RIASE
REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

CARING IN INSTITUTION: THE APPROACH OF *HUMANITUDE* AS A RELATIONAL RESOURCE FOR WELL-BEING IN OLD AGE

O CUIDAR EM INSTITUIÇÃO: A ABORDAGEM DA *HUMANITUDE* COMO UM RECURSO RELACIONAL PARA O BEM-ESTAR NA VELHICE

EL CUIDADO EN LA INSTITUCIÓN: EL ENFOQUE DE LA *HUMANITUDE* COMO UN RECURSO RELACIONAL PARA EL BIENESTAR EN LA VEJEZ

Helena Reis Amaro da Luz – Psychology and Educational Sciences College, University of Coimbra, Coimbra, Portugal.
ORCID: https://orcid.org/0000-0003-1592-0953

Rosa Cândida Carvalho Pereira de Melo – Nursing School of Coimbra. Coimbra, Portugal.
ORCID: http://orcid.org/0000-0002-0941-407X

Corresponding Author/Autor Correspondente:
Helena Reis Amaro da Luz – University of Coimbra, Portugal. helenareis2008@gmail.com

Received/Recebido: 2020-05-25 Accepted/Aceite: 2020-06-22 Published/Publicado: 2020-12-29

DOI: http://dx.doi.org/10.24902/r.riase.2020.6(3).444.277-291

©Author(s) (or their employer(s)) and RIASE 2020. Re-use permitted under CC BY-NC. No commercial re-use.
©Autor(es) (ou seu(s) empregador(es)) e RIASE 2020. Reutilização permitida de acordo com CC BY-NC. Nenhuma reutilização comercial.

ABSTRACT

Objectives: To analyze the contours of differentiated old age in residential institutions focusing on longevity, dependence and care articulation; to reflect on the implementation of the *Humanitude* care methodology (HCM) in the operationalization of the caregiver and cared-for person interaction for achieving well-being in old age and to discuss the importance of organizational resources for the success of caring in *Humanitude*.

Method: This is a theoretical reflection based on a literature review on scientific evidence of the HCM for institutionalized elderly people care.

Results: The *Humanitude* approach allows to consider the "different old ages" in care practices, it improves older adults capacity based on the relational pillars (look, word and touch) and the operationalization of the relationship through the structured sequence of *humanitude* care procedures, allowing the effectiveness of care.

Conclusion: As a predictor of dependency, longevity heightens the tension on care policies agents, namely residential institutions. The *Humanitude* approach shows strong opportunities with elderly people with a clinical picture of dependence and cognitive deterioration since it configures personalized interventions and autonomy capacity. Committed to the quality and qualification of professionals it is important for the institutions to implement the HCM to avoid depersonalized care practices, harming well-being in old age.

Keywords: Caring; *Humanitude*; Interdisciplinarity; Relationship; Well-being.

RESUMO

Objetivos: Analisar os contornos da velhice diferenciada nas instituições residenciais procedendo à reflexão em torno da articulação entre longevidade, dependência e cuidado; refletir sobre a implementação da metodologia de cuidado *Humanitude* (MCH) na operacionalização da interação cuidador e pessoa cuidada, contribuindo para o bem-estar na velhice e discutir a importância dos recursos organizacionais para o sucesso do cuidar em *Humanitude*.

Método: Trata-se de uma reflexão teórica assente numa revisão da literatura sobre a evidência científica da MCH no cuidado à pessoa idosa institucionalizada.

Resultados: A abordagem da *Humanitude* permite considerar as "diferentes velhices" nas práticas do cuidado, a capacitação dos idosos assentes nos pilares relacionais (olhar, palavra e toque) e a operacionalização da relação por meio da sequência estruturada de procedimentos cuidativos *Humanitude*, permitindo a efetividade do cuidado.

Conclusão: A longevidade sendo um preditor da dependência coloca tensões aos agentes das políticas de cuidado, designadamente às instituições residenciais. A abordagem *Humanitude* mostra-se oportuna junto de idosos com quadro clínico de dependência e deterioração cognitiva, pois configura intervenções personalizadas e de capacitação da sua autonomia. Comprometidas com a qualidade e qualificação dos profissionais importa às instituições implementarem a MCH para evitar a prática de cuidados despersonalizados e penalizadores do bem-estar na velhice.

Palavras-chave: Bem-estar; Cuidar; *Humanitude*; Interdisciplinaridade; Relação.

RESUMEN

Objetivos: Analizar los contornos de la vejez diferenciada en instituciones residenciales enfatizando la articulación entre longevidad, dependencia y cuidado; reflexionar sobre la implementación de la metodología del cuidado de la *humanitude* (MCH) en la operacionalización de la interacción cuidador y la persona cuidada, contribuyendo al bienestar en la vejez y discutir la importancia de los recursos de la organización para el éxito del cuidado de la *Humanitude*.

Método: Esta es una reflexión teórica basada en una revisión de la literatura sobre la evidencia científica de la MCH en el cuidado a personas mayores institucionalizadas.

Resultados: El enfoque de la *Humanitude* permite considerar las "diferentes edades" en las prácticas del cuidado, la capacitación de los ancianos en función de los pilares relacionales (mirada, palabra y tacto) y la operacionalización de la relación a través de la secuencia estructurada de los procedimientos del cuidado de la *Humanitude*, permitiendo la efectividad del cuidado.

Conclusion: La longevidad, al ser un predictor de dependencia pone tensión en los agentes de las políticas del cuidado, a saber, a las instituciones residenciales. El enfoque de la *Humanitude* demuestra ser oportuno para las personas mayores con un cuadro clínico de dependencia y deterioro cognitivo, ya que configura intervenciones personalizadas y el entrenamiento de su autonomía. Comprometidos con la calidad y la calificación de los profesionales es importante que las instituciones implementen la MCH para evitar la práctica del cuidado despersonalizado, perjudicando el bienestar en la vejez.

Descriptores: Bienestar; Cuidado; Humanidad; Interdisciplinariedad; Relación.

INTRODUCTION

The changes that occurred in the 20th century, influencing the living conditions of the populations, configured the transition from the century of growth to the century of population aging in a "silent" way, making this a phenomenon that characterizes societies and, in particular, developed. In the gray-haired European context[1], the elderly population represents a fifth (19.4%) of the population of the 28 Member States (MS)[2], whereas in southern European countries and in the Portuguese case, the expression of aging arising from demographic involution[3-4] takes on such contours, whose greatness has already made Portuguese society stand out as an hyper aged society[4], or as a reality that is distinguished by the "aging of aging"[5]. In this context, in which longevity constitutes a societal attribute and for which several factors contribute, which, on the whole, add years to the lives, it is also recognized, on the one hand, that the extension of life is specific and does not reveal itself standardized vis-à-vis a collective (of the older adults) and on the other, that the extension of life is not always accompanied by quality of life. Equating dependency as a risk in old age is a concern placed on the agenda of formal care providers, given their commitment to ensure well-being and to promote significant care, presenting in these environments the approach of *Humanitude* as differentiating, because it personalizes and focuses the elderly person through relational techniques, which contribute to give dignity to the condition of life in old age.

This reflection aims to discuss the opportunity of HCM as an organizational philosophy and culture, particularly in residential structures that provide health and relational services, given the scarcity of studies related to this theme.

Objectives

To analyze the contours of differentiated old age in residential institutions, reflecting on the articulation between longevity, dependence and care; to reflect on the implementation of the *Humanitude* Care Methodology in the operationalization of the caregiver and cared-for person interaction, contributing to well-being in old age and discussing the importance of organizational resources for the success of caring in *Humanitude*.

METHOD

It is a theoretical reflection based on a literature review on the scientific evidence of care for institutionalized elderly people, as well as on the authors' experience. The review for the discussion of the phenomenon of aging and the respective implications on the structures of care provision covered specialized bibliography, namely works and scientific articles, documents with statistical information, reports and legal diplomas. The analysis of the implementation of the HCM was carried out based on reference works in the area of *Humanitude* and four scientific articles selected in the search engine EBSCOhost, using the databases CINAHL complete and MEDLINE complete, with the descriptors *Humanitude* and elderly people.

The structuring of the text includes the following sections: introduction; objectives; method; results; discussion: longevity, dependency and institutional care; *Humanitude* as a resource for differentiated care in an institution; and human and organizational resources as "predictors" of the success of care in *Humanitude*, limitations, contributions to practice and health policies; and conclusions.

RESULTS

In the care agenda, the *Humanitude* approach has been revealing potentialities to consider the "different old ages", by emphasizing, in the conceptions and practices of care, attitudes of a holistic nature and empowerment of older people based on relational pillars (gaze, verbal communication and touch) and inherent structured sequence of *Humanitude* care procedures. For the effectiveness of care, the professionals that implement the HCM are central elements in the entire process.

DISCUSSION

Longevity, dependence and institutional care: articulations

In a unique way in the history of Humanity, the 20th century was characterized by profound transformations in the age structure of the populations, standing out among them and expressively, the decline in fertility, mortality and the increase in average life expectancy, constituting them, markers of a marked demographic transmutation, which favored the expected increase in the number of elderly individuals aged 65 or over, in Europe, in the first decades of the 21st century.

Indeed, population aging is a phenomenon that is originally European[6], with Europe as the most aged continent in the world[1], with 19.4% of people aged 65 or over and estimated to represent 29.1% of the European population, by 2080[2]. The pattern of longevity stands out from this panorama, which has been reinforced by the increase in life expectancy, making visible both the segment of very old people and the phenomenon of democratization of old age. As Légare informs[7], in developed societies life expectancy is close to 80 years-old, resulting in the fact that old age becomes increasingly accessible and that death tends less and less to occur due to fatalism and more following the old age.

It should be noted that among this reality, in the countries of southern Europe and mainly in Portugal, the pace has been intensifying, being considered the sixth oldest country in the world[5] and the third most aged in Europe[8], portraying it as a hyper-aged country[9], since 21.8% of residents are 65 or older[10] and the contingent of very old adults (80 and more) represents 26.5% of the population aged 65 and over and 5.6% of the Portuguese population[11], translating this, the picture of the "ageing of ageing"[5] among us.

While it is certain that old age is prolonged in the present and that individuals can experience their greater longevity in more favorable conditions compared to past times, it is also recognized that the extension of life is not necessarily accompanied by quality life, that is, although it persists the probability of being able to live another 20.4 years from the age of 65, it is assumed, at the same time, that the temporality of life without disability is considerably reduced, since it is estimated at 7.9% and 6.7 %, survival without disability, from 65 years-old, for men and women, respectively[8].

In this scenario in which aging is presented as irreversible, based on the heterogeneity or "bricolage" of processes related to the long live and that result from the inter-influence of multiple variables[12], it is also true that with advanced age, risk of the emergence of chronic diseases and difficulties in the field of functionality and mental health, enhancing the emergence of dependence and impaired quality of life, particularly among very old peo-

ple. As pointed out by Nogueira[13], at present, the issues of autonomy versus dependence are priority aspects in the European debate regarding the ends and means of social support in the face of old age and/or dependence. Thus, promoting quality of life during old age, and ensuring longevity with dignity conditions are central challenges in this 21st century[14]. This raises greater attention on the part of institutional care agents to issues related to with the new contours of old age and with the adequacy of institutions in terms of modes of operation, in order to address the best response to the expectations of the elderly and their families.

Regarding formal care, Portugal has a set of social and health resources from the State, the market and organizations with a solidarity impetus, the latter covering various types, but where IPSS predominate[15]. These IPSS have a long tradition in responding to the elderly people, in need of support and/or in a condition of dependency, with this provision mostly occurring in the form of equipment and services. It should be noted the weight of non-profit entities (71.8%) in the set of entities in the service and equipment network and those of solidarity provision, namely IPSS and similar (59.4%), which were the basis for the emergence of 72% of social responses in 2017, and within the scope of those that assume greater representativeness orientated to Elderly People (i.e., Residential Structure for Elderly People (RSEP), Day Care Center (DCC) and Home Support Service (HSS)) there was a growth in the order of 74%, between 2000 and 2017, in terms of making available the number of seats/capacity, which makes, according to the latest data revealed, a coverage in terms of supply, of about 272 000 seats in these responses[10]. Mainly it is up to these entities to act in order to minimize the loneliness and social isolation of the elderly, delay the deterioration of the aging process, stimulating the activation and promotion of the autonomy of the elderly people, and respond to basic and other needs, through multiple services and the allocation of plural resources. In this context, as several studies point out, there are different profiles of elderly people in need of support, which differ to a large extent depending on age and their health condition. In effect, institutional care largely centralizes its action for audiences aged 80 or over (e.g., RSEP – 72.5%; HSS – 56.6% and DCC – 52%)[10], being this reality in a transversal perspective suggesting new age groups permeable to the distinction between fifth age (90 to 99 years-old), age of centenarians (100 to 109 years-old) and supercentenarians (110 years-old or more)[16]. On the other hand, dependency often associated with older adults (65 or more years old) and very old people (80 or more years old), defined as the situation of "individuals who cannot independently perform the acts essential to the satisfaction of the basic needs of life daily life, lacking the assistance of others [including acts] related to the performance of domestic services, locomotion and hygiene care"[17], it is very present in social responses, especially those of a residential type with high levels of dependence in all basic activities of

daily living[10]. Fundamentally, in the face of conditions of dependency, temporary or permanent, with regard to the commitment to the exercise of citizenship rights of the elderly people, also associating with the weakening of their self-determination, participation and training, requiring the reinforcement of their autonomy. Above all, it is argued that institutional care should increasingly be oriented towards focusing on the user/elderly person, positivizing care, to address the complexity that currently confronts the provision of long-term care[18] and to proceed in an adaptive way in view of the new profiles of elderly people who already constitute the new institutional demand, which is why taking on differentiated and comprehensive care reflects the challenge that plays a role for all institutions, positioning *Humanitude* in this framework, as a methodology capable of contributing to that purpose.

Humanitude as a resource for differentiated care in an institution: the relational approach

Conceived in the 70's of the 20th century by Yves Gineste and Rosette Marescotti, the *Humanitude* Care Methodology (HCM), also known as the Gineste-Marescotti® Care Methodology (MGM®)[19] and which was originally called Relational Maintenance[20], is an approach based on a concept that refers to a humanist perspective of the individual, viewing him as an "autonomous being of relationship [and that acquires] experiential dignity"[20]. It follows that in its essence, the *Humanitude* philosophy is rooted in the understanding of the human being, rising coupled with a vision that distinguishes humanization as the purpose underlying the dignified way of understanding and being in relationship.

In this regard, it is emphasized[21] that the notion of human refers to human nature, assumed as humanitarian and based on kindness or motivated to do good, ending the same sense identical to that of humanity, connoted with benevolence and a sense of compassion towards the other, but also valuing the person in himself. In this segment, humanizing means practicing humanity, concerning something specific to human beings, a practical intentionality that attempts to achieve well-being, whether from an individual or in a wider perspective, i.e., collectively and contextually specific. Humanizing also means apprehending human beings in their individuality, as well as recognizing their social and sociable nature, as well as their values and beliefs, with the guarantee of exercising the right to self-determination and making choices in freedom, in various areas, lacking to understand that these premises are extendable to all human beings. Under this meaning, the concept of *Humanitude* incorporating an evolutionary perspective of human development assumes its complexity and focuses its attention to the acts that each human being manifests in relation to himself and to the other[20]. Talking about *Humanitude* presupposes understanding and interacting with others through behaviors and actions that meet human being and essentiality (e.g., individuality, self-determination, respect for life), an approach that proves inseparable from care and the intentionality of care.

Underpinned in a relational paradigm based on personalization, humanization and oriented to promote the realization and empowerment of people, promoting their autonomy and exercise of citizenship, *Humanitude* reveals to be a differentiated care methodology, which carries to practice feelings such as attention, concern and responsibility to satisfy the needs of others, involving high personal involvement. Although it is a transversal methodology to any care, regardless of the age of the person being cared for and the health problem evidenced, it is particularly opportune to be applied to the elderly in situations of vulnerability and fragility caused by illness, as well as in clinical conditions revealing cognitive alterations[22].

In this respect, it is known that situations of dependency limit individual capacities and condition the possibilities of making an informed choice, a reality that becomes especially visible when dependence emerges associated with mental and cognitive impairment, with the institutions triggering the activation of methodologies able to stimulate the autonomy and empowerment of individuals who are in a situation of dependency. In truth and as it is recognized[16], it is important in the face of any conditions of dependency to consider the elderly person in their entirety, seeking to ensure a dignified life while preserving their quality of life. In fact, in terms of dignity and respect for the rights of the older adults, the current guidelines that regulate residential care stipulate that it is important in RSEP "to recognize the immeasurable value of the dignity of the human person"[23], and it is equally imperative to guide them based on in interdisciplinarity, for a humanized, personalized action that considers the real and specific needs of each situation, with residents as the core of all action. Based on these assumptions and assuming that, even in situations of great vulnerability, and in a restricted way, the elderly people still have the ability to express feelings and desires that cannot be neglected, for the sake of their quality of life, the HCM is guided by an integral vision of the human being equated in the permanent relationship with the other, and it is distinguished in operational terms, either by the provision of care based on the relational pillars (gaze, verbal communication, and touch), or by the use of a structured sequence of *Humanitude* care procedures.

As for the former, the gaze (which channels the first contact, the attention and keeps it), the verbal communication (communicated in a soft and tender way, even in the face of people who do not communicate verbally) the touch (professionalized, softly moving away from touch of claw hands and tweezers) as well as verticality, an identity pillar (which contradicts immobility, decadence posture and the feeling of worthlessness and defeat), embody the practices of professionalization and appropriation of technical-relational procedures or be it the operationalization of the humanization of care[20,24]. Regarding the structuring of the care procedures, its sequence follows the pursuit of five stages that pro-

ve to be dynamic and subsequent, covering: the pre-preliminaries – stage that facilitates the approximation between people in the care relationship, and which aims to prepare the person for the meeting with the caregiver; the preliminaries – stage that presupposes the establishment of a positive relationship to promote the acceptance of the care to be developed; the sensory circle – stage that contemplates the integration of the relational pillars and that culminates in well-being; the emotional consolidation – a stage that values the efforts and progress achieved, thanking the person cared for the moment of relationship; the appointment – phase that refers to the programming of the next meeting and that is intended to avoid the feeling of abandonment and contempt[20,22,24]. In this way, the *Humanitude* approach enhances personalized interventions and the capacity of autonomy, supplanting depersonalized care that always proves to penalize the dignity and quality of life of the individuals covered by it. For this care effectiveness to occur, the professionals associated with the implementation of the HCM are central elements in the entire process and in which the institutions need to focus.

Human and organizational resources as "predictors" of the success of care in Humanitude

As several studies have been discussing, HCM has shown benefits in quality of care provided, with direct repercussions on the beneficiaries – the older people are an example. At this level, we emphasize gains with people with a condition of dependence or with dementia, such as the reduction of agitation behaviors and refusal to care, as well as the decrease in the consumption of psychotropics, greater predisposition to self-care and verticality[24-25].

Thus, due to the use of relational techniques based on softness, gains in well-being, calm and satisfaction are obtained, as well as positive sensory stimulation and incentive to activity[20].

In a recent investigation used to the perception of the difficulties and benefits of the implementation of *Humanitude*[22], the systematization of care, through the care procedures was highlighted, as well as the respect for the autonomy of people, obtained by the relationship of proximity that is established and that centralizes attention to quality.

As reported in the Study on the Challenges in Long-Term Care in Europe, promoted by the European Commission[18], when considering the quality challenge, it is important to consider not only quality for beneficiaries, but also for people who work and provide services. In this sense, quality needs to be intrinsically linked to the qualification of professionals and to the awareness of the importance that this methodology has for the organization, with regard to the pursuit of its mission.

Therefore, it is considered that it is important to the institutional system, to consider several orientations with the objective of promoting a successful intervention based on *Humanitude*, namely:

Internalizing the culture of comprehensive and interdisciplinary care. This means adopting a global vision of older people, understanding that aging incorporates different dimensions of physical, psychological and social nature that are determinants for the valorization of care; however, it cannot be undervalued the personal dimension based on individuality, in the knowledge of the elderly people from their life trajectory, which gives meaning to their human condition, even when it is configured by dependence. In view of this understanding, it is important to foster care centered on interdisciplinarity, calling for the integration and joint work of the different professionals associated with care (nurses, direct action assistants/formal caregivers, technical directors, organizational leaders, among others), which from their own competences of a scientific, technical and relational nature, are better able to achieve the common objective and that passes, either by carrying out the diagnostic evaluation, or by following up on a care plan anchored in the specificity of the cases in question[20,22,24].

Conciliating quality of life and quality of services. Under the aegis of *Humanitude*, each service, each professional, each action is at the service of the same mission which is based on the support and/or care for people in situations of vulnerability, assuming a great personal variability with regard to their intensity and typology. Likewise and even if the quality of life (of the elderly people) is the priority focus of the *Humanitude* intervention in order to improve their existential situation and well-being (e.g., meeting their particularities, preferences and expectations), it matters considering the contextual factors or the broader care environment, where concerns about the level of various resources and the allocation of professional competences to the care sphere fall. Thus, the quality of services is an indispensable condition for the effectiveness of the provision provided.

Assuming *Humanitude* as an organizational philosophy and culture. In this regard, the involvement of the management domain and institutional support is essential to make this approach possible. Concretely, the implication of leadership, openness and receptivity to the practice in *Humanitude* are requirements at the organizational level capable of provoking the necessary change that provides influential environments in care. This refers not only to the assumption of an attitude predisposed to channel social value to the organization, reflected in health gains for users and professionals (e.g., minimization of burnout, absenteeism, job dissatisfaction), but also the availability to create an entire environment (e.g., a calm, less pressing environment, minimizing conflict) converging with the principles of *Humanitude*. With this aim, stimulating learning and training in *Huma-*

nitude are parameters of great need, especially for raising awareness and to incorporate in practices, relational techniques, focusing on the action in the interaction with the person and not in the tasks[21,24] to accomplish.

Limitations

The study's limitation stems from the incipience of the research related to the implementation of the *Humanitude* care methodology in the context of residential care for the older adults and, above all, aimed at focusing on the institutional system – client system interrelations. The need of more studies is emphasized by adopting a perspective of holistic and integral analysis, in order to make known transversally across the board the repercussions of HCM in terms of effectiveness for organizational care as a whole.

Contributions to health practice and policies

This reflection article points to a methodology for the care of older people that is considered to have a great opportunity in the context of residential structures for them, which is not only an incursion into the processes that build this approach – relational pillars, *Humanitude* philosophy and structured sequence of *Humanitude* care procedures – but it also provides a whole set of guidelines that should be considered for a successful implementation of *Humanitude* in the organizational framework. For the domain of public health policy, contributions emerge fundamentally to equate HCM as a strategy capable of better facilitating the achievement of the objectives that govern policies regarding the quality of care and the promotion of active aging.

CONCLUSION

Longevity represents an irreversible challenge for contemporary societies, symbolizing the development and important achievements of humanity, but which cannot be seen in a passive and disintegrated way, by the agents who have responsibility in the field of the design and/or operationalization of care policies. Fundamentally, it contributes to the aging phase to be an increasingly heterogeneous phenomenon, influencing the greater probability of occurrence of dependency situations. Thus, facing old age in the present implies understanding the transmutation underlying it and dynamizing an organizational culture that incorporates an integral view of the older people and their needs in terms of care. This is especially relevant in formal contexts of elderly people care, given the demand that has been registering the responses of the network of services and equipment, and also their indispensability to provide care, which, based on the interrelationship (caregivers and people cared for), reconcile support in the face of limitations, but that does not neglect the potential and capabilities that individuals have, even at an advanced age and a situation of clinical impairment.

Therefore, this constitutes the main argument that values the implementation of *Humanitude*, understanding it as a methodology that systematizes and operationalizes the interaction between the caregiver and the person cared for, giving intentionality to the way in which the approach to the person cared for is done through the relational pillars, fulfilling a structured sequence of *Humanitude* procedures, contributing to well-being in old age and active aging and commitment to life. However, for the success of caring in *Humanitude*, it is essential to internalize the culture of comprehensive and interdisciplinary care, the training of all professionals and the involvement of leaders in the whole process of changing care practices.

Ethical Disclosures
Conflicts of interest: The authors have no conflicts of interest to declare.
Financing Support: This work has not received any contribution, grant or scholarship.
Provenance and Peer Review: Not commissioned; externally peer reviewed.

Responsabilidades Éticas
Conflitos de Interesse: Os autores declaram não possuir conflitos de interesse.
Suporte Financeiro: O presente trabalho não foi suportado por nenhum subsidio o bolsa ou bolsa.
Proveniência e Revisão por Pares: Não comissionado; revisão externa por pares.

REFERENCES

1. Rosa MJ. O Envelhecimento da Sociedade Portuguesa. Lisboa: FFMS; 2012.

2. Eurostat. Estrutura populacional e envelhecimento. Luxemburgo: Comissão Europeia; 2018. [accessed 2019 Jun]. Available from: https://ec.europa.eu/eurostat/statisticsexplained/

3. Fernandes AA. Velhice, Solidariedades Familiares e Política Social: Itinerário de pesquisa em torno do aumento da esperança de vida. Sociol Probl Prát. 2001;36:39-52.

4. Luz MH. Problemas sociais complexos – wicked problems – e intermediação das organizações de economia social: Estratégias adaptativas no campo do envelhecimento ativo (EA). Comunicação apresentada no XVIII Congresso AHILA; September 7, 2017; Valência, Espanha.

5. Rodrigues T. Envelhecimento e políticas de saúde. Lisboa: FFMS; 2018.

6. Fernandes AA. Questões Demográficas: Demografia e Sociologia da População. Lisboa: Edições Colibri; 2008.

7. Légaré J. Le vieillissement des populations : incontournable certes... mais un plus, s'il est géré dans un esprit d'éthique intergénérationnelle. Lien Social Politiques. 2009;62:15-28.

8. Pordata. Base de dados de Portugal Contemporâneo. Lisboa: Pordata; 2019. [accessed 2019 Jun]. Available from: http://www.pordata.pt

9. Coulmas F. Population Decline and Ageing in Japan: The Social Consequences. Chicago: Routledge; 2007.

10. GEP Carta social – Rede de Serviços e Equipamentos. Relatório 2017. Lisboa: GEP/MSSS; 2017.

11. Brandão D, Ribeiro O, Paúl C. Functional, sensorial, mobility and communication difficulties in the portuguese oldest old (80+). Acta Med Port. 2017;30:463-71. doi: 10.20344/amp.8060.

12. Calha A. A condição sénior no Sul da Europa e na Escandinávia. Saúde Soc. 2015;24:527-42. doi: 10.1590/S0104-12902015000200011.

13. Nogueira JM. A dependência: o apoio informal, a rede de serviços e equipamentos e os cuidados continuados integrados. Lisboa: GEP-CID; 2009.

14. Albuquerque CP. Um novo contrato de solidariedade intergeracional. Debates e questões críticas. In: Luz MH, Miguel I (Orgs). Gerontologia social perspetivas de análise e intervenção. Coimbra: ISBB; 2014.

15. Decreto-Lei n.º 172-A/2014, de 14 de novembro – Quinta alteração ao Decreto-Lei n.º 119/83, de 25 de fevereiro, que aprova o Estatuto das Instituições Particulares de Solidariedade Social.

16. Côrte B, Brandão V. Longevidade Avançada - A reinvenção do tempo. Rev Kairós. 2018; 21:213-41. doi: 10.23925/2176-901X.2018v21i1p213-241

17. Decreto-Lei n.º 265/99 de 14 de Julho – Definição e regulação da protecção social a conceder a pensionistas em situação de dependência.

18. Spasova S, Baeten R, Coster S, Ghailani, D, Peña-Casas R, Vanhercke, B. Challenges in long-term care in Europe: A study of national policies. Bruxelles: EC; 2018. [accessed 2019 Jun]. Available from: https://ec.europa.eu/social/main.jsp?langId=pt&catId=89&newsId=9185

19. Gineste Y, Pellissier J. *Humanitude*: Cuidar e compreender a velhice. Lisboa: Instituto Piaget; 2008.

20. Simões MM. Cuidar *Humanitude*-Enfermagem neurorelacional. Coimbra. [accessed 2019 Jun]. Available from: http://rihuc.huc.min-saude.pt/bitstream/10400.4/1793/1/Livro%20M%C3%A1rio%20Sim%C3%B5es%20VD.pdf

21. Melo RC, Costa PJ, Henriques LV, Queirós PJ, Araújo JP. *Humanitude* na humanização da assistência a idosos: relato de experiência em um serviço de saúde. Rev Bras Enferm. 2019;72:865-9.

22. Figueiredo AM, Melo RC, Ribeiro OP. Metodologia do cuidado *humanitude*: dificuldades e benefícios da sua implementação na prática. Rev Enf Ref. 2018;4:53-62.

23. Portaria n.º 67/2012 de 21 de março – Define as condições de organização, funcionamento e instalação das estruturas residenciais para pessoas idosas.

24. Melo RC, Queirós PJ, Tanaka LH, Salgueiro NR, Alves, RE, Araújo JP, et al. Estado da arte da implementação da metodologia de cuidado *humanitude* em Portugal. Rev Enf Ref. 2017;4:53-62.

25. Henriques L, Dourado M, Melo RC, Tanaka LH. Implementation of the *Humanitude* Care Methodology: contribution to the quality of health care. Rev. Latino-Am. Enferm. 2019;27:e3123.