

Integrating narrative nursing and diversified health education in postherpetic neuralgia care

A retrospective study

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Abstract

This study investigates the impact of narrative nursing combined with diversified health education on negative emotions and self-management abilities in patients with postherpetic neuralgia (PHN). A retrospective analysis was conducted on 182 PHN patients treated at the Second Affiliated Hospital of Soochow University from July 2023 to June 2024. Patients were divided into an observation group and a control group, with 91 cases in each. The control group received standard care, while the observation group received narrative nursing combined with diversified health education in addition to standard care. The average pain levels of patients before and after the intervention were assessed using the numerical rating scale. Negative emotions were evaluated using the self-rating anxiety scale and the self-rating depression scale, while self-efficacy levels were measured using the chronic pain self-efficacy scale. Patient satisfaction with nursing care was surveyed at discharge using the inpatient nursing satisfaction scale. Post-intervention, the observation group showed significantly lower scores on the numerical rating scale, self-rating anxiety scale, and self-rating depression scale compared to the control group. Additionally, the observation group demonstrated markedly higher scores on the chronic pain self-efficacy and the nursing satisfaction scales than the control group. Narrative nursing combined with diversified health education effectively reduces pain levels and negative emotions in PHN patients, enhances their self-efficacy in managing chronic pain, and increases satisfaction with nursing care. This approach merits clinical promotion and application.

Abbreviations: CPSS = chronic pain self-efficacy scale, NRS = numerical rating scale, PHN = postherpetic neuralgia, SAS = self-rating anxiety scale, SDS = self-rating depression scale.

Keywords: diversified health education, narrative nursing, negative emotions, postherpetic neuralgia

1. Introduction

Postherpetic neuralgia (PHN) is a condition characterized by persistent, often severe pain in the dermatomal distribution of nerves previously affected by herpes zoster, commonly known as shingles, even after the rash has resolved.^[1] It is the most common complication of *herpes zoster*.^[2] According to guidelines established in Germany in 2019, PHN is defined as pain that persists for 3 months or longer following the disappearance of cutaneous lesions.^[3] Studies indicate that approximately 25% of patients with shingles develop PHN, with the incidence progressively increasing with age.^[4,5] Patients with PHN often experience prolonged pain, which can lead to anxiety, depression, social impairment, and significantly affect overall physical and mental health as well as quality of life.^[6,7] Currently, the clinical treatment for PHN primarily involves pharmacological therapy.

However, due to issues such as inadequate patient understanding of the condition and the substantial psychological burden, enhancing nursing interventions for patients with PHN is crucial.

Narrative nursing is an innovative model that incorporates narrative therapy.^[8] It emphasizes the importance of listening to patients' stories, understanding their inner feelings, and helping them reconstruct a positive sense of life, thereby improving psychological health.^[9–11] In contrast, diversified health education provides patients with comprehensive and systematic health knowledge through various formats and channels, aiming to enhance their self-management capabilities and improve their quality of life.^[12] Despite the increasing recognition of the benefits of narrative nursing in enhancing health outcomes for both patients and nurses, there is a notable gap in research exploring

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its integration with diversified health education in the context of PHN.

This study aims to bridge the gap by examining the effectiveness of narrative nursing combined with diversified health education in patients with PHN, offering a reference for clinical nursing practices. By focusing on this integrated approach, we aim to provide a more holistic and patient-centered care model that addresses not only the physical symptoms of PHN but also the psychological and social aspects of patients' lives, potentially leading to improved overall well-being and quality of life.

2. Methods

2.1. Study design

This retrospective study initially planned to enroll 188 patients with PHN. However, 4 patients were excluded due to exclusion criteria, and 2 were excluded for incomplete data, resulting in a final cohort of 182 patients. The patients included in the analysis were treated at the Department of Pain Medicine, Second Affiliated Hospital of Soochow University, between July 2023 and June 2024. They were divided into a control group ($n = 91$, receiving standard care) and an observation group ($n = 91$, receiving narrative nursing and diversified health education in addition to standard care). The study flowchart is presented in Figure 1.

2.2. Ethical approval and informed consent

The study adhered to the principles outlined in the Declaration of Helsinki (as revised in 2013) and was conducted with the approval of the Ethics Committee of the Second Affiliated Hospital of Soochow University for the collection and use of patient data (approval no. JD-LK2024087). Written informed consent was obtained from all patients prior to treatment, and they were informed that their medical records might be used for future medical research.

2.3. Inclusion and exclusion criteria

Inclusion criteria:

1. Patients met the diagnostic criteria for PHN.^[3]
2. Patients were aged 18 years or older.
3. Patients were fully conscious and capable of normal communication and interaction.

Exclusion criteria:

1. Patients with severe comorbidities affecting the heart, liver, kidneys, or other organs.
2. Patients with a history of psychiatric disorders or cognitive impairments.
3. Patients who were not fully conscious or unable to communicate and interact normally.

2.4. Sample size estimation

Sample size was calculated based on continuous variable sample size from a preliminary study, with an alpha level (α) set at 0.05 (2-tailed) and a beta level (β) at 0.20 (1-tailed), corresponding to $Z\alpha = 1.96$ and $Z\beta = 0.84$. The estimated variance (σ^2) was determined to be 37.747, derived from the preliminary results, and the difference in means (d) between the 2 groups post-intervention was set at 2.7. Utilizing these parameters, the required sample size per group was calculated to be 82. Accounting for an anticipated dropout rate of 10%, we increased the sample size to 91 participants per group to ensure adequate statistical power.

In the formula used:

σ represents the estimated standard deviation.

d represents the difference in means of the continuous variables between the 2 groups.

$Z\alpha$ corresponds to the standard normal deviate for the α level.

$Z\beta$ corresponds to the standard normal deviate for the $1-\beta$ level.

N is the calculated sample size for 1 group.

2.5. Interventions for patients

The control group received standard care, which included monitoring of the condition, medication guidance, pain management, dietary care, psychological support, and health education. The observation group, in addition to the standard care provided to the control group, received narrative nursing combined with diversified health education. The specific interventions included the following measures (Fig. 2):

2.5.1. Formation of the narrative nursing and diversified health education intervention team. An intervention team was formed, consisting of the head nurse from the pain department, the head of the pain department, a psychological counselor, a member of the research team, and a member of the health education team.

All team members completed a 4-week training program focused on narrative nursing theory and practice. The training incorporated both online and offline methods, including in-depth reading, case analysis, mock medical record writing, and group sharing. Theoretical learning was based on professional books,^[13] while practical skills were developed through scenario simulations and group discussions. All participants successfully passed the final assessments.

2.5.2. Design and arrangement of the narrative environment.

The narrative environment was designed with 3 key areas: a soul reading area for patients to borrow and reflect on narrative literary works; a soul mailbox where patients could write their own life stories for emotional organization and healing; and a soul dock for private one-on-one narrative nursing and group psychological interventions.

2.5.3. Implementation of narrative nursing intervention.

Narrative nursing intervention was implemented in 4 phases. Phase 1 involved building trust and initiating narrative through conversations during admission. Phase 2 focused on externalizing problems and deconstructing narratives, guiding patients to clarify issues and confront the impact of their pain. Phase 3 aimed to identify exemplars and positive events to inspire patients and help them set goals. Phase 4 assisted patients in reconstructing their narratives by reframing negative experiences into positive ones and rebuilding their sense of self.

2.5.4. Diversified health education intervention.

The health education team developed educational materials, including brochures, posters, and videos, that addressed disease knowledge, dietary advice, exercise recommendations, medication information, psychological support, and self-management. These materials were reviewed and approved by the head nurse and department chair. The intervention methods comprised individualized education tailored to patients' backgrounds, group education seminars featuring expert lectures, multimedia education using videos and booklets, and peer education where recovered patients shared their experiences.

2.6. Evaluation methods

General data survey form: This form collects information on age, gender, educational level, disease duration, average pain level, self-rating anxiety scale (SAS) score, self-rating depression scale (SDS) score, and chronic pain self-efficacy scores.

Flowchart of the Research

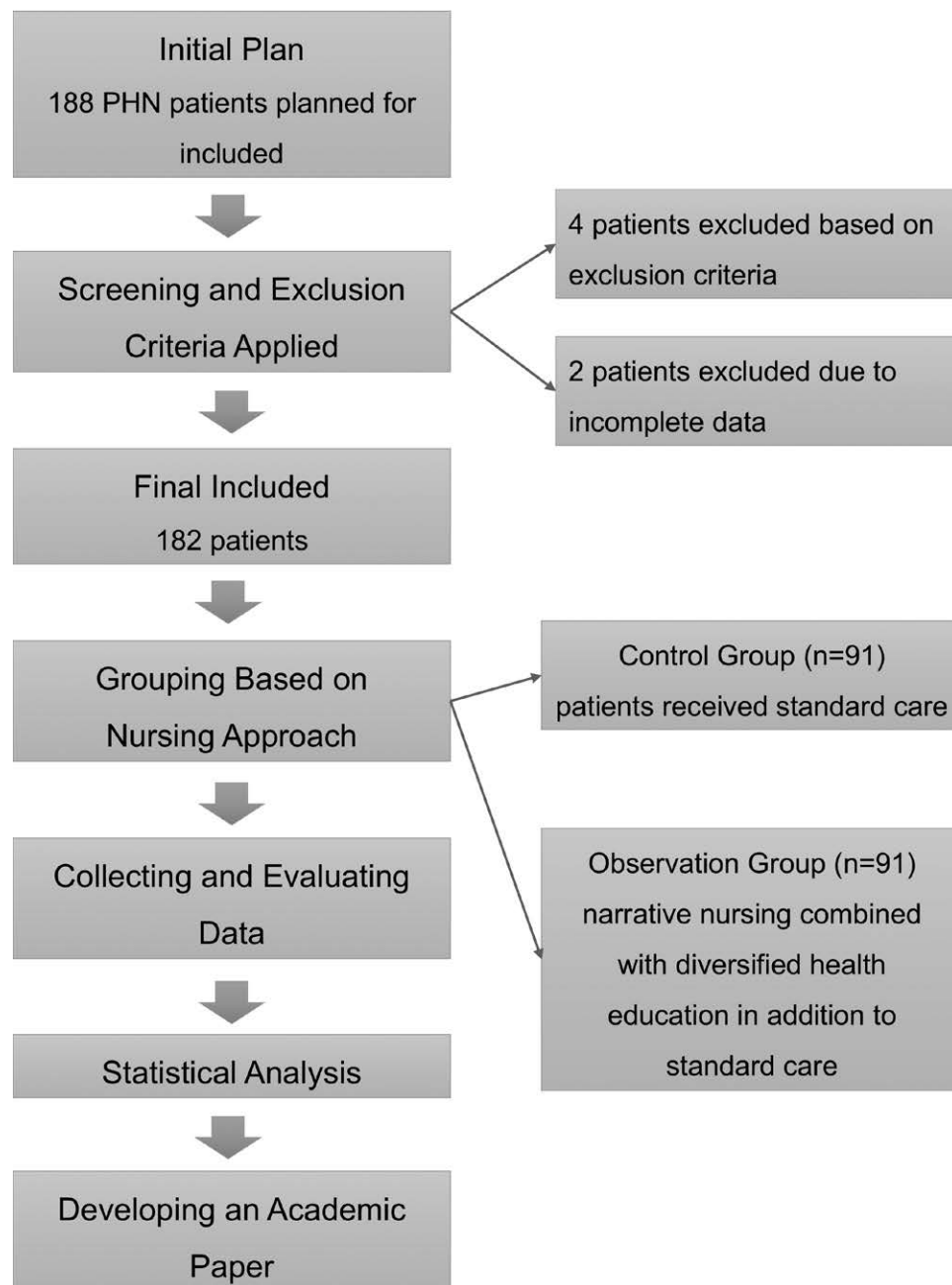


Figure 1. The flowchart of the present study.

Pain assessment: The average pain level of patients is evaluated both before and after the intervention. Pain assessment employs the numerical rating scale (NRS),^[14] a method that is widely applicable across diverse populations and accurately measures the degree of a patient's pain. The NRS consists of a scale from 0 to 10, where patients describe their pain numerically: 0 indicates no pain, 1 to 3 indicates mild pain, 4 to 6 indicates moderate pain, 7 to 9 indicates severe pain, and 10 indicates intense pain. This scale provides a standardized and quantifiable measure of pain, which is essential for tracking changes in pain levels throughout the intervention.

Assessment of negative emotions: Anxiety and depressive symptoms in patients were evaluated before and after the intervention using the SAS and the SDS. Both scales were developed

by William W.K. Zung in 1965^[15] and 1971,^[16] respectively. These self-assessment tools are designed to measure the severity of depressive and anxious states, as well as the changes that occur throughout treatment. The assessment period covers the most recent week. The scales are easy to administer and understand, with scoring that is not influenced by factors such as age, gender, or socioeconomic status. They effectively reflect the relevant symptoms of depression and anxiety, along with their severity and changes over time. Higher scores on the SAS and SDS indicate more severe levels of anxiety and depression, respectively.

Chronic pain self-efficacy assessment scale: The chronic pain self-efficacy scale (CPSS) was developed by American scholar Anderson in 1994.^[17] The CPSS encompasses 3

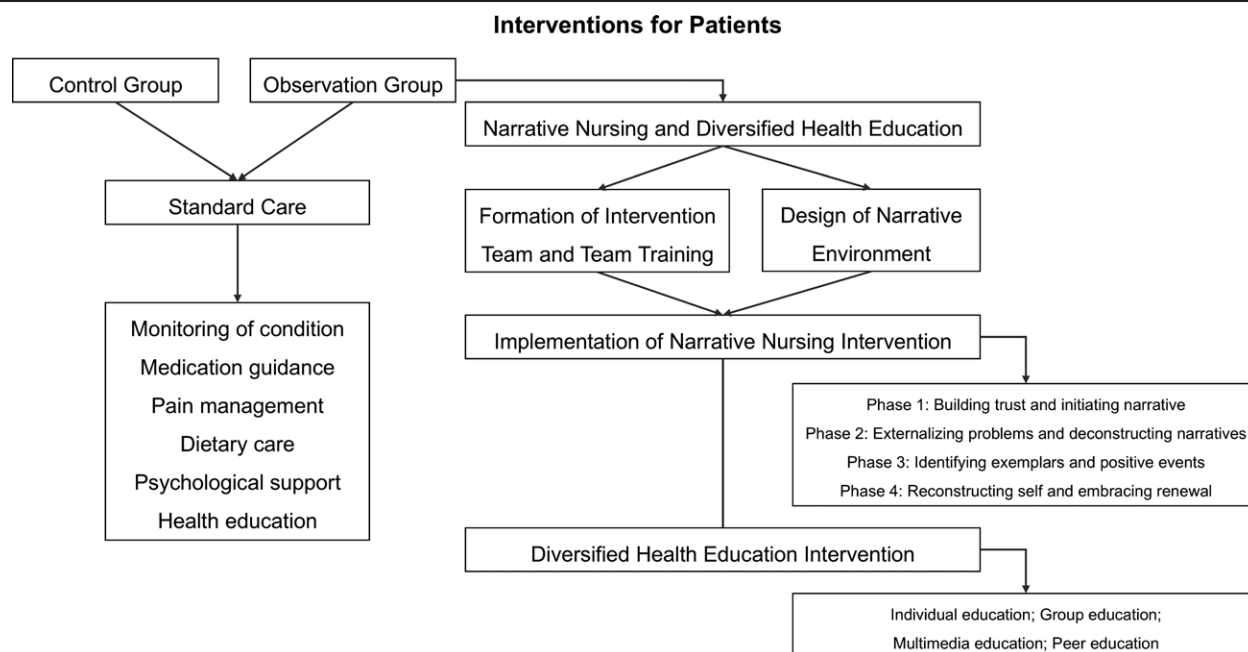


Figure 2. Interventions for patients.

dimensions: self-efficacy in chronic pain management, self-efficacy in physical functioning, and self-efficacy in symptom coping, comprising a total of 22 items. Each dimension contains the following number of items: 5 for chronic pain management, 9 for physical functioning, and 8 for symptom coping. Scoring is conducted using a 5-point Likert scale (1 = not confident at all; 2 = somewhat confident; 3 = moderately confident; 4 = very confident; 5 = extremely confident). Item scores are summed to derive both the dimension score and the total scale score, which ranges from 22 to 110, with higher scores indicating greater self-efficacy in patients. The Cronbach alpha coefficients for the total scale and each dimension range from 0.834 to 0.948. Additionally, the Guttman split-half reliability coefficients range from 0.760 to 0.904, and the test–retest reliability coefficients range from 0.819 to 0.904, demonstrating good reliability and validity of the scale.

Inpatient nursing satisfaction survey: Upon discharge, patients were surveyed using the Inpatient Nursing Satisfaction Scale developed by American scholar Risserl in 1975.^[18] This scale consists of 3 dimensions: professional technical ability, educational relationship, and trust relationship, totaling 21 items. Specifically, there are 11 items related to trust, 5 items related to professional technical ability, and 5 items related to education. All items are scored on a 5-point Likert scale ranging from “strongly disagree” to “strongly agree,” with scores assigned from 1 to 5. Items numbered 2, 3, 5, 7, 10, 13, 15, and 20 are reverse-scored. Higher scores indicate greater patient satisfaction. This scale has been widely used in clinical settings to measure nursing satisfaction and has demonstrated excellent content validity (0.98), internal consistency reliability (Cronbach alpha of 0.80), and test–retest reliability (0.93), confirming its robust psychometric properties.

2.7. Statistical analysis

Data analysis was conducted using SPSS version 26 statistical software. Quantitative data are expressed as mean ± standard deviation and were analyzed using *t* tests. Categorical data are presented as percentages (%) and were analyzed using chi-square (χ^2) tests. A *P*-value of less than .05 was

considered statistically significant. To ensure analytical rigor, we balanced baseline characteristics (e.g., age, gender) and used ANCOVA to control for potential confounders like disease duration and education level. The intervention implementation consistency (Kappa = 0.85) was also recorded to minimize bias.

3. Results

3.1. General characteristics

An analysis of the general clinical data for both patient group is presented in Table 1. There were no statistically significant differences between the control and observation groups regarding gender, age, educational level, and disease duration (*P* > .05 for all comparisons), indicating that the study groups were comparable.

3.2. Average pain levels for pre- and post-intervention

The NRS was used to assess the average pain levels of the control and observation groups both before the intervention and at discharge (post-intervention). Table 2 displays the NRS scores for both groups. Prior to the intervention, the observation group had an NRS score of 6.87 ± 1.83 , while the control group had a score of 6.95 ± 1.85 (*P* = .779; Cohen *d* [95% CI] = 1.843 [-0.332, 0.249]). After the intervention, the observation group’s NRS score decreased to 2.66 ± 1.06 , compared to the control group’s score of 3.26 ± 1.21 (*P* < .000; Cohen *d* [95% CI] = 1.136 [-0.827, -0.236]), indicating the effectiveness of the intervention measures.

3.3. SAS and SDS scores for pre- and post-intervention

The SAS and SDS were used to assess anxiety and depression levels in both patient groups before the intervention and at discharge (post-intervention), as detailed in Table 3. Prior to the intervention, the observation group had mean SAS and SDS scores of 57.03 ± 5.68 and 58.36 ± 4.58 , respectively, while the control group had mean scores of 57.67 ± 5.87 for SAS and 59.40 ± 4.87 for SDS. There were no significant

differences in SAS ($P = .458$; Cohen d [95% CI] = 5.780 [-0.401, -0.181]) and SDS ($P = .142$; Cohen d [95% CI] = 4.730 [-0.510, -0.073]) scores between the 2 groups before the intervention. After the intervention, the observation group's SAS and SDS scores decreased to 49.19 ± 7.21 and 50.57 ± 5.81 , respectively, while the control group's scores were 51.84 ± 7.22 for SAS and 53.18 ± 5.52 for SDS. Significant differences were observed in SAS ($P = .014$; Cohen d [95% CI] = 7.214 [-0.660, -0.074]) and SDS ($P = .002$; Cohen d [95% CI] = 5.669 [-0.75, -0.164]) scores between the 2 groups post-intervention, indicating the efficacy of the intervention measures.

Table 1
General information of the 2 groups of patients before intervention.

Items	Control group (cases, %)	Observation group (cases, %)	χ^2	P -value
Gender				
Male	33 (36.26%)	40 (43.96)	1.121	.290
Female	58 (63.74%)	51 (56.04)		
Age (yr)				
18–50	7 (7.69%)	6 (6.59%)	2.397	.494
51–60	13 (14.29%)	14 (15.38%)		
61–70	30 (32.97%)	39 (42.86%)		
71 and above	41 (45.05%)	32 (35.16%)		
Education				
Primary school and below	10 (10.99%)	9 (9.89%)	3.566	.468
Junior high school (technical secondary school)	17 (18.68%)	23 (25.27%)		
High school	10 (10.99%)	12 (13.19%)		
College	35 (38.46%)	24 (26.37%)		
Bachelor degree and above	19 (20.88%)	23 (25.27%)		
History of pain				
<1 yr	42 (46.15%)	45 (49.45%)	0.670	.715
1–3 yr	29 (31.87%)	24 (26.37%)		
3 yr or more	20 (21.98%)	22 (24.18%)		

3.4. Chronic pain self-efficacy for pre- and post-intervention

The CPSS was utilized to assess the level of chronic pain self-efficacy in both patient groups before the intervention and at discharge (post-intervention), as detailed in Table 4. Prior to the intervention, the observation group had a total self-efficacy score of 65.79 ± 16.55 , while the control group scored 67.57 ± 18.63 ($P = .496$; Cohen d [95% CI] = 17.619 [-0.392, -0.190]). After the intervention, the observation group's total CPSS score increased to 78.20 ± 12.60 , compared to the control group's score of 72.41 ± 17.74 ($P = .012$; Cohen d [95% CI] = 15.384 [0.083, -0.669]), indicating the effectiveness of the intervention measures. Further analysis of scores for each dimension revealed that the observation group's scores for chronic pain management self-efficacy, physical functioning self-efficacy, and symptom coping self-efficacy were 16.55 ± 2.81 , 33.27 ± 5.83 , and 28.37 ± 5.41 , respectively. In contrast, the control group's scores for these dimensions were 15.70 ± 2.71 , 30.77 ± 8.09 , and 25.93 ± 7.68 , respectively. The analysis indicated statistically significant differences in the scores for each dimension between the 2 groups after the intervention ($P = .040$, Cohen d [95% CI] = 2.762 [0.014–0.598]; $P = .018$, Cohen d [95% CI] = 7.049 [0.062–0.648]; $P = .014$, Cohen d [95% CI] = 6.645 [0.074–0.660]), further confirming the efficacy of the intervention measures.

3.5. Post-intervention nursing satisfaction

Patient satisfaction with nursing care was assessed at discharge using the Inpatient Nursing Satisfaction Scale, with results presented in Table 5 for both the control and observation groups. The total nursing satisfaction score for the observation group was 91.89 ± 5.83 , with scores for professional technical ability, educational relationship, and trust relationship recorded at 48.45 ± 4.70 , 21.74 ± 1.90 , and 21.70 ± 1.63 , respectively. In contrast, the control group's scores for the same categories were 87.43 ± 6.25 , 47.74 ± 3.82 , 19.77 ± 2.65 , and 19.92 ± 1.94 , respectively. The analysis revealed no significant difference in scores for professional technical ability ($P = .270$; Cohen d [95% CI] = 4.284 [-0.127, -0.455]), but significant statistical differences were observed in overall satisfaction

Table 2
Mean NRS scores between the 2 groups before and after intervention.

	Observation group (n = 91)	Control group (n = 91)	t -value	P -value	Cohen d (95% CI)
Before intervention	6.87 ± 1.83	6.95 ± 1.85	-0.282	.779	1.843 (-0.332, 0.249)
After intervention	2.66 ± 1.06	3.26 ± 1.21	-3.590	<.000*	1.136 (-0.827, -0.236)

Compared with the control group.

NRS = numerical rating scale.

* $P < .05$.

Table 3
SAS and SDS scores between the 2 groups before and after intervention.

Group	SAS		SDS	
	Before intervention	After intervention	Before intervention	After intervention
Observation group (n = 91)	57.03 ± 5.68	49.19 ± 7.21	58.36 ± 4.58	50.57 ± 5.81
Control group (n = 91)	57.67 ± 5.87	51.84 ± 7.22	59.40 ± 4.87	53.18 ± 5.52
t -value	-0.744	-2.476	-1.473	-3.099
P -value	.458	.014*	.142	.002*
Cohen d (95% CI)	5.780 (-0.401 to 0.181)	7.214 (-0.660 to 0.074)	4.730 (-0.510 to 0.073)	5.669 (-0.75 to 0.164)

Compared with the control group.

SAS = self-rating anxiety scale, SDS = self-rating depression scale.

* $P < .05$.

Table 4
Chronic pain self-efficacy between the 2 groups before and after intervention.

Group	Before intervention		After intervention		
	Total score of questionnaire	Total score of questionnaire	Chronic pain management self-efficacy	Physical function	Symptoms
<i>Self-efficacy</i>					
Observation group (n = 91)	65.79 ± 16.55	78.20 ± 12.60	16.55 ± 2.81	33.27 ± 5.83	28.37 ± 5.41
Control group (n = 91)	67.57 ± 18.63	72.41 ± 17.74	15.70 ± 2.71	30.77 ± 8.09	25.93 ± 7.68
t-value	-0.682	2.539	2.066	2.398	2.477
P-value	.496	.012*	.040*	.018*	.014*
Cohen d (95% CI)	17.619 (-0.392 to 0.190)	15.384 (0.083–0.669)	2.762 (0.014–0.598)	7.049 (0.062–0.648)	6.645 (0.074–0.660)

Compared with the control group.

*P < .05.

Table 5
Nursing satisfaction scores between the 2 groups after intervention.

Group	Professional and technical ability score	Educational relations score	Trust relationship score	Total score of nursing satisfaction
Observation group (n = 91)	48.45 ± 4.70	21.74 ± 1.90	21.70 ± 1.63	91.89 ± 5.83
Control group (n = 91)	47.74 ± 3.82	19.77 ± 2.65	19.92 ± 1.94	87.43 ± 6.25
t-value	1.107	5.752	6.704	4.966
P	.270	<.000*	<.000*	<.000*
Cohen d (95% CI)	4.284 (-0.127 to 0.455)	2.307 (0.548–1.155)	1.791 (0.685–1.301)	6.045 (0.435–1.036)

Compared with the control group.

*P < .001.

(P < .000; Cohen d [95% CI] = 6.045 (0.435, –1.036)) and scores for educational (P < .000; Cohen d [95% CI] = 2.307 (0.548, –1.155)) and trust relationships (P < .000; Cohen d [95% CI] = 1.791 (0.685, –1.301)). This indicates that the intervention measures had a pronounced effect on the educational and trust aspects of the nursing relationship, as well as on overall satisfaction.

4. Discussion

The primary objective of this study was to investigate the impact of narrative nursing combined with diversified health education on the negative emotions and self-management abilities of patients with PHN. The findings revealed that, post-intervention, the observation group exhibited significantly lower scores on the NRS for pain, as well as on the SAS and SDS, compared to the control group. Additionally, the observation group demonstrated markedly higher scores on the chronic pain self-efficacy and nursing satisfaction scales than the control group. These outcomes align with our hypotheses, indicating that the integration of narrative nursing and diversified health education can effectively reduce pain levels and negative emotions in PHN patients, while also enhancing their self-efficacy and satisfaction with nursing care.

PHN often inflicts severe pain on patients, leading to negative emotions such as anxiety and depression.^[3,6] Narrative nursing enables caregivers to deeply understand the experiences of patients suffering from pain, allowing for targeted interventions that address psychological issues and alleviate the disappointment and helplessness caused by an excessive focus on negative emotions.^[19,20] In contrast, diversified health education enhances patients' self-management abilities by providing comprehensive health knowledge. The combination of these 2 approaches may improve patients' understanding of their condition and self-management skills, reduce pain perception, decrease negative emotions, and increase nursing satisfaction. In this study, we focus on how narrative nursing can reduce patients' perception of pain by establishing trust and empathy. The essence of narrative nursing lies in helping patients discover their strengths and

resources through storytelling and listening, thereby improving their ability to cope with pain.

Furthermore, we found that diversified health education plays a pivotal role in enhancing patients' self-management capabilities. It imparts knowledge and skills in areas such as pain management, skin care, dietary adjustments, and exercise, helping patients learn to manage their conditions independently. Narrative nursing encourages patients to reflect on their behaviors and lifestyles, prompting active participation in disease management by modifying daily habits and cooperating with treatments. This engagement increases their enthusiasm and initiative in self-management.^[21] Once patients recognize, through narrative nursing, the impact of poor lifestyle habits on their disease, they proactively alter their routines and dietary practices. The combination of narrative nursing and diversified health education positively influences patients on psychological, cognitive, and behavioral levels, facilitating better cooperation with treatment and rehabilitation exercises, thereby accelerating the recovery process. A correct understanding of the disease, a positive attitude, and strong self-management skills,^[21] create favorable conditions for physical recovery. The implementation of narrative nursing alongside diversified health education has improved patients' psychological states and self-management abilities, significantly enhancing their quality of life. Patients are better equipped to cope with the challenges posed by their illness, reengage in social activities and daily life, and enjoy a higher quality of life.

The limitations of this study include a relatively small sample size and the fact that it was conducted at a single medical center, which may restrict the generalizability of the results. Subjective bias is another limitation, as pain and emotional scores depended on patient self-assessment; future studies could incorporate objective indicators, such as cortisol levels. Additionally, the lack of blinding due to the nature of the intervention may have introduced expectation effects. Future research should involve larger samples and multiple medical centers to validate these findings. Long-term follow-up studies are necessary to evaluate the sustained effects of the combined intervention, providing a more comprehensive understanding of its impact over time.

5. Conclusion

The findings of this study support the effectiveness of narrative nursing and diversified health education in managing chronic pain, providing a novel perspective for clinical nursing. This approach not only improves treatment outcomes for patients with PHN but may also yield similarly positive effects for other patients suffering from chronic pain conditions. Additionally, broader implementation of this method could enhance the overall quality of nursing care and patient satisfaction. By integrating narrative practices and comprehensive educational strategies, healthcare providers can foster a more patient-centered and effective care environment.

Author contributions

Conceptualization: Yachen Chu, Xuling Pan.

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Methodology: Yachen Chu, Xiaomei Song.

Project administration: Yachen Chu.

Supervision: Xuling Pan.

Validation: Yue Zhang.

Writing – original draft: Yachen Chu.

Writing – review & editing: Yachen Chu, Xuling Pan.

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