REVIEW

CONCEPTUALIZING A THEORY OF COMFORT

Janice M. Morse, PhD, FAAN
Professor of Nursing & Director of the International Insititute for Qualitative Methodology - University of Alberta
Adjunct Professor, the Pennsylvania State University

ABSTRACT

In this article, the centrality of comfort for nursing is explicated, and, using examples of the extremely distressed patients in the trauma room, the comforting role of the nurse is described. Comfort is considered a relative state, and the goal of nursing is to assist the patient to endure and to attain comfort. Nurses assess the patient's state of comfort since comfort must be provided within the patient's comfort level, and is distinct and particular to the patient's level. When providing comfort, nurses respond to the patient's cues, to situational clues, and draw upon their nursing assessment skills. They then select and administer an appropriate comforting strategy, reassess the patient, apply an other strategy, and so forth, until comfort is attained.

OPSOMMING

In hierdie artikel word die essensie van gemak vir verpleging omskryf. Die ontstelde trauma pasiënt word as voorbeeld gebruik in die beskrywing van die verpleegkundige se rol as die voorsiener van pasiënt-gemak. Gemak word as 'n relatiewe toestand beskou. Die doel van verpleging is om die pasiënt by te staan in die strewe na gemak. Synde gemak slegs binne die pasiënt se vlak van gemakservaring gelewer kan word, sal die verpleegkundige die pasiënt se gemakstoestand moet beraam. Die gemak voorsien is uniek en spesifiek tot die pasiënt se vlak van gemak. Verpleegkundiges, in die voorsiening van gemak, reageer op pasiënt- sowel as situasionele leidrade en maak staat op hul verpleeg-beramingsvermoeë om die korrekte gemakstrategie toe te pas. Indien onsuksesvol word die pasiënt weer beraam en 'n ander gemakstratetegie geselekteer. Hierdie proses word herhaal totdat die pasiënt ten volle gemak ervaar.

CONCEPTUALIZING A THEORY OF COMFORT

Once, several years ago, I sat in the Faculty Club, and a very elderly woman joined us. She was distressed, for among other reasons, one of our group had scratched her car while parking, and she was forced to wait while the cars were disentangled. But she relaxed immediately—and we were partly forgiven—when she learned we were nurses. "Well," she said, "if a flock of geese is called a gaggle, what do you call a group of nurses?" We looked blank. With the four or more decades between us, we had not had the advantage of growing up with word games of wit. We had no idea of the answer. The lady paused, waiting for her moment. "A comfort!" she said. "A group of nurses is called a comfort!"

Since Florence Nightingale—and probably before—"making the patient comfortable" has been the charge of the good nurse. But as the above story illustrates, the integral role of comfort in nursing has changed over time, and nowadays it seems to have been almost forgotten.[1] In our clinical practice, comfort is an old-fashioned term that brings to mind images of "pillow fluffing" and other extraneous tasks that are irrelevant to nursing concerns when caring for the patient in our high-tech clinical setting. Similarly, to the sick, the image of comfort as a pain-free gold standard makes little sense and is perhaps only achieved when the patient falls fitfully asleep after the injection of some analgesic. One nurse told a story about a patient who was shivering with shock as her blood pressure "bottomed out." Another nurse, attending to the patient's "comfort needs," acted inappropriately by snatching a warm blanket rather than by starting an IV.

In this article, I will present a conception of comfort that does fit nursing in the 90's. Using a program of research, I have been exploring the utilization of comfort in the clinical setting. I argue that comfort is not only directly relevant to nursing care but that comfort still remains the primary goal of nursing. I also argue that comfort is so integral to patient care, that eventually we will be able to demonstrate the efficacy of comfort by the reduction of morbidity and mortality. Comfort is crucial for patient safety.

Efforts from the past 15 years in nursing have focused on caring as a paradigm to bind and to guide nursing knowledge and practice. Enormous efforts have been expended to establish caring as the essence of nursing, and large number of philosophic, theoretical, research articles have appeared on this topic in the nursing literature. Earlier, in 1992, I wrote that caring was inadequate as a paradigm for

nursing for several reasons. Most importantly, caring is a nurse-focused concept. It targets the nurse and some, but not all of, nursing actions. That is, caring research may examine the nurse, nursing affect, and the nurse's responsiveness to the patient. Somehow the patient is included in this framework only as the instigator or recipient of care. If we select *comfort* as the focus of nursing—and incorporate caring within our conceptualization of comfort—then our model becomes more balanced. The model becomes patient-centered and pragmatic, with nursing actions conceptualized as interventions. Caring remains in the models as the motivation for nursing care and is the concept that keeps the procedure humanistic. Thus, with comfort as the focus of our research, our research program changes focus from the nurse to the patient, and our nursing interventions become measurable as outcomes. Within this framework, nurses' use of touch and talk are not indicators of caring *per se,* rather they are *indicators of caring* ***that are comforting.*** They remain **strategies** for***providing comfort*** (Morse, 1995*a*, pp. 199-200). I have defined comfort as a state of well-being that may occur during any stage of the illness-health continuum. At this time, two comfort states have been identified: a temporal state that eases, relieves, and assists the patient to endure; and the achievement of a more constant, long-term state, such as the attainment of optimal health.

WHAT IS INVOLVED IN COMFORTING?

I am suggesting that patient discomfort or distress results in the individual seeking to identify the problem, requesting assistance, or sending cues that signal the distress or discomfort to others. Caregivers respond to patient signals of distress in a number of ways. Empathy and caring serve as motivators for providing assistance, and the nurse may use intuition or the compathetic response to assess the patient needs. And, of course, there are procedural modes of assessment using the nursing skills to assess the patient, the family, and the environment. Note that this is a patient-led model, with the nurse responding to the patient's needs. However, comfort is also provided in the absence of signals, cues, or requests. Comfort may be provided because nursing knowledge indicates or dictates that such procedures be conducted. The procedures may initially provide comforting relief or may cause distress, but in the long-term, they ease and relieve. An example of the latter, is the nurse's instance of getting a patient out of bed postoperatively, despite the patient's protests. While early ambulation increases the patient's immediate distress, it aids recovery and prevents complications.

The immediate, short-term goal of comfort, to ease and relieve or to assist the patient to endure, to last though a procedure, is congruent with the dictionary definition of comfort: to ease, relieve, or to "make strong." When patients are comfortable—that is, when comfort is attained—they have no need for a nurse. The long term-goal of comfort is the achievement of relief or optimal health.

PROVIDING COMFORT

I suggest that comforting procedures consist of the nurse recognizing a patient cue (indicating a patient need), assessing, and intervening with a comforting strategy or procedure. The outcome or patient response cues are then assessed or evaluated by the nurse, another strategy implemented, and so forth. It sounds very simple, but it is extraordinarily difficult to research and to document the efficacy of comforting strategies. At the moment, our research is focused on behavioral cues and nurse responses, which we examine using observational research methods (mainly videotaped data) and patient reports (using tape-recorded interviews).

WHAT IS A PATIENT CUE?

Comfort is frequently offered in response to a patient cue. A patient cue is the manifestation of patient distress or patient need. It may be in the form of a pain response, restlessness, a signal of distress, an utterance, expression, or even a request. In an earlier study of the modes of comforting post-operative neonates, we observed that nurse comforting touch was usually initiated by the infant (Morse, Solberg, & Edwards, 1993; Solberg, & Morse, 1991). As these infants were intubated, they had a silent cry. Despite the facial grimaces, tears, and other signals of crying—the lack of vocalization resulted in very little evidence of vocal comforting on the part of the nurse. Rather, nurses comforted using patterns of touch, such as stroking or patting, for only a few moments. The nurses consciously or unconsciously observed the infant for a positive response. If the comforting strategy did not produce a positive response, the type of touching changed (for instance from patting to stroking). If the response was negative (for example, if the crying increased or if the infant withdrew), then the nurse tried another comforting strategy, such as giving the infant a soother or rocking. However, if the infant did not respond after the nurse had tried several strategies, the nurse abandoned the attempts at comforting and resumed charting or whatever task needed attending. I will discuss this study later.

THE COMFORT LEVEL

Comfort is a relative state, and the degree of comfort experienced by a person (or the amount of *discomfort tolerated)* is referred to by nurses as the *comfort level.* The comfort level pertains both to the nurse's comfort with providing care, as well as to the patient's present state. For the nurse, the comfort level is determined by his or her perception of the patient as a person[2], the degree of patient's suffering[3] due to the illness or injury, the nature of the procedure, the amount of pain the care will inflict on the patient and the efficacy of that treatment, the perceived benefit of nursing care and the degree these may be buffered by comforting strategies. In other words, the nurse's *level of comfort for providing care* may be assessed by the amount of empathy and compathy experienced by the caregiver and the perceived therapeutic efficacy of those actions.[4]

From the patients' perspective, *attaining comfort* includes the ability to trust; be supported; to hope; to receive competent, well-paced, and synchronized care; and a medical management of the injury or illness that is bearable; the symptoms sufferable; and the treatments tolerable. For instance, in the emergency department, patient comfort is not achieved until the patient *feels safe.* For the patient to *feel safe,* the nurse must demonstrate competence, caring, and vigilance by *being there;* the patient may test the nurse, learn to trust, and then *relinquish* to the care of the nurse. Yet, *feeling safe* does not alter the pain and the distress.

In the clinical setting, in Nightingale's sense that they may have no needs, patients are seldom comfortable. Rather, the patient usually has some form of discomfort, which fluctuates according to the time since analgesics were administered, level of activity, and so forth. The patient's *comfort level* is the degree of discomfort that is tolerable or bearable, and the goal of nursing is always to minimize the patient's discomfort and to maximize the patient's comfort state. The comfort level may thus be perceived as a continuum ranging from complete comfort to extreme agony, and the patient's comfort level is dynamic, continuously fluctuating on this continuum. Patients are aware of their comfort level and consciously work to attaining comfort and to reduce

discomfort. At the same time, the goal of nursing is to ensure the patient's distress is at a minimal level. Thus, this context-dependent state of **relative maximum comfort** is referred to as the *patient's comfort level.*

HOW DO NURSES ASSESS THE PATIENT'S COMFORT LEVEL?

Nurses continuously, consciously and subconsciously, assess the patient's comfort level. There are two kinds of nursing assessment. The first is the type that is included in their basic education and continues throughout a nursing career; that is, the evaluation and interpretation of physical signs and symptoms. Nurses learn how to listen to patient's complaints of discomfort, to monitor a patient's physical condition, and to intervene whenever necessary.

Less is known about the second type of nursing assessment. It uses nurse's perception, insight, and experience. Although vital to patient safety, it is less researched, not well understood, and not truly a part of nursing's formal education. Most has been written about empathy, and empathy is a formal part of the psychosocial components of nursing care. A good nurse is expected to be empathetic, and less emphasis is place on the sympathetic, commiserate, and compassionate; and elsewhere we have suggested that the repertoire of psychosocial responses of nurses used for providing comfort be explored and expanded (Morse, Anderson, Bottorff, Yonge, O'Brien, Solberg, & McIlveen, 1992).

Next, there is a growing body of literature on nursing intuition. Nursing intuition allows a nurse to assess a patient's condition and even to predict impending changes. There are many documented cases whereby a nurse predicted a crisis and called the code team before the patient actually coded. Elsewhere, I have criticized this research because investigators have only documented or reported instances in which the intuition was correct—we have no information about incorrect intuits (in which the code team was called and the patient did not code), or instances in which the nurse did not act on her intuition, and the patient's condition either did or did not subsequently change. Nevertheless, this literature is important and needs to be investigated further, perhaps using new approaches in order to understand the phenomenon, such as, using subliminal theory to identify the patient cues in that special "look" that these patients get (Morse, Miles, Clark, & Doberneck, 1994).

Despite the utility of intuition in intensive care and emergency settings, we do not have a great deal of information about the use of nursing intuition in everyday nursing care. Nursing intuition would be most useful, it seems, in identifying, interpreting, and responding to patient cues indicating discomfort; for example, by adjusting the patient's position, offering or administering pain medications, and so forth. In other words, its major role should be used as a means that motivates the nurse to provide comforting strategies, even if the patient has not requested such care.

The third concept that provides insight into the patient's condition is compathy (Morse, 1995*b*; Morse & Mitcham, in press*a*; Morse, Mitcham, & van der Steen, in review). Compathy is the ability of the caregiver to "feel" or to sense the patient's pain. While the compathetic response may be so sensitive and subsequently severe as to immobilize the caregiver and to inhibit caregiving, over time, caregivers learn to block the response so that care may proceeded. However, a blocked compathetic response may also be harmful because the humanistic concerns for the person may be overridden with aggressive treatment goals (Morse, Mitcham, & van der Steen, in review). Most appropriately, experienced caregivers should be able to control the compathetic response, blocking it appropriately and using it appropriately, in order to provide excellent care, moral care, care that remains in the patient's best interest.

WHAT IS A COMFORT STRATEGY?

Comforting strategies are methods or techniques of comforting the distressed person. While not unique to nursing, it is nursing's role—and privilege—to use comfort strategies when caring for the distressed person. Comfort strategies may be **direct**; that is, strategies administered directly to the patient; or **indirect**; that is, strategies that control the actions of others or the manipulate the environment. *Direct strategies* are patterns of touch, talking, and listening, which may be used to keep the patient in control by eye contact, voice, and touch, such as in *talking the patient through* painful procedures, the responsive use of touch, providing appropriate explanations, as well as providing competent care. *Indirect strategies* include such actions as providing warmth, quiet, or darkness and are used for protecting the patient, to pace and sequence care to minimize distress, and to manipulate the environment to maximize patient rest and prevent fatigue.

Direct strategies include universal patterns of touching, talking, and listening that are targeted to maximize the patient's comfort level and to help the person regain or to maintain control in extraordinarily painful situations. While comforting strategies are patterned, they are also particular to the patient's state. For example, if the patient is terrified, then touching and talking patterns particular to a terrified state must be used to comfort the terrified patient; and similarly, appropriate patterns for frightened, scared, hysterical, and anxious patients, or for patients with particular response to illness or pain. Patterns of touch (stroking, patting, holding, and so forth) and talking—or verbalizations—are specific to each state and are apparently learned by nurses intuitively and by role modeling in the clinical setting. It is crucial that the comfort strategies match the patient's comfort level because using comfort strategies that are intended for a different state will result in the escalation of discomfort. For instance, to use comfort strategies for a scared patient with a patient who is actually anxious, will result in the escalation of the anxiety. In this sense the model is patient-led. Comfort strategies are variable. The experienced nurse has a large repertoire and changes the strategies with the patient's state. Thus, while the comfort strategies used are nurse-controlled, they are patient-led.

Comfort strategies vary in complexity. They may be as simple as placing a hand on the patient's shoulder; it may be as technical as responding to a code with efficiency, speed, and competence. A comfort strategy may be keeping vigilance while the patient "sleeps," or it may be forcefully getting the patient out of bed, despite protests of, "It hurts!", "Not today!", and "Wait—I'm not ready."

Nurse comforting strategies buffer the injury/illness experience and alleviate symptoms for the patient. Because comfort strategies are *variable*, and *context dependent*, they cannot be formulated. Rather, the expert nurse has an enormous repertoire of comforting strategies and is versatile in their application. The expert nurse "reads the patient" by reassessing situational *clues*, patient *cues,* and responds to triggers in the situation. The expert nurse is *versatile*, so that if a comforting strategy does not work, is ineffective, or causes discomfort, then another comforting strategy is used. Assessment of the attainment of the optimal comfort level is ongoing.

THE BACKFIRING OF COMFORTING STRATEGIES

Previously it was noted that comforting strategies are varied and versatile, and the nurse consciously or unconsciously selects a comforting strategy that matches the patient's comfort level. What then happens if an inappropriate comforting strategy is used?

We call the "mismanagement" of comfort, "backfiring", because the patient's comfort level escalates. The following problems have thus far been identified:

1) Although well intentioned, the strategy is not comforting (see Stern & Kerry, 1996). Examples of verbal non-comforting strategies—and we are all guilty—are statements such as: *"Of course you are not going to 'throw up,'" "Just relax,"* and *"What, you've had a baby before and you don't know how to push!"*
Touch may also be non-comforting, and this may happen when the part of the body touched is tender or sore, when the touch is poorly timed or unexpected, or when the touch is culturally inappropriate,

2) *Repeating a strategy, even though it was unsuccessful the first time:* Comfort strategies must be versatile since comfort needs are individualized; strategies that may be successful with one person, may not be comforting to another—as any mother who has had one infant that "settles" when his back is tickled, and another one that didn't. Repeating a failed strategy resembles victim blaming, for it appears as "What is wrong with *you* if you don't respond. . ." Such actions are useless, a waste of time, and frustrating for all.

3) *Refusing to answer or to give an answer:* When a head injured patient asks repeatedly for information, the "endless loop" of questions and answers, of repeating, "You're in the hospital" or "Your family is OK," are unavoidable. The patient *cannot* recall the information that has been given—the constant repeating of requests is not intentional. The nurse responding, no matter how kindly, "I've told you that before," only escalates the patient's distress.

4) *Talking over the patient's head:* Explanations, intended to prepare the patient for a painful procedure or an invasive procedure, are not comforting if they are incomprehensible.For instance, one does not say to an 11-year-old boy, "And now I'm going to catheterize you."

5) *Care that is not paced:* Explanations must be given sufficiently in advance of the procedure for the patient to process the information and to psychologically prepare, to get ready to "take it." Information that is given simultaneously with the procedure is useless. Care must be paced so that one procedure is given at a time. Multiple procedures, given simultaneously, lead to assaultive care and the patient losing control.

6) *Inconsistency in comforting strategies:* If the patient has a support person, that person must remain with the patient until the care is given. Ideally, that person should not be involved in the care or have other responsibilities since keeping the patient "with it," talking them through painful procedures, holding, touching, and being there will absorb the nurse's concentration; deserting or not responding will result in the instantaneous escalation of distress, particularly in children.

The above strategies, intended to comfort, but causing discomfort, remove the patient's feeling of trust and feeling of safety. As the patient becomes more distressed and distraught, care is slowed and the patient's condition escalates. Thus, when comforting, a nurse constantly observes the patient for cues that a comforting strategy is effective or the strategy is changed. For example, in trauma care, nurses' comfort strategies aim to keep patients in control and responsive, cooperative, and receptive to care. Despite the pain, they try to remain still, to endure, to "take it," to "bear it," and not to cry out. These patients work with staff—the patient who has completely relinquished realizes that care is necessary and submits to "whatever needs to be done." The result is that care is given quickly and safely. However, the comfort level is a dynamic continuum, and the patient's comfort level may change rapidly. Nursing assessment is continuous, and comfort strategies continually changing.

THE VERSATILITY OF COMFORTING

In the Australian book, *Nursing for Life*, Knepfer and Johns (1989) wrote that the public health nurse "was like a chameleon, fitting herself into each unique situation, knowing how to handle an array of people. I [the observer]was tired, hungry, and fascinated." Unconsciously, nurses adapt their style of care to the patients. They either matching the patient's affect, greeting patients as they need to be greeted, or counter the patient's affect, cajoling the depressed patient or being stern with the non-compliant. The nurse-patient interaction with each patient is different. It is most noticeable in the intermediate level care, the med-surg unit of the emergency department: here the nurse may be observed moving from bed to bed, talking softly to the patient in pain, with her head inches from the patient's ear; teasing the responsive, anxious patients to normalize the situation; approaching children very cautiously and waiting until they receive a cue indicating the child has assessed them and will permit them to approach.
These various approaches, or "styles of care," are complex collections of comforting strategies, including environmental manipulation for the "comforting role of the nurse". These roles meet the patient's needs, countering and absorbing, easing and relieving the patient's distress.

RELINQUISHMENT FOR CARE

When providing care—in particular to a distressed patient— the goal is to have patients accept that care and not to fight it. Nurses do this by working within the patient's comfort level. Once patients have attained a maximum level of comfort, they *feel safe*, will trust staff, feel in control, and will relinquish to care. However, relinquishment is not an either/or process—there are levels and types of relinquishment. Briefly these are:

1) *Complete relinquishment:* The patient is unconscious or the patient relinquishes totally to the nurse, urging the nurse to do "whatever is necessary."

2) *Relaxed relinquishment:* The patient passively lies or dozes and lets the nurse give care. The patient trusts the nurse and senses her vigilance, "watching over," and monitoring his or her condition.

3) *Guarded relinquishment:* The patient watches what the nurse does and follows the nurses action with his or her eyes. The patient holds still and permits care but doesn't trust the nurse or has limited trust.

4) *Conditional Relinquishment:* Bargaining takes place between the patient and the caregiver—the patient demands information about the procedure, sometimes in great detail. This behavior is often seen in children.

5) *Reluctant relinquishment:* After bargaining, the patient continues to protest throughout the procedure. The patient often must be persuaded with a bribe.

6) *Forced relinquishment:* The patient protests, refuses care, and has to be held down. He or she constantly tries to pull away, shouts, or begs the nurse to "Hurry!"

In trauma care, for instance, patients who are in control have relinquished to care, are responsive, cooperative, and receptive to care. Despite the pain, they try to remain passive and to hold still, to "take it", to "bear it," and not to cry out. They work with staff—the patient who has completely relinquished realizes that care is necessary and submits to "whatever needs to be done." The result is that care is given quickly and safely. Again, the comfort level is a dynamic continuum, and patients are generally somewhere between these two extremes.

PROVIDING COMFORT DURING EMERGENCY CARE

In emergency situations, the patient's physical condition receives priority. Time is of the essence, so that care is provided rapidly; sometimes two procedures are administered simultaneously, often without pacing to the patient's state of "readiness." From the patient's perspective, some procedures appear assaultive and unnecessary. For example, many patients report having their clothes cut off as a very violating procedure. Others are angered by the assaultive nature of seemingly irrelevant diagnostic procedures that violate body boundaries that "weren't hurt," such as a rectal exam or the insertion of a catheter. In the noise, the haste, and the pain, the treatment is easily misconstrued as abuse—or as one wee tot complained to her mother, "Nobody here loves me!"

The role of comfort in trauma care is to *keep the patient in control* or to help the patient maintain or regain control. Physicians, involved with the urgency of diagnosis, often lose sight of the patient as a person, and this is necessary because ironically, in this situation, a physician cannot give humanistic care if the patient is viewed as a human. On the other hand, it is well documented that the technical tasks of nursing can be provided automatically while the nurse maintains her focus on the patient, and we see this phenomenon frequently on our tapes. Nurses have often reported during interviews that nursing is able to see the "bigger picture," thus keeping physicians' care "on track" (Morse 1992). This has been confirmed from our observations and taped data.

THE ATTAINMENT OF COMFORT IN TRAUMA CARE

I have argued that care must be congruent with and provided at the patient's *comfort level.* The concept of *comfort level* as it pertains to trauma care is shown on Figure 1. At one end of the continuum the patient is considered to be *out of control.* Patients who are out of control are not receptive to care, they vocalize—shout—protest, fight care and become combative; care is slowed and must be forced. Staff responses to the patient are reactive. Patients are restrained physically or with mechanical restraints. I do not know the physiological ramifications of *fury* compounding critical injuries, but I imagine that the patient's physical exertion, attempts to protect self, and to fight off staff, as the patient's state escalates, do not improve the prognosis. Frequently, patients who are out of control have high blood alcohol or have used drugs, swear, and cannot be reasoned with. But these patients may also have received a head injury or be experiencing overwhelming pain and shock. It is evident that being "out of control" is a dangerous state, and these patients who are in a critical condition are often paralyzed so that care may be given.

Thus, if the patient is in a terrified state, the nurse must respond to the patient as *terrified*: to respond to the patient as a *scared* patient, for example, will increase the patient's distress. Recognition of this has several ramifications. First, it means that nurses must be able to make instantaneous assessment of the patient's state. In trauma care, the nurse must be able to recognize and distinguish between a patient who is "in control" or "out of control," and who is "hysterical," "panicked," "terrified," "frightened," or "scared." Second, care that is provided for each of these patient states is distinct, and this care is implicitly learned onsite from expert nurses. Patterns of touch and talking are distinct for each state and are synchronized to the patient's cues. Should the care be unmatched to the patient's state or provided without warning before the patient is ready, the patient's distress increases. Thus, appropriate care is *patient-led.* To treat, for example, a terrified patient as a frightened patient, will increase the patient's terror. If the care matches the patient's state, is synchronized with the patient's acknowledgment of that care, and is perceived by the patient to be competent and necessary care, then the patient will *relinquish* to care. While still continuing to

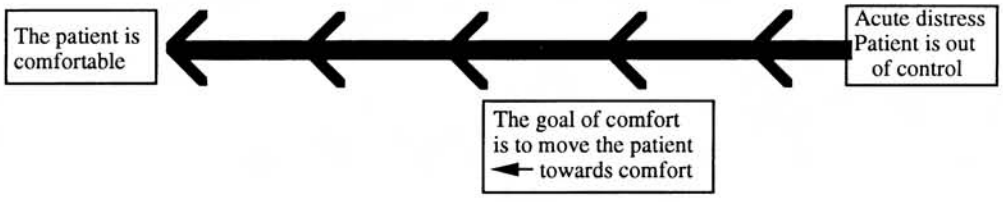

Figure 1: Schematic representation of the comfort level.

respond with appropriate pain responses, the patient will allow the staff to give treatments as quickly and as efficiently as possible. Therefore, comfort in this setting is *helping the patient to regain and maintain control.*

One of the patient states classified as *out of control* is given the emic label of "hysterical" by nursing staff. The major sign of hysterical behaviors is "losing it" verbally. Hysterical patients may shout and scream, yet do not respond when spoken to. Or they may not be able to speak at all. They violently withdraw when touched or fight off the caregiver. Interviews with patients long after the event report that they were barely aware of the emergency department environment, or of their own bodies. Although some level of "dialogue" would be continuing in their head: *I thought, "Why is that woman screaming?. . ., and then I felt it in my throat, and I realized it was me* (Morse & Mitcham, in press*b*).

There is a fine line—labeled as "over the edge"—where the patient can feel themselves "losing it." In our data set we have a tape of an 11-year-old who experienced a penetrating wound to his abdomen following a car-bicycle accident. In a trembling voice he said, "I can't talk anymore." The nurse was instantly beside him: "Why not? Do you know where you are?" The nurse quickly did a neuro assessment, apparently decided the patient was about to lose it and began talking to him about school, using distraction as a strategy, "normalizing" the situation, altering the focus of this attention, and thereby reducing his distress and maximizing his comfort level. Thus, talking is the major strategy that keeps patients "with it."

ANALYSIS OF NURSE COMFORTING STRATEGIES

The comforting role assumed by the nurse is determined by the patient's response to the situation and is reflected in the patient's comfort level. The nurse instantly responds to the patient's comfort level and assumes the nursing role—or style of care—by reading patient cues, by assessing, and by reflexively responding to patient triggers; that is, intervening. This cyclic process of providing comfort is repeated until the patient attains comfort. This process will be described as it is evidenced in the trauma room.

When observing trauma care, everyone appears to be speaking (or shouting) at once. Yet those who are speaking somehow manage to communicate with others using distinctive tone and volume. We have labeled these as "channels of communication" (Proctor & Morse, 1996), and all caregivers tune into the channel that is being used to provide the information that they need to hear. Despite the close proximity of the nurse and the patient (often only 10 inches), the nurse communicates with the patient on the highest and loudest of all channels, and the nurses and the patient's voice may be heard over the top of all the other voices. The nurse uses a singsong voice that is immediately responsive to any patient utterance. She uses a singsong voice that often interrupts the patient; for instance, during the patient's response to pain, the nurse will immediately respond with: "I know. I know, honey." We have labeled this particular style of speech as the *Comfort Talk Register* (Proctor & Morse, 1996).

When the dialogue between the nurse and the patient is transcribed verbatim, including the patient's vocalizations, the immediate responsiveness of the nurse is evident. All of the patient's dialogue is communicated through the nurse, who also interprets the team's care to the patient, warning the patient about treatments, instructing and providing information and feedback. Thus, comfort talk not only warns the patient of impending procedures and assists the patient to endure procedures, it also paces the team's care, so that rather than simply going ahead, the team is forced to wait until the patient is ready. In this way care is paced.

When comforting the distressed patient, the nurse postures in a particular way. The nurse leans over the patient assuming an *en face* position, positioning her face parallel to the patient's, with a distance of approximately 10 inches between the patient's and the nurse's face. If the patient's eyes are open, the nurse holds the patient's gaze with her own eyes, and the patient responds. The nurse's touch is a firm, palmar touch on the patient's arm or chest. The touch is continuous. On one of the video tapes in our data set, the nurse moved from the patient's side to reach for something, and medical students moved between the nurse and the patient. The nurse maintained tactile contact with the patient, reaching between the medical students, and continued her comforting talk over their heads.

In this way, using the direct strategies of patterned talking, posturing, and touch, the nurse enables the acutely distressed patient to endure and to maintain control. The comforting strategies are continuous and assist the patient to "get through" the painful experience, procedure by procedure. Therefore, comfort in the trauma setting is *helping the patient to regain and maintain control.*

BUILDING A THEORY OF COMFORT?

The many components of comfort present here have been identified from a systematic program of qualitative research. We have studied comforting at different levels of abstraction, from microanalytic strategies of touching and talking to more macro behavioral state. We have explored abstract concepts that are inherent in the concept of comfort. And this work in ongoing.

Thus far, a theory of comfort may be outlined as follows:

> Comforting occurs either as a normal and routinized part of nursing care as determined by the patient's situation or as a response to an expressed need. The nurse assesses the patient and, in response to the patient's cues, to situational clues, or to an expressed need, identifies an appropriate comforting strategy. The nursing approach may consist of a single strategy or a combination of strategies for a nursing *style of care.* The nurse also consciously or intuitively determines the patient's comfort level, and, to be effective, the comforting strategies identified are particular to and congruent with the patient's comfort level. Comforting strategies may consist of indirect strategies, such as manipulation of the environment; or direct strategies, such as nursing procedures administered to the patients and patterns of comforting behaviors, such as touch and comfort talk that ease and relieve the patient. Comfort strategies are synchronized with the patient's cues, thus appropriate care is *patient-led.* If the care is appropriate to the patient's state, is synchronized with the patient's acknowledgment of that care, and is perceived by the patient to be competent and necessary care, then the patient will *relinquish to care.* While still continuing to respond with appropriate pain responses, the patient will allow the staff to give treatments as quickly and as efficiently as possible. The nurse continuously reassesses the patient and, if comfort has not been attained, identifies and administers another comforting strategy, reassesses, and so forth, until the patient is comfortable.

ACKNOWLEDGEMENTS:

The research is supported by NIH NINR 2 R01 NR02130-08. An earlier version of this paper was presented in Brazil and is to be published as a part of the proceedings as *A Enfermagem como Conforto: Um Novo Enfoque do Cuidado Profissional*.

REFERENCES

KNEPFER, G & JOHNS, C 1989: Nursing for Life. Sydney: Pan Books.

MCILVEEN, KM, & MORSE, JM 1995: The role of comfort in nursing care: 1900-1980. Clinical Nursing Research, 4(92): 127-148.

MORSE, JM 1992: Comfort: The refocusing of nursing care. Clinical Nursing Research, 1, 91-113.

MORSE, JM 1995a: Defining comfort for the improvement of patient care. In J. M. Morse & P. A. Field (eds.), Qualitative research methods for health professionals (pp. 194-205). Newbury Park, CA: Sage Publ.

MORSE, J M 1995b: Exploring the theoretical basis of nursing using advanced techniques of concept analysis. Advances in Nursing Science, 17(3), 31-46.

MORSE, J M, ANDERSON, G, BOTTORFF, J, YONGE, O, O'BRIEN, B, SOLBERG, S, & MCILVEEN, K 1992: Exploring empathy: A conceptual fit for nursing practice? Image: Journal of Nursing Scholarship, 24(4), 274-280.

MORSE, JM, MILES, MW, CLARK, DA, & DOBERNECK, BM 1994: Sensing patient needs: Exploring concepts of nursing insight and receptivity used in nursing assessment. Scholarly Inquiry for Nursing Practice, 8(3), 233-254.

MORSE, JM & MITCHAM, C (in press). Compathy: The Contagion of Physical Distress . Journal of Advanced Nursing.

MORSE, JM, & MITCHAM, C (In pressa). The experience of agony and signals of disembodiment. Journal of Psychosomatic Research.

MORSE, JM, MITCHAM, C, & VAN DER STEEN, WJ (In review). Compathy or physical empathy: Implications for the caregiver relationship.

MORSE, JM, SOLBERG, S & EDWARDS, J 1993: Caregiver-infant interaction: Comforting the postoperative infant. Scandinavian Journal of Caring Sciences, 7, 105-111.

MORSE, J M, WHITAKER, H & TASÙN, M 1996: The caretakers of suffering. In J. Chesworth (ed.), Transpersonal healing: Essays on the ecology of health (pp. 91-104). Newbury Park, CA: Sage Publ.

PROCTOR, A & MORSE, J M 1996: Sounds of comfort in the trauma center: How nurses talk to patients in pain. Social Sciences & Medicine, 42(12), 1669-1680.

SOLBERG, S & MORSE, JM 1991: The comforting behaviors of caregivers toward distressed post-operative neonates. Issues in Comprehensive Pediatric Nursing, 14(2), 77-92.

STERN, PN & KEFFER, J 1996: Restructuring life after home loss fire. Image: Journal of Nursing Scholarship, 28, 11-16.