

# Easing your perioperative practice through Comfort Talk®

Non-pharmacological means of reducing patient's anxiety and pain have been widely researched and now form an integral part of all UK recommendations for surgical surgical/ interventional care, such as those from the Royal Colleges of Anaesthetists and of Nursing. In fact, perioperative care, at its core, follows principles of multimodal analgesia, including both pharmacological and non-pharmacological treatments.

In this article, **Dr Elvira Lang** summarises years of research investigating an approach called Comfort Talk® and shares a few cost-neutral 'techniques' which have proven beneficial for conscious patients in the operating theatres.

**D**uring my 40 years of experience as an Interventional Radiologist, I became quite familiar with anxious patients and the challenges they can pose.

While serving at the US Department of Veterans Affairs (VA), I treated an extremely anxious young Vietnam veteran who was too scared to even get on the operating table for a straightforward tube change he needed every three months. He required large amounts of sedatives that also extended his recovery time. This was the first time I saw how an imagery process or self-hypnotic intervention made a big difference. After his first hypnotic session he no longer needed drugs or his friend to drive him.

As a clinician and a researcher, I wanted to know whether such an intervention would work for other patients and how it could be applied by regular staff in the operating theatre. Efforts to reduce the need for sedation drugs at the VA became more acute after we lost half the hospital, including the anaesthesia recovery rooms, after the Loma Prieta earthquake in 1989.

These and subsequent experiences as well as validation in large clinical trials resulted in what we now call Comfort Talk®. This program provides sedation without any medication and has also been used as an adjunct to reduced medication (Lang & Laser 2009). It consists of rapid rapport techniques, a slight change in wording one may use, and hypnoidal language, often applied by reading a script or using snippets from a script. Sometimes acute tension diffusion and reframing of distressing thoughts are added. With this approach procedures became more comfortable, safer, and faster; patients experience less pain, anxiety, need for drugs, and complications while operational efficiency and patient satisfaction improve

(Lang et al 2000, Lang et al 2006, Lang et al 2008, Lang & Rosen 2002, Ladapo et al 2018, Ajam et al 2017).

## Why does Comfort Talk® work?

Through our research we became more consciously aware of how time effects the course of a surgical intervention: under standard of care, pain increases relatively unaffected by the invasiveness of the procedures nor the amount of drugs provided in a conscious sedation model (Lang et al 2014). However, when a one to three minute script was read this increase in pain did not occur (Lang et al 2014, Lang et al 2000, Lang et al 2006, Lang et al 2008). One explanation is that in a setting of ambiguity our survival mechanism kicks in and we interpret in the worst possible fashion (Ewin & Eimer 2006). Once a stimulus is experienced as painful all subsequent stimuli will be interpreted as more painful even when bland (Bayer et al 1998). Anxiety further adversely affects the experience (Colloca & Benedetti 2007), prolongs the case (Schupp et al 2005), and transfers onto the treatment team, risking more complications (Kadom et al 2017). The script language prompted a fundamental reframing of how pain and anxiety are processed by the patient that allowed everyone in the operating room to remain more relaxed.

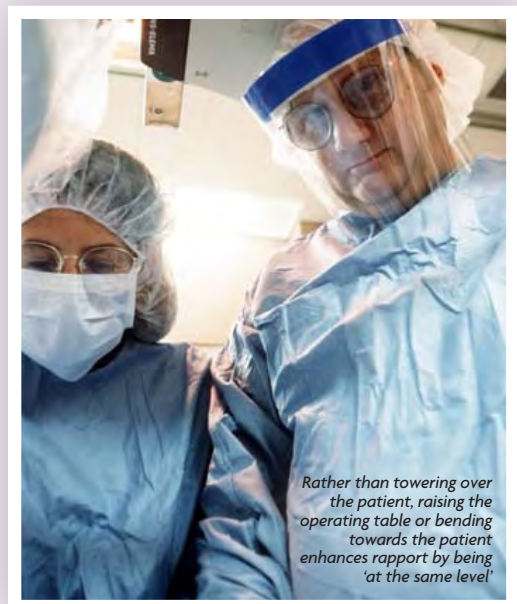
## Techniques for immediate use

**Avoidance of negative suggestions:** Patients are already in a highly suggestible state when they come to us and take everything literally for better or worse. Words such as 'hurt',

'pain', or 'worry' made things worse even when accompanied by 'little', or 'no' (Cyna & Lang 2011, Lang et al 2005). Instead, when giving local anaesthetic, say 'You may experience some warmth or cool.' Or 'I am applying now the numbing medicine.'

**Perception of control:** In the operating theatre, patients can become distressed because they feel deprived of any control over what is happening. To ease this feeling of helplessness, you can still offer a perception of control: 'Would you prefer your IV on the right arm or the left arm?' or 'Would you prefer to get on the table from the right side or the left side?'

**Correct use of 'try':** When we ask patients what we would like them to do, the word 'try' commonly sneaks in, but 'try' implies that one cannot do it. If you ask your patient to try to hold still, or try to get on the table, you subconsciously indicate that the person cannot fulfil the task. You could say instead 'See if you can...'



*Rather than towering over the patient, raising the operating table or bending towards the patient enhances rapport by being 'at the same level'*



One physiotherapist we trained remained sceptical until one day she decided to test it and invited every other patient to either 'get on the table' or 'try to get on the table.' Avoidance of 'try' yielded a strongly convincing result of patient cooperation.

Conversely, you can use 'try' if you want the opposite to happen. If a patient doesn't want to relax and keeps looking around, you can say 'That's ok, just try to keep your eyes open.'

**Encouragement** cannot only be used to elicit patient cooperation but can become an important tool for positive medical team building, which is even more important in these stressful times. Encouragement is not to be confused with praise. Praise labels a person 'You are a great nurse, patient, mother, etc.' or 'You are so smart, beautiful etc...'

Encouragement focusses on the deed and what it contributes to the overall good. When we conduct our live Comfort Talk® training for medical teams, we conduct a round where one person gives the next an encouragement. The ingredients of an encouragement are a thank you or word appreciation for a deed or action (not characteristic) and how that was helpful. We have seen hospital staff working together for many years who never expressed their appreciation in this way, commonly assuming the co-worker knew. This is often not the case. Comments such as 'When I was brand-new on the job you took extra time to show me how things are easiest done here. That took a lot of my fears and made me a much better nurse. Thank you.'

When using encouragement for patients, we often use it even before the desired action happened, for example when a patient moves, we may say during

imaging, 'Thank you for holding still so well, that helps obtain good pictures' or '...makes the treatment go smoother.' We often hear the objection, 'But the patient did move.' That may have been true but pointing it out will only build resistance and denial in the patient. You may think of how often in daily routine we end an email in which we ask someone for a favour with 'thank you,' even though the deed has not occurred.

### More options

There are many more ways of using the power of words and establishing rapid rapport. You can check our website, [comforttalk.com](http://comforttalk.com), for more tips and videos. Slight changes in behaviour and wording go a long way without requiring extra time and are easily applied in daily interactions, eventually becoming second nature. For more complex usages, more training online for individuals and on-site for entire teams is available. ■

Article by **Elvira V Lang, MD**

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