interferencias en la comunicación ligadas al anciano y al profesional; reconocimiento de las funciones y dimensiones no verbales. El aspecto sobre percepción frente a las influencias para el suceso comunicacional, por parte del profesional, se mostro insatisfactorio. **Conclusión:** La reproducción del programa es pertinente y actualizado para los servicios hospitalares, manteniendose de esa forma la eficiencia de los profesionales de salud.

Palabras clave: Comunicación No Verbal; Geriatria; Educación.

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INTRODUCTION

In Latin America, and especially in Brazil, population aging occurs in a significantly accelerated way with different characteristics from the ones experienced in developed countries. Over the past 60 years, the absolute number of elderly has increased nine times⁽¹⁾ reaching today more than 12.5% of the total population, or approximately 26 million people aged more than 60 years old.

The aging of the population, besides being a great achievement, is a phenomenon with multiple impacts: in individuals, in family structures, in the society, in public policies, particularly imposing challenges to the state, society and families⁽¹⁾.

Worried about this scenario, the São Paulo State Government established the "São Paulo Friend of the Elderly" state program in May 2013, aiming at contributing towards a society for all ages, with the objective of valuing the elderly, in order to guarantee and to defend their rights and encouraging the creation of a health care network that would guarantee the quality of direct care to these people, with support to the families and professional training⁽²⁾.

Elderly assistance can happen at various levels of attention, and hospital assistance is one of them. The hospital is a place where the human frailties are more exposed, an environment where the search for answers and solutions to problems are a frequent reality. Technical knowledge is not always combined with relational knowledge, and the results are far from the expected and desired by the individuals who are there, which can generate anxieties, frustrations, and worsen health condition.

In 2009, a training program in non-verbal communication in gerontology was proposed and developed, being applied and validated in two hospitals in the countryside of the state of São Paulo. In the evaluation, the quality of the content related to self-knowledge and teamwork; the aging process; myths and stereotypes of the elderly; the non-verbal dimensions; the quality of teaching resources used and the actual organization of the meetings were highlighted as positive aspects⁽³⁾.

The results have allowed us to state that the participants were skilled and sensitive in the responses, identifying the communication resources as fundamental tools to be applied in personal and professional scopes, enabling the elderly to a more conscious, consistent, real, effective and affective care⁽³⁾.

This study is justified by the fact that the elderly receive government attention, since they represent an increasingly relevant and present clientele in social spaces and in health services. And, yet, by considering that when taking part in specific training courses, health professionals have the opportunity to experience new concepts, and through them they can change their practice, starting to understand the breadth of meaning of communication and, still, being able to take professional attitudes tuned with the goals that promote appropriate gerontologic care.

OBJECTIVE

From the replication of the training program on non-verbal communication based on the theoretical framework of interpersonal communication, non-verbal encoding and aspects of aging, this study aimed to:

- identify the knowledge of health professionals on human communication (interpersonal and non-verbal) in the context of gerontology;
- check the satisfaction of the assimilation of the contents applied immediately after the participation in the training.

METHOD

Exploratory and descriptive field research conducted in three hospitals of large and medium sizes under the direct administration of the state of São Paulo, exclusively with SUS assistance, belonging to the Regional Health Care Network in the State of São Paulo (RRAS 06 - Capital) and which have the elderly as a client in their scenario. Nursing undergraduates, graduate students, residents or health professionals were invited to participate in the technical study, once they were compulsorily bound to the institution either through employment or school relations; showing interest and willingness to attend on the days scheduled for training; taking commitment to be present at all meetings and accepted to participate spontaneously of the research by signing an Informed Consent Form. The survey obeyed all the rules established in Resolution 466/2012 of the National Health Council, having a legal opinion approved under number: 351.492/ 2013.

The training program respected a specific pedagogical matrix⁽³⁾, with a duration of 12 hours divided into three 4-hour meetings, held on weekdays during the day. Two evaluation tools (questionnaires) have been applied, being immediately held at the beginning of the first meeting to check for prior knowledge and assimilation at the end of each of the three meetings.

The processing of data in the immediate evaluation was carried out according to the following steps: reading the answers; correction based on specific theoretical references⁽⁴⁻¹¹⁾; acknowledgment of similarities of the responses; creation of categories⁽¹²⁾; establishment of criteria facing the assimilation of the items prioritized to determine the kind of satisfaction, namely:

- Very satisfactory (VS) – when the answers belonged to three or more groups or contained three or more correct characteristics of the item evaluated;
- Satisfactory (S) – when the answers belonged to two groups or contained two correct characteristics of the item evaluated, and
- Unsatisfactory (U) – when the answers belong to a single group or contained only one correct characteristic of the item evaluated or were blank or wrong.

RESULTS

Health professionals participated in the training, being separated into three groups, varying in their quantitative total depending on the meeting between 102, 93 and 100 professionals. Of these, 78.4% were top-level, being 47.5% nurses, 18.7% psychologists, 13.8% social assistants, 8.8% physiotherapists, 3.8% pharmacists and 7.4% from other areas. The technical level group, 21.6% (22), was composed exclusively of nursing technicians. As for the profile, the majority was composed of women 92.2% (94), with average age of 43.8 years old and

median 46 years old. Among men (7.8%, $n=8$) the average age was 40 years old, and the median 34 years old.

The first evaluation, which had an immediate assimilation of contents, prioritized the following items: 1. Human aging; 2. Actions that favor the autonomy or independence of the elderly; 3. Factors related to the elderly and aging that interfere with communication; 4. Factors related to the health professional that interfere with communication; 5. Functions of non-verbal communication; 6. To the success of professional influences on communication; 7. Dimensions of non-verbal communication, including: Paralanguage: environmental factors, Tacesics, Proxemics, Kinesics, and physical characteristics.

It should be noted that the same answer in a given item may be present in more than one grouping, hence the sum, in this case, does not make up 100%.

- **Human aging** - The results have been split into 5 different groups: aging as a dynamic process (65.9%), biopsychosocial changes and modifications (62.7%); presence of limitations, weaknesses and diseases that should be the focus of attention of health professionals (36.3%); situations and individual experiences (44.1%) and irreversible, individual and universal condition (24.5%);
- **Actions that favor the autonomy or independence of the elderly** - The results showed that 95.1% of the participants knew how to quote at least one action that could collaborate in the autonomy and independence of the elderly. The responses could be grouped into: related to self-care (41.2%); the physical environment and equipment (28.4%); respect for decisions (25.5%); the overall assessment of the elderly and attendance in team (24.5%); the communication (21.6%); family aspects (7.8%) and recreational and physiotherapeutic activities (2.0%);
- **Factors related to the elderly that interfere in communication** - Eight distinct groups were identified: sensory changes (57.8%), cognitive changes (52.9%); personality and psychological alterations (51.0%); changes in health conditions (44.1%); relationship with the professionals (20.6%); environmental changes (12.7%), and family and cultural aspects (9.8%);
- **Factors related to the health professional that interfere in communication** - The answers were grouped into: physical and emotional conditions (55.9%), qualifying time on the interaction (49.0%), gerontological knowledge (40.2%); prejudices and affinity with the elderly (31.4%); verbal communication (17.6%); professional features (16.7%); administrative and political issues (13.7%); professional-escort relationship (8.8%), and culpability assigned to take care of the elderly (5.9%);
- **Influences for the success of the professional facing communication issues** - Many factors can influence the communication in the context of health. Silva⁽⁷⁾ establishes eight items for the effectiveness of communication that must be known and applied by health professionals when in a customer interaction, whose responses were grouped in:

observing their own non-verbal language and the other's (62.4%), being sensitive to the needs of others, including client, family and team (29.0%), being empathetic, caring, patient and respectful (12.9%), knowing yourself, your characteristics and needs (10.7%), using words carefully (8.6%), acknowledging your own feelings and the other's (6.5%), recognizing the differences between people (4.3%), and enhancing the reports (complaints) of people (2.2%);

- **Functions of non-verbal communication** - The results of the responses to the recognition of four main functions of non-verbal communication⁽⁷⁾ were: complement, ratify and enforce the verbal language (64.5%), show feelings and emotions (54.8%), replace verbal language (23.7%) and contradict the verbal language (23.7%). It should be noted that 94.6% managed to identify at least one of the functions aforementioned;
- **Dimensions of non-verbal communication** - In paralanguage four groupings were obtained: voice (50.5%), reactions caused by the type of speech (34.4%), silences, pauses and interruptions (26.9%) and phonoaudiological conditions of the elderly (16.1%). In relation to environmental factors that can interfere with the communication with the elderly, 100% of the participants were able to respond appropriately to the question, citing at least one factor. Eight groups were built: spacial and decorative (62.4%), sound and vibration (55.0%), noises and sounds of the hospital environment (carts, people and equipment) (41.9%), thermal and ventilation (24.7%), colors (23.7%), adaptive (17.2%), hygienic and safety (11.8%) and signaling (9.7%). Regarding tacesics (factors or conditions that must be observed when touching the elderly), six groups were identified: initial permission and continuity (57.0%), context and meanings (38.7%), intentionality (38.7%), condition of the elderly (37.6%), frequency, pressure and duration of touch (36.6%) and location of touch (32.3%). Concerning proxemics, the answers were treated in two different ways: the first one identified which of the three invasive mechanisms contained the answers (invasion, contamination and infringement), and the second one identified whether the examples mentioned referred to the invasion of personal space, territory, or both with: invasion (96.0%), violation (33.0%), and contamination (31.0%). When applying the classification regarding the kind of invasion, the answers that have identified one or more types of invasion, the results revealed: 15.0% concerning invasion of personal space, 16% territorial invasion and 68% both. As the physical characteristics that could assist the communication obtained five groupings: value to the professional image (50%), value to garments (26%), informational value about the elderly (26%), value on the initial and final impact (16%), and value to the biotype (16%). Finally, in relation to the kinesics, four groupings were obtained: bodily movements (55%), visual contact (47%), sensitivity to the elderly (46%), and gestures (31%).

Table 1 presents the results related to the assimilation of the contents worked in the training by the participants.

Table 1 - Items prioritized and assessed immediately after the participation of health professionals in the training program on non-verbal communication, São Paulo, Brazil, 2014

Prioritized items	Assimilation Criteria (%)		
	VS	S	U
Human aging	27.5	42.1	30.4
Actions that favor the autonomy or independence of the elderly	36.3	41.2	22.5
Factors related to the elderly that interfere in the communication	49.0	35.3	15.7
Factors related to the health professional that interfere in the communication	40.2	45.1	14.7
Influences for the success of the professional facing communication issues	8.6	31.2	60.2
Functions of non-verbal communication	20.4	57.0	22.6
Dimensions of non-verbal communication			
Paralanguage	33.3	57.0	9.7
Environmental factors	52.7	34.4	12.9
Tacesics	9.7	75.3	15.0
Proxemics	68.0	22.0	10.0
Physical Characteristics	45.0	45.0	10.0
Kinesics	22.0	39.0	39.0

Notes: VS = very satisfactory; S = satisfactory; U = unsatisfactory

DISCUSSION

Aging surpasses the limits of private life, and currently it is questioned as a social risk to be assumed. It should not be seen as a disease, but as an achievement. It is a dynamic, natural, biopsychosocial and progressive process accompanied by huge challenges to public policies in force⁽¹³⁾. Although, in the study, most professionals have brought previous concepts relating to the topic, the assimilation of the content proved to be unsatisfactory. This reinforces the importance of the constructs socially established and their influence in building relations with the elderly.

Historically, aging is accompanied by stereotypes and prejudices related to cognitive or physical disability, which only more recently are being widely questioned. These influence the identity construction of the elderly person themselves, and of those surrounding that individual, relatives and friends or who at some point will relate to them, such as health professionals. It is urgent that health professionals break with the restricted and prejudiced vision against older people and organize new forms of appropriate attention to the demands of that group⁽¹⁴⁾.

Autonomy involves making decisions regarding hospital procedures and therapies that can permeate conflicts of moral and ethical nature. The consent of the elderly in these situations is complex and needs to be seen as an integrated process to the professional-elder relationship. It also gathers aspects linked to independence and self-control, which qualify their behavior in the context⁽¹⁵⁾.

The length of hospital stay for the elderly tends to be higher due to the decrease of their functional reserve, which leads to a longer response time to therapies adopted. Hospitalization

is often also accompanied by functional decline, which in the most extreme cases, can lead to dependency⁽¹⁴⁾. A study reveals that one in three hospitalized elderly evolves with loss of the ability to perform basic activities of daily life, thus requiring a caregiver, and at least 20% may have *delirium* episodes during hospitalization⁽¹⁶⁾. These issues are present in the everyday life of the professionals interviewed, having been reinforced with the training conducted. All the professionals mentioned at least one of the topics related to the hospital environment. Enabling and safe structures allow the elderly to develop interactive activities that help in communication and are supportive in maintaining and maximizing physical autonomy and independence⁽¹⁷⁾.

Sensory changes, such as presbycusis and presbyopia tend to be present in the elderly, interfering in the communication with professionals, decreasing their interaction with the environment and generating mood changes⁽³⁾. The presence of presbycusis and speech intelligibility (voice pitch), even in comfortable conditions may compromise the communicational process. Professionals should be directed to encourage the orofacial reading and the visual and tactile aspects as additional sensory channels⁽¹⁸⁾. Now, presbyopia prevents the person from focusing and observing well within a short distance, with complaints of headache and progressive eye nuisance being common. These changes make it difficult to identify the hospital environment, which is foreign to the elderly, and can result in accidents⁽¹⁹⁾.

Hospitalization can be a challenging experience in general to elders for causing personal insecurity, autonomy impairment, and a certain fear of the outcomes. Due to that, the person can start walking a suffering path which includes experiencing emotions and feelings of unease and sadness that

can be followed by moments of aggression or dullness. It is essential that the professional identifies these peculiarities⁽²⁰⁾.

It is up to the professional to understand the pathological and physiological changes associated with aging, behavioral oscillations resulting from the anxiety that accompanies the hospitalization process. Thus, being a facilitator in the adaptation of the elderly to this process, helping them to participate actively in the decisions, procedures and conducts to be adopted. Facial expressions, body gestures and the speech of the individual may reveal feelings⁽⁷⁾.

Understanding the speech depends directly on syntactic and semantic information⁽²¹⁾. Pronunciation or language sounds production patterns can be changed as a result of neurological deficits that affect motor programming or the neuromuscular speech execution. These changes are mainly related to neuromotor programming and/or execution⁽²¹⁾. The structures and functions in the peripheral mechanism of speech suffer changes with aging, however, there is no scientific consensus that explains its causes. The deterioration of this function can be associated with the absence of teeth or poorly adapted dentures. Generating muscle changes, they cause difficulty in articulating words, leading to wheezing and also to the accumulation of saliva in the labial commissures⁽²²⁾.

The factors related to the professionals that contribute to the communicational interference are buoyed in their attitudes, emotional, and physical condition, in qualifying the interaction time, in geriatric knowledge, in prejudices and affinities with the elderly, and the characteristics of the work.

Health care professionals should seek to know themselves, observe their own actions, check their skills and understand that, as humans, they have feelings and psychological, social and physical barriers that can be associated with an exhaustive work and that might hinder their optimum performance. Becoming aware of this possibility of not being well and ready to take care of someone should be a reality to be faced⁽²³⁾.

The items related to the influence of communication (both verbal and non-verbal) in the professional success were not assimilated in a satisfactory manner, which is worrisome because it tends to significantly affect the quality of the care provided, and should therefore serve as a warning to institutional managers.

Biased socially established conceptions about the elderly, as good-for-nothing and sick people can promote a purely reductionist curative care practice with limited benefits⁽³⁾.

A proper care associates technical competence to interpersonal communication. The latter demands some requirements such as wanting to be with someone else and enjoying what you do. Everyone knows the routine imposed and the difficulty to manage the time of assistance, but, when you take care of someone, this relationship is built compulsorily. The care itself gives rise to the opening of a space to listen to the elderly, interact, understand their difficulties and needs. Ensuring quality in social interaction and bonding is due to the option of wanting to be with the other. It is a professional decision on how to invest in the time while being with someone else, on the intention to see and observe and communicate consciously with the someone else⁽²⁴⁾.

Communication occurs both in verbal and non-verbal forms, and emotions are mostly exposed by non-verbal channels. Emotional signals are emitted unconsciously and we react to them similarly. Paralinguistic signs demonstrate feelings, personality traits, attitudes, interpersonal relationships, and self-concept. Hence, it is essential to be aware of it when using, for example, cough or grunt or breaks in an interaction. It may be that they represent something that goes beyond the usual and requires to be valued. Stopping the elderly when he/she speaks disfavors the creation of a key bond for his/her recovery⁽⁷⁾. In some situations, the elderly may not want to talk about being scared, are ashamed to ask and clarify their doubts, or even because they believe that the professional is in a hurry or does not want to spend more time with him/her.

A study performed with patients observed during the first hour of anesthetic recovery who were subsequently interviewed, found that they had difficulty starting verbalization, and mostly have not had their needs perceived by those who assisted them. Such perception only occurred after three or more attempts of verbalization of the patient⁽²⁵⁾.

The type of accent or intonation given to words externalizes the root, culture, location, region, and education of people. Intolerance or misunderstanding of these peculiarities tends to cause linguistic prejudice that can lead to social exclusion⁽⁸⁾.

Situations such as aphasia or dysphasia consist of language disorder, in which there is impairment of the production capacity or verbal understanding caused by structural injury to the Central Nervous System. In these situations, the paralinguistic resources tend to be used with greater intensity⁽²⁶⁾.

Regarding environmental factors, it should be considered that inpatient sectors or closed units tend to cause confinement and isolation. These sites are not always provided with the necessary information so that the elderly will understand what is going on with them and in their surroundings. Many times, they are deprived of their usual daily life, and at the same time they are submitted to other people, who are unknown, strange and unpleasant. This situation leads part of the elderly to present *delirium* episodes or even hallucinations, as well as mood swings expressed by fear, aggressiveness, introversion, and even depression, all with significant impact on communication⁽²⁷⁾. The organization of the space, including ornaments and necessary equipment for hospital assistance, the existing sound condition and the one produced in the environment, as well as the visual communication elements interfere with the interaction of the elderly with the hospital environment^(5,7).

Touch is another important dimension of non-verbal communication, being considered as the silent language capable of causing well-being, essential to human development. Its value is related to the real possibility of shortening the emotional and physical distances between people. In professional interactions in the health area, touch is described as procedural, a time when physical contact occurs due to the procedure or assistance task, which is expressive, when associated with the spontaneity of its occurrence, regardless of the technical liaison with the task itself⁽²⁸⁾.

A study conducted in England with doctors who practiced palliative care and their patients has confirmed that an

appropriate touch qualifies the communication positively. Touch helps establishing an empathic encounter, and translates into courtesy, reception and warmth, contributing to a more relaxed and comfortable recognition of the encounter between the professional and the patient⁽²⁸⁾.

A research has found that the two most common reasons for the patient in the hospital to not feel comfortable with the use of the touch are: the invasion of personal space and the feelings of discomfort in relation to the gender of the professional. There is no evidence that religious, cultural or family beliefs are discouraging of the use of touch, however, they should always be considered⁽²⁸⁾.

When you touch a person, sensations and feelings are stimulated in both individuals involved. Both the intentionality of the act as well as the receptivity get distinct repercussions, and the most common one is the expression of affection. The elements that interfere with the acceptance, in the continuity and the result caused by touch depend on how the approach is made, the time used in the contact, the place where it occurs, and the pressure exerted on the body^(7,9). The awareness of the touch and the issues involving it are paramount to the success of the action because they translate attention and zeal when assisting the elderly. Thus, it is recommended that professionals develop communication skills to be able to recognize the moment, the location, the duration and the intensity suited to every touch⁽⁵⁾.

Proxemics refers to the use that humans make of the space as a cultural product⁽⁹⁾. The space used, claimed and defended by the people has been featured in the essays^(7,9-10). Depending on the distance between the bodies, space takes on distinct classification, such as: intimate, personal, social, and public. When this area around the body is surpassed without authorization, there is an invasion. Personal invasion is a relevant element because it brings together physical and psychological aspects, representing a means of communication between people^(7,10). The attitude of care requires respect for the personal and territorial space of the elderly, regardless of whether they are conscious, sedated, or in a coma. A research developed with professionals who worked in intensive care units demonstrated breaches of personal space while performing everyday functions in that environment⁽²⁹⁾.

Aspects related to physical characteristics, such as the dimension of non-verbal communication can also be applied in favor of the communication. Depending on the profession, in the health area, it is seen and identified for a kind of gender, with healthy-looking, educated young adult, often with exclusionary and discriminatory racial representations. Now this imaginary can interfere in the professional ideal by whom the elderly want to take care of them, and vice versa, to the elderly the professional is expected to take care of. The result of that perception can affect the establishment and the maintenance of the bond, which is special and necessary in the hospital scenario, interfering with the interaction⁽³⁰⁾.

Physical appearance is just one of the many parts used to validate someone's personality (elderly or professional). Their aspects bring clues about emotions, values, beliefs, physical and mental health conditions of the individuals. The motivation to keep up with a particular appearance goes through

countless conditions. It is common for people with a different appearance than the social and cultural norms establish to cause an uncomfortable situation to others, and as a result, they are victims of negative attitudes⁽⁸⁾.

The elder expects health professionals to have a good physical appearance, including clean nails and hair, and neat clothes, because just then, in their imagination, they are able to convey security at the moment which requires care⁽³⁾.

The kinesics is a dimension that studies the physiology of the body movement and it does not have a definitive meaning because the body movement is related to the context and the culture, and these undergo changes⁽⁷⁾. Body movements most often only reflect a physical condition or a temporary state of mind and not a more permanent trace of personality of the individual, but can reveal valuable information⁽⁸⁾. The face is the central location of perception and transmission of non-verbal signals in human communication. It is the location in which the production of language becomes visible along with the emotional states of the human being which are expressed more directly. That is why the face is regarded as the best non-verbal *liar*. Regarding looks, the functions in the communicational scope are based on the eye movement potential, with three important variables: frequency, duration and direction of gaze⁽¹¹⁾.

Although the functions of non-verbal communication have been cited by 94.6% of the training participants, it can be observed that in the assimilative evaluation they were unsatisfactory, significantly compromising the quality of care directed to the elderly person.

We put forth the premise that decoding non-verbal manifestations of human behavior is a skill necessary for the success of the relationship, hence the idea that empowering professionals in kinesics and in other dimensions is an effective way that tends to interfere with the quality of the provision of gerontological assistance.

FINAL CONSIDERATIONS

Professionals that participated in the training brought prior knowledge which was socially constructed. It became apparent in the speeches that there was a need for deepening further the issues related to gerontology aspects, since the elderly will remain a relevant representative health services clientele.

On the assimilative evaluation it was observed that, despite the aging manifesting itself through a decline of the functions of the various organs, it ranges from one person to another one of the same age. They have identified that the vision that have regarding the elderly interferes with the way they relate to them. They admitted that sometimes the prejudice against the elderly and aging is dormant and is part of everyday reality, which was given little thought before. After training, it can be better tackled.

The comparison of the obtained results shows that the skills are mediated by knowledge, attitude and individual and collective way to make things. The presence of verbal or written reports by itself does not guarantee the actual presence of the instrumental ability, enough to change the context of the work

or the relationship with the elderly. Capacity building is an attempt to mobilize and exploit health professionals who care for the elderly.

The rate of assimilation of the contents contained in the program immediately after applying the training was very satisfying in all the items investigated, except when identifying

factors that contribute to effective professional communication in the health context.

It can be concluded that the replication of the program has turned out to be relevant and updated to the hospital services scenario, being efficient and applicable to professionals of the healthcare area.

REFERENCES

1. Nogueira SL, Geraldo JM, Machado JC, Ribeiro RCL. Distribuição espacial e crescimento da população idosa nas capitais brasileiras de 1980 a 2006: estudo ecológico. *Rev Bras Estud Popul* [Internet]. 2008[cited 2015 Apr 02];25(1):195-8. Available from: <http://www.scielo.br/pdf/rbepop/v25n1/v25n1a12>
2. São Paulo. Decreto n. 58047 de 15 de maio de 2012. Institui o Programa Estadual São Paulo Amigo do Idoso e o Selo Amigo do Idoso e dá providências e correlatos. *Diário Oficial do Estado de São Paulo*, 16 mai 2012. Executivo. Seção I, p.1.
3. Prochet TC. Capacitação em comunicação não-verbal: um caminho para ações de cuidado efetivo/afetivo ao idoso [tese]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 2010.
4. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Envelhecimento e saúde da pessoa idosa. Brasília: Ministério da Saúde; 2006. (Cadernos de Atenção Básica, n.19).
5. Farias N, Buchalla CM. Classificação internacional de funcionalidade, incapacidade e saúde da Organização Mundial da Saúde: conceitos, usos e perspectivas. *Rev Bras Epidemiol* [Internet]. 2005[cited 2015 Apr 02];8(02):187-93. Available from: <http://www.scielo.br/pdf/rbepid/v8n2/11.pdf>
6. Prochet TC, Silva MJP. Estratégias que colaboram na independência física e autonomia do idoso hospitalizado. *Rev RENE* [Internet]. 2011[cited 2015 Apr 02];12(04):678-83. Available from: http://www.saude.sp.gov.br/resources/humanizacao/biblioteca/artigos-cientificos/a005_-_estrategias_que_contribuem_na_independencia_fisica_e_autonomia_do_idoso_hospitalizado_-_rene_2011.pdf
7. Silva MJP. Comunicação tem remédio. 8.ed São Paulo: Loyola; 2011.
8. Dimitrius J, Mazzarella WP. Decifrar pessoas: como entender e prever o comportamento humano. 4. ed. São Paulo: Elsevier; 2009.
9. Montagu A. O tocar: o significado humano da pele. 9. ed. São Paulo: Summus; 1988.
10. Hall ET. A dimensão oculta. São Paulo: Martins; 2005.
11. Elkman P. Linguagem das emoções. São Paulo: Leya; 2011.
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13. ed. São Paulo: Hucitec; 2013.
13. Lima AP, Delgado EI. A melhor idade do Brasil: aspectos biopsicossociais decorrentes do processo de envelhecimento. *Ulbra e Movimento* [Internet]. 2010[cited 2015 Apr 02];1(2):76-91. Available from: <http://revista.ulbrajp.edu.br/ojs/index.php/actabrasileira/article/viewFile/630/142>
14. Sales MVC, Silva TJA, Gil Junior LA, Jacob Filho W. Efeitos adversos da internação hospitalar para o idoso. *Rev Bras Geriatr Gerontol*. 2010;4(4):238-45
15. Silveira MM, Pasqualotti A, Colussi EL. Educação gerontológica, envelhecimento humano e tecnologias educacionais: reflexões sobre velhice ativa. *Estud Interdiscipl Envelhec* [Internet]. 2012[cited 2015 Apr 02];17(2):387-98. Available from: <http://seer.ufrgs.br/RevEnvelhecer/article/view/26983>
16. Rodrigues RAP, Seudeller PG, Pedrazzi EC, Schiavetto FV, Lange C [Morbidity and interference in seniors' functional ability]. *Acta Paul Enferm* [Internet]. 2008[cited 2015 Apr 02];21(4):643-8. Available from: <http://www.scielo.br/pdf/ape/v21n4/a17v21n4.pdf> Portuguese.
17. Bessa MEP, Silva MJ, Borges CL, Moraes GLA, Freitas CASL. Elderly residents in long-term institutions: the use of spaces in the construction of everyday life. *Acta Paul Enferm* [Internet]. 2012[cited 2015 Apr 02];25(2):177-82. Available from: http://www2.unifesp.br/acta/pdf/v25n2/v25n2a4_en.pdf
18. Marques ACO, Kozlowskii L, Marques JM. [Auditory rehabilitation in the elderly]. *Rev Bras Otorrinolaringol* [Internet]. 2004[cited 2015 Apr 02];70(6):806-11. Available from: <http://www.scielo.br/pdf/rboto/v70n6/a17v70n6.pdf> Portuguese.
19. Damasceno NA, Damasceno EF. Análise da capacidade de acomodação em pacientes presbítas com baixo índice de massa corporal. *Rev Bras Oftalmol* [Internet]. 2013[cited 2015 Apr 02];72(5):294-300. Available from: <http://www.scielo.br/pdf/rbof/v72n5/03.pdf>
20. Carreta MC, Bettinelli LA, Erdmann AL. [Reflections on the care of nursing and the autonomy of the human being under the condition of hospitalized elderly]. *Rev Bras Enferm* [Internet]. 2011[cited 2015 Apr 02];64(5):958-62. Available from: <http://www.scielo.br/pdf/reben/v64n5/a24v64n5.pdf> Portuguese.
21. Schlindwein-Zanini R. [Dementia in the elderly: neuropsychological aspects]. *Rev Neurocienc* [Internet]. 2010[cited 2015 Apr 02];18(2):220-6. Available from: <http://www.revistaneurociencias.com.br/edicoes/2010/RN1802/262%20revisao.pdf> Portuguese.
22. Castro SAFN, Santos AC, Gonçalves LHT. A fala dos idosos: modificações associadas ao envelhecimento do sistema estomatognático. *Rev Bras de Ciên do Envelh Hum* [Internet]. 2004[cited 2015 Apr 02];1(2): 41-51. Available from: <http://www.upf.br/seer/index.php/rbceh/article/view/13/7>
23. Dias KCCO, Lopes MEL, Zaccara AAL, Duarte MCS, Morais GSN, Vasconcelos MF. O cuidado em enfermagem direcionado para a pessoa idosa: revisão integrativa. *Rev Enferm UFPE*

- online [Internet]. 2014[cited 2015 Apr 02];8(5):1337-46. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/5500/pdf_5107
24. Prochet TC, Silva MJP. [Perception of the elderly in the view of affective behaviors expressed by the Nursing Team]. *Esc Anna Nery* [Internet]. 2011[cited 2015 Apr 02];15(4):784-90. Available from: <http://www.scielo.br/pdf/ean/v15n4/a18v15n4.pdf> Portuguese.
 25. Marins AC, Araújo STC. A percepção auditiva da paralinguagem do paciente após tireoidectomia subtotal: ensino e pesquisa em enfermagem. *Esc Anna Nery R Enferm* [Internet]. 2006[cited 2015 Apr 02];10(3):586-91. Available from: http://www.scielo.br/pdf/ean/v10n3/en_v10n3a32.pdf
 26. Rocha MAS, Lima MLT. Caracterização dos distúrbios miofuncionais orofaciais de idosos institucionalizados. *Rev Bras Ciênc Env Hum* [Internet]. 2010[cited 2015 Apr 02];4(1):21-6. Available from: <http://www.upf.br/seer/index.php/rbceh/article/view/282-292/pdf>
 27. Vidal LPP, Araújo STC, Perreault M, Azevedo AL. Family companionship as a behavioural stimulus for intensive care patients. *Esc Anna Nery* [Internet]. 2013[cited 2012 May 18];17(3):409-15. Available from: http://www.scielo.br/pdf/ean/v17n3/en_1414-8145-ean-17-03-0409.pdf
 28. Cocksedge S, George B, Renwick S, Chew-Graham CA. Touch in primary care consultations: qualitative investigation of doctors' and patients' perceptions. *Br J Gen Pract* [Internet]. 2013[cited 2014 May 18]; 63(609):283-9. Available from: <http://bjgp.org/content/63/609/e283>
 29. Bettinelli LA, Pomatti DM, Brock J. [Privacy invasion of UTI patients: perceptions of professionals]. *Bioethikos* [Internet]. 2010[cited 2012 May 18];4(1):44-50. Available from: <http://www.saocamilo-sp.br/pdf/bioethikos/73/44a50.pdf> Portuguese.
 30. Campos PFS, Oguisso T. [The University of São Paulo, School of Nursing and the Brazilian Nursing professional identity re-configuration]. *Rev Bras Enferm* [Internet]. 2008[cited 2012 May 18];61(6):892-8. Available from: <http://www.scielo.br/pdf/reben/v61n6/a17v61n6.pdf> Portuguese.
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