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The Impact of Therapeutic Communication Based on Humanistic Care on Nursing Satisfaction and Negative Emotions in Patients with Acute Renal Colic

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Abstract: *Objective*: To analyze the nursing effect of therapeutic communication guided by humanistic care on patients with acute renal colic. *Methods*: A total of 84 patients with acute renal colic admitted to the observation room from November 2022 to November 2024 were selected and evenly divided using a random number table. The experimental group received therapeutic communication guided by humanistic care, while the reference group received routine nursing care. Nursing indicators were compared between the two groups. *Results*: The experimental group exhibited higher nursing satisfaction than the reference group, lower scores for negative emotions after nursing, higher scores for knowledge mastery, lower scores for disease uncertainty, and superior scores for coping strategies ($p < 0.05$). *Conclusion*: Implementing therapeutic communication guided by humanistic care for emergency patients can enhance their nursing satisfaction, improve negative emotions, increase their knowledge mastery, reduce disease uncertainty, and correct inappropriate disease coping strategies.

Keywords: Humanistic care; Therapeutic communication; Emergency patients; Nursing satisfaction; Negative emotions; Renal colic

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1. Introduction

The emergency department admits critically ill patients, with a wide range of nursing tasks and a heavy workload, making it prone to adverse events such as nurse-patient disputes [1]. Additionally, patients and their families in the emergency department often exhibit significant negative emotions, and their understanding and acceptance of emergency nursing procedures are often inadequate, which directly affects their treatment compliance, particularly in patients experiencing acute episodes of renal colic. Therefore, it is necessary to strengthen nursing interventions for emergency patients, engaging in comprehensive and targeted communication under the concept of humanistic

care to effectively improve the quality of nursing. Therapeutic communication is a relatively novel means of nurse-patient communication that can bring the nurse-patient relationship closer, comprehensively assess the patient's physical and mental state, and enable individualized communication in various forms, demonstrating high scientific nursing value [2]. Based on this, this study selected 84 emergency patients to evaluate the implementation effects of therapeutic communication guided by humanistic care.

2. Materials and methods

2.1. General information

Eighty-four patients with emergency renal colic admitted to the hospital between November 2022 and November 2024 were selected and evenly divided using a random number table into an experimental group and a reference group, with 42 cases in each. In the experimental group, there were 25 males and 17 females; their ages ranged from 25 to 76 years, with an average age of (42.65 ± 3.74) years; regarding educational attainment, 12 cases had completed junior high school or below, 19 cases had completed high school to undergraduate studies, and 11 cases had completed education beyond undergraduate level. In the reference group, there were 26 males and 16 females; their ages ranged from 24 to 75 years, with an average age of (42.71 ± 3.62) years; regarding educational attainment, 11 cases had completed junior high school or below, 20 cases had completed high school to undergraduate studies, and 11 cases had completed education beyond undergraduate level. There were no significant differences in the data between the two groups ($p > 0.05$).

2.1.1. Inclusion criteria

Stable vital signs; normal consciousness and communication ability; complete basic information; able to cooperate throughout the study; informed and consented to participate in the study.

2.1.2. Exclusion criteria

Transferred to a specialized department for further treatment due to worsening condition; abnormal heart, liver, or kidney function; presence of malignant tumors; presence of mental disorders; withdrawal from the study midway.

2.2. Methods

The reference group received routine nursing care, which included detailed explanations of disease knowledge and treatment plans, informing patients of precautions during emergency treatment, increasing the frequency of rounds, irregularly inquiring about patients' physical discomfort, and providing targeted nursing care.

The experimental group received therapeutic communication guided by humanistic care:

(1) Establishment of a nursing team

The team leader was the head nurse of the emergency department, and the team members consisted of five senior nursing staff. The team conducted nursing rounds, optimized the admission and observation processes for patients with emergency renal colic, and provided psychological care, among other tasks. The head nurse provided unified training, elaborating on the principles and precautions for nursing patients with emergency renal colic, ensuring that all nursing staff were qualified after assessment before starting their duties.

(2) Relational communication

Nursing staff comprehensively collected patients' basic information within 15 minutes, established

electronic medical records, and recorded detailed information about patients' diseases, treatment plans, and past medical histories. Subsequently, they introduced the qualifications of medical staff, explained the rules and regulations as well as precautions for observation in the emergency department, and inquired about patients' feelings regarding the emergency environment. They provided items such as tissues and vomit bags to improve patient comfort. They patiently and friendly explained methods of nursing cooperation, guided patients in monitoring the aggravation or alleviation of their pain and vital signs, and instructed them to immediately report any worsening discomfort to medical staff.

(3) Evaluative communication

Before each treatment procedure, nursing staff communicated with patients to assess their past medical and treatment histories, gaining a comprehensive understanding of their physical condition. They evaluated patients' personality traits, educational levels, and family backgrounds, analyzed the causes of their negative psychological states, encouraged patients to express their inner feelings, actively listened to their concerns, and used methods such as verbal counseling, emotional diversion, or interest cultivation to improve patients' negative emotions, such as discussing topics of interest or encouraging them to listen to music.

(4) Therapeutic communication

Based on clinical diagnostic results, utilize video presentations, knowledge brochures, and other formats to explain disease-related information to patients, or guide them to follow the hospital's official account to view popular science knowledge on the platform. During and after treatment, communicate with patients multiple times to introduce common complications of the treatment plan and coping strategies, inform them of the purposes, clinical significance, and cooperation methods of common examination items, and alleviate their resistance. Actively inquire about patients' concerns or doubts regarding the treatment plan and provide one-on-one answers from clinical doctors. After emergency treatment is completed, provide rehabilitation guidance based on the patient's recovery status, listing precautions related to diet, treatment, hydration, exercise, etc., and explaining medication methods and treatment duration to improve patients' medication compliance.

2.3. Observation indicators

(1) Nursing satisfaction

A self-designed nursing satisfaction questionnaire was used, covering aspects such as service attitude and communication frequency, with a total score of 100 points [3]. Scores above 85 indicate high satisfaction, scores between 45 and 85 indicate moderate satisfaction, and scores below 45 indicate dissatisfaction. The Cronbach's α coefficient of this questionnaire is 0.968, and the test-retest reliability is 0.850, indicating good reliability and validity.

(2) Negative emotions

The Hospital Anxiety and Depression Scale (HADS) was selected, which includes anxiety (7 items) and depression (7 items) subscales. Each item is scored from 0 to 3, with negative emotions positively correlated with the score.

(3) Knowledge mastery level

A self-developed "Health Education Knowledge Assessment Scale" was used, encompassing disease knowledge, treatment plans, common complications, key points of nursing cooperation, and self-care methods, each section carrying a score of 20 points, with positive scoring for mastery level [4]. The Cronbach's α coefficient of this scale was 0.857, and its test-retest reliability was 0.851, indicating good

reliability and validity.

(4) Uncertainty in illness

The Mishel Uncertainty in Illness Scale (MUIS) was selected, which includes complexity factors (ranging from 10 to 50 points) and ambiguity factors (ranging from 15 to 75 points), with positive scoring for uncertainty in illness.

(5) Coping styles

The Medical Coping Modes Questionnaire (MCMQ) was chosen, which includes subscales for resignation (5 items), confrontation (8 items), and avoidance (7 items), with each item scored from 1 to 4 points and positive scoring for coping styles.

2.4. Statistical analysis

Data were processed using SPSS 28.0 software. Continuous variables were compared/tested using *t*-values, while categorical variables were compared/tested using chi-square (χ^2) values. Statistical significance was considered as $p < 0.05$.

3. Results

3.1. Comparison of nursing satisfaction between the two groups

The nursing satisfaction level in the experimental group was higher than that in the reference group ($p < 0.05$), refer **Table 1**.

Table 1. Comparison of nursing satisfaction between the two groups [n/%]

Group	n	Very satisfied	Basically satisfied	Dissatisfied	Satisfaction rate
Experimental group	42	22 (52.38)	19 (45.24)	1 (2.38)	97.62 (41/42)
Control group	42	18 (42.86)	17 (40.48)	7 (16.67)	83.33 (35/42)
χ^2	-	-	-	-	4.974
p value	-	-	-	-	0.026

3.2. Comparison of negative emotion scores between the two groups

Before nursing care, there was no significant difference in negative emotion scores between the two groups ($p > 0.05$). After nursing care, the negative emotion scores in the experimental group were lower than those in the reference group ($p < 0.05$). refer **Table 2**.

Table 2. Comparison of negative emotion scores between the two groups [$\overline{x} \pm$ s, points]

Group	n	Anxiety		Depression	
		Before care	After care	Before care	After care
Experimental group	42	14.15 ± 2.61	7.16 ± 1.77	12.53 ± 2.06	6.17 ± 1.35
Control group	42	13.95 ± 2.53	9.42 ± 1.81	12.59 ± 2.10	7.98 ± 1.41
t-value	-	0.357	5.785	0.132	6.009
p value	-	0.722	0.000	0.895	0.000

3.3. Comparison of knowledge mastery scores between the two groups

The knowledge mastery scores in the experimental group were higher than those in the reference group ($p < 0.05$) refer **Table 3**.

Table 3. Comparison of knowledge mastery scores between the two groups [$\overline{x} \pm s$, points]

Group	n	Disease knowledge	Treatment plan	Common complications	Key points of nursing cooperation	Self-care methods
Experimental group	42	17.21 ± 1.73	17.05 ± 1.33	16.37 ± 1.82	16.59 ± 2.11	17.28 ± 1.46
Control group	42	15.03 ± 1.61	15.19 ± 1.25	14.02 ± 1.80	14.04 ± 2.06	15.10 ± 1.34
t-value	-	5.978	6.604	5.950	5.604	7.129
p value	-	0.000	0.000	0.000	0.000	0.000

3.4. Comparison of disease uncertainty scores between the two groups

Before nursing care, there was no significant difference in disease uncertainty scores between the two groups ($p > 0.05$). After nursing care, the disease uncertainty scores in the experimental group were lower than those in the reference group ($p < 0.05$) refer **Table 4**.

Table 4. Comparison of disease uncertainty scores between the two groups [$\overline{x} \pm s$, points]

Group	n	Complexity factors		Ambiguity factors	
		Before care	After care	Before care	After care
Experimental group	42	26.54 ± 3.41	11.15 ± 2.07	38.65 ± 4.19	13.45 ± 2.93
Control group	42	25.97 ± 3.52	14.39 ± 2.10	39.01 ± 4.22	17.16 ± 2.97
t-value	-	0.754	7.121	0.392	5.763
p value	-	0.453	0.000	0.696	0.000

3.5. Comparison of coping style scores between the two groups

Before nursing care, there was no significant difference in coping style scores between the two groups ($p > 0.05$). After nursing care, the coping style scores in the experimental group were better than those in the reference group ($p < 0.05$) refer **Table 5**.

Table 5. Comparison of coping style scores between the two groups [$\overline{x} \pm s$, points]

Group	n	Yield		Face		Avoidance	
		Before care	After care	Before care	After care	Before care	After care
Experimental group	42	13.42 ± 2.18	8.69 ± 1.72	18.25 ± 2.97	24.19 ± 3.41	20.15 ± 3.64	14.05 ± 2.74
Control group	42	13.18 ± 2.20	10.22 ± 1.84	18.29 ± 2.91	21.33 ± 3.35	20.07 ± 3.69	16.97 ± 2.80
t-value	-	0.502	3.937	0.062	3.877	0.100	4.830
p value	-	0.617	0.000	0.950	0.000	0.921	0.000

4. Discussion

There are many types of diseases causing acute pain in patients in the emergency department, with rapid disease progression that can easily lead to various complications, posing a high disease risk. Most patients with acute renal colic have limited understanding of their own conditions. When entering an unfamiliar environment for the first time, they may experience psychological issues such as anxiety and depression. Coupled with the complexity of disease development, this significantly increases their psychological burden, thereby affecting treatment compliance. For this reason, clinical practice often involves providing routine care to emergency patients, paying close attention to their physical and mental states, and offering targeted nursing guidance to improve their cooperation with care. However, routine care has limited content and a relatively singular form, failing to meet the diverse care needs of emergency patients, thus having limitations [5].

Humanistic care is a widely used nursing method that provides individualized guidance based on the patient's disease condition and psychological state. It emphasizes nursing initiative, requiring nursing staff to actively communicate with patients, understand their current care needs, and reasonably optimize the nursing process, thereby embodying the concept of humanistic care in various nursing details and improving the quality of care [6]. Therapeutic communication is a planned and purposeful communication process centered around the needs of patients. It utilizes specific communication skills to establish a close nurse-patient relationship, actively guiding patients to express their inner feelings and nursing needs, thereby alleviating their negative emotions, assisting them in resolving nursing issues, and ultimately promoting their physical and mental well-being. Humanistic care-guided therapeutic communication highly aligns with the disease characteristics and nursing needs of emergency patients, demonstrating high professionalism and feasibility in nursing [7].

The results showed that the nursing satisfaction in the experimental group was higher than that in the reference group, while the scores for negative emotions were lower. The scores for knowledge mastery were higher in the experimental group, whereas the scores for disease uncertainty were lower. Additionally, the coping style scores were superior in the experimental group compared to the reference group ($p < 0.05$). The analysis attributes these results to the fact that humanistic care-guided therapeutic communication can enhance patients' awareness of relevant knowledge, strengthen their understanding of their own diseases, nursing plans, and treatment procedures, thereby increasing their sense of disease control and reducing negative emotions [8]. Strengthening nurse-patient communication allows for dynamic assessment of patients' nursing needs, enabling appropriate adjustments to treatment plans and nursing content based on their inner expectations. This involvement of patients in treatment and nursing decision-making enhances their treatment confidence and reduces disease uncertainty [9]. Moreover, during the communication process, nursing staff can convey positive energy to patients, provide them with emotional counseling, psychological comfort, and informational support, and deliver disease-related knowledge through multiple channels. As a result, patients tend to have a better grasp of knowledge. At the same time, therapeutic communication can guide patients to correctly cooperate with disease examination and treatment procedures, enhance their understanding of potential complications associated with treatment plans, enabling them to face their diseases rationally and optimistically, actively change their coping strategies from avoidance or submission, and maximize the role of nursing participation [10]. Under the aforementioned nursing interventions, patients can fully experience humanistic care, actively communicate with nursing staff, and express their nursing opinions, leading to higher satisfaction levels.

5. Conclusion

In summary, providing humanistic care-guided therapeutic communication nursing for patients with emergency renal colic yields high satisfaction levels, corrects negative emotions, improves their knowledge and disease coping abilities, and eliminates their uncertainty about the disease, demonstrating significant nursing value.

Disclosure statement

The authors declare no conflict of interest.

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