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EDITORIAL

Language, literacy and reassurance: do videos calm the anxious child or caregiver?

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Preoperative anxiety in children is a significant and well-recognised problem. It is associated with adverse behavioural outcomes, increased analgesic requirements, and prolonged recovery times, placing an additional burden on both the perioperative team and the child's family.[1,2] This challenge has motivated anaesthetists and surgical teams to investigate various strategies to mitigate anxiety, ranging from sedative premedication to parental presence and child-friendly preoperative environments.[3-5] Among the more recent innovations is the use of audiovisual media as an educational and distraction tool, a concept particularly appealing in the era of smartphones and digital accessibility.

In this issue of SAJAA, Nkosi and colleagues report a prospective, non-randomised controlled study assessing a short preoperative information video, available in isiZulu or English, aimed at reducing anxiety in paediatric surgical patients and their caregivers at Greys Hospital.[6] Despite high hopes for video-based education, the intervention (a five-minute ward video plus a one-minute segment at induction) did not significantly reduce anxiety in children (mYPAS) or caregivers (STAI-6).

The authors deserve credit for tackling a locally relevant clinical question using a culturally and linguistically tailored intervention. The video, available in isiZulu and English and narrated by a local anaesthetist, was reviewed for cultural relevance by first-language isiZulu staff. The study was methodologically sound, employing validated anxiety tools and a well-defined population. Although it did not show a significant reduction in anxiety, it adds valuable local data and prompts important questions about how perioperative anxiety is experienced and measured.

The finding that caregiver and child anxiety remained high despite video exposure mirrors those of similar studies internationally. Härter et al.[7] found no significant difference in anxiety scores between control and intervention groups despite video preparation. Similarly, Baghele et al.[8] noted that although preoperative education improved knowledge, its effect on reducing anxiety was limited. These findings suggest that while information provision is essential, it may not be sufficient on its own to alleviate anxiety.

The authors suggest that direct interaction with the anaesthetist may have a greater psychological effect than video alone, echoing findings that live, personalised communication is more effective at reducing anxiety than passive media.[9] The high caregiver anxiety levels seen in this study (over 70% with "high anxiety") likely reflect broader systemic challenges, such as unfamiliar hospital settings, language barriers, and financial stress; beyond what a short video can address.[10]

Nonetheless, the study underscores the importance of culturally and linguistically appropriate information. While anxiety scores were unchanged, caregivers and nurses viewed the video positively, and some shared it with others, indicating its perceived value in supporting understanding and consent, especially where literacy or language barriers exist.

One of the study's strengths is its dual focus on both the child and caregiver. A growing body of evidence supports the idea that children's anxiety is strongly influenced by that of their caregivers.[11,12] However, few interventions attempt to address both concurrently. That this video failed to do so may reflect its limitations in addressing deeper emotional concerns or the need for more interactive, personalised preparation strategies.

The authors note a key limitation: the lack of a validated isiZulu STAI-6, despite efforts to translate and review it locally. Future studies would benefit from formally validated tools. Additionally, while mYPAS is well-established, its subjectivity may miss subtle behaviours in diverse populations.[13]

The study did not assess the impact of video exposure on induction compliance, though some children reportedly mimicked behaviours from the video, suggesting improved cooperation. This echoes findings by Hou et al.,[14] who showed video interventions improved mask compliance without reducing anxiety. Future studies could include compliance as a secondary outcome, especially where resources for premedication or child-life support are limited.

What should readers take from this study? First, that audiovisual tools alone may not reduce preoperative anxiety, but they remain valuable, particularly as low-cost, scalable tools for delivering consistent, language-appropriate education across diverse settings.

Second, the study supports a more holistic approach to anxiety, where videos are combined with empathetic communication, caregiver support, and possibly peer mentorship. It also

highlights the broader need for structural support, reliable transport, financial security, accessible information, and trust in the system, which videos alone cannot provide.

Finally, this study illustrates how local research can respond to local challenges. In resource-limited settings, simple, culturally adapted tools are worth exploring not for their novelty, but for their practicality. As anaesthetists, our role includes finding better ways to inform and reassure, recognising that no single solution fits all, but each step forward matters.

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