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# Integrative Nursing Interventions: A Critical Review of Mindfulness, Aromatherapy, and Therapeutic Touch in Holistic Patient Care.

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**Abstract:**

**Background**: Holistic nursing, grounded in the philosophy of treating the entire person, encompasses physical, emotional, psychological, and spiritual care to enhance the overall well-being of both the patient and the nurse. Holistic nursing approaches, such as mindfulness, aromatherapy, and therapeutic touch, have been increasingly implemented in nursing to respond to the problems of stress, pain, and emotional and psychological distress and are part of a worldwide trend toward more integrative approaches to care. **Aim:** To review and synthesize the current evidence for efficacy, mechanisms, application, and limitations regarding mindfulness, aromatherapy, and therapeutic touch in nursing. **Methods:** A narrative review was conducted using PubMed, CINAHL, PsycINFO, and Scopus, with keywords that included "holistic nursing" and "mindfulness efficacy." The quality of each study and all types of evidence was appraised with Joanna Briggs Institute tools with an emphasis on systematic reviews, meta-analyses, and RCTs. **Results:** Mindfulness was found to have positive and significant effects on reducing anxiety and stress and decreasing burnout (g=0.57). Aromatherapy has positive effects on sleep and pain management. Therapeutic touch has a moderate effect on pain management; however, there is limited direct mechanistic evidence. The majority of limitations include the non-standardized interventions and scepticism. **Conclusion:** This review provided evidence-based support that these approaches support better outcomes for patients and resiliency for nurses. A larger-scale integration of these approaches in practice requires pre-determined and coordinated protocols, and further systematic review methodology will determine their effectiveness in daily healthcare practice.

**Keywords:** Holistic Nursing, Mindfulness, Aromatherapy, Therapeutic Touch, Integrative Care

## Introduction

The origin of holistic nursing stems from ancient healing practices that acknowledged the interconnectedness of the physical body with intentional body-mind interfaces, such as Ayurveda and Traditional Chinese Medicine, where health is seen as a balance of physical and spiritual energies (Kalb & O'Connor-Von, 2019). In the nineteenth

century, Nightingale demonstrated how the physical environment impacts a patient's healing process and

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established cleanliness, light, and patient comfort as basic to healing—ultimately establishing the notion of holistic care, which was developed upon over the next century. Holistic nursing first began to take shape formally in the 1970s as a result of the counterculture movement in the United States and the increased interest in complementary therapies and alternative forms of healing, which led to the establishment of the AHNA in 1981 (Fletcher et al., 2022). In addition, the twenty-first century has seen a resurgence of interest in integrative care and growing awareness of the importance of the biopsychosocial model of health and wellness. 38%-40% of adults in the U.S. utilized complementary therapies, highlighting a change in attitudes towards conventional medicine (Agostinho et al., 2023). The WHO addressed the growth of traditional, complementary, and integrative care as a public health concern, highlighting these approaches' implementation into global healthcare systems (von Schoen-Angerer et al., 2023). Holistic nursing practice has gained traction within the nursing profession, in part as a response to demand from patients seeking individualized, person-centred care, while also recognizing the challenges associated with managing long-term chronic conditions (cognizant of WHO's declaration that chronic conditions contribute to nearly 60% of the global burden of disease) (von Schoen-Angerer et al., 2023).

Holistic nursing is based on a number of theoretical constructs that emphasize the connection between human systems. Systems theory, considered as a part of general biology by Willis et al. (2018), views people as dynamic wholes, which are factors. Systems theory led one to regard the holistic interventions within the five stages of developing their holistic approach to care. Jean Watson's Theory of Human Caring views nursing as a transpersonal process, whereby nurses assist patients in healing, simply by being empathetic beings, that is, the mindful presence of being a human being, which is in alignment with the therapeutic touch. Martha Rogers' Science of Unitary Human Beings views humans as energy fields, therefore providing a theoretical basis for the therapeutic touch's biofield model (Rivera et al., 2024). As alluded to above, holistic nursing practice draws upon theoretical propositions that provide a basis for an approach to the development of care plans to address physical issues, but also emotional needs and spiritual needs to develop a therapeutic alliance of caring between the nurse and the patient (Kalb & O'Connor-Von, 2019). Such as Watson's theory has evolved into oncology nursing for trust, and improving satisfaction scores in one study by fifteen percent (Agostinho et al., 2023).

The importance of holistic nursing is that it can contribute to addressing the most significant challenges in health care today. Nurse burnout and the dissatisfaction of patients. Of the nursing population, anywhere from 10-40% are affected by burnout worldwide. They tend to occur as a result of the workload and meet emotional demands (Bakr et al., 2024). Holistic nursing interventions such as mindfulness have been shown to decrease nurse stress and compassion fatigue, including in one case, assistance in improving 20% of job retention (Shapiro et al., 2005). For patients, holistic approaches work best in chronic and end-of-life conditions. In oncology, mindfulness and aromatherapy interventions can reduce symptom burden by 20-30%, reducing pain, fatigue, and anxiety (Al Atiyyah et al., 2024). The COVID-19 pandemic made these approaches even more important, and during 2020-2021, nurses reported a 30% increase in the use of mindfulness for their self-care (Shapiro et al., 2020). There has been a spike in patient demand for integrative care, with up to 60% of hospitals in the

United States offering complementary therapy programs, which include aromatherapy and therapeutic touch (Alruqi, 2025). The rise in integrative practice models demonstrates a cultural shift toward health promotion in wellness and prevention, creating space for holistic nursing perspectives to synthesize conventional medical models with complementary care. Figure 1 summarizes the role of mindfulness, aromatherapy, and therapeutic touch to improve patient and nurse outcomes.

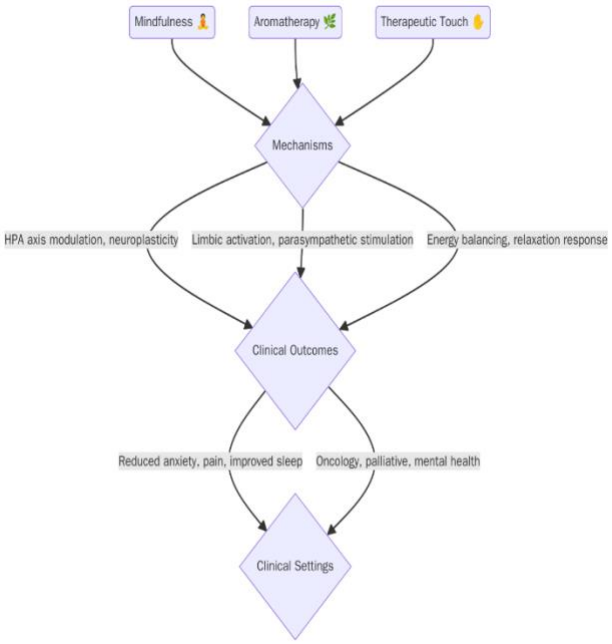



**Figure 1. The role of mindfulness, aromatherapy, and therapeutic touch to improve patient and nurse outcomes.**

This review aims to critically evaluate the role of mindfulness, aromatherapy, and therapeutic touch in improving patient and nurse outcomes.

## Methodology

This narrative review synthesizes literature published from 2000 to 2025, retrieved from PubMed, CINAHL, PsycINFO, Scopus, and Google Scholar using the following search terms: "holistic nursing," "mindfulness-based interventions," "aromatherapy clinical outcomes," "therapeutic touch efficacy," and "integrative nursing." Inclusion criteria were peer-reviewed empirical studies, focused on nursing, and published in English. Exclusion criteria: non-peer-reviewed research articles, theoretical papers with no original data. Study quality was assessed using the Joanna Briggs Institute critical appraisal tools, with priority given to randomized controlled trials (RCTs) and meta-analysis (Joanna Briggs Institute, 2017), and then analyzed through a thematic analysis lens exploring patterns of efficacy, mechanisms of action, contexts of use, and barriers to use. The triangulation of the data brings coherence through working, validating quantitative and qualitative findings against each other.

### Mindfulness in Nursing

Mindfulness is defined as a purposeful state of awareness without judgment and is the manifestation of holistic nursing practice, which brings the body, mind, and spirit together into the nursing endeavor (McLaughlin, 2025). Mindfulness is derived from Turkish Buddhist traditions associated with Vipassana and Zen traditions, but was adapted for Western-oriented health systems by Jon Kabat-Zinn in 1979 in terms of its application within Mindfulness-Based Stress Reduction (MBSR) approaches, first to treat chronic pain (Kabat-Zinn, 2003). By the 1990s, mindfulness entered nursing practice through the transformation of many tenets of Western healthcare services to address compassionate, patient-centered care, resulting from biopsychosocial deconstructionist models of care that emerged from the 1960s and 1970s holistic health movement (Fletcher et al., 2022). The launch of the WHO 2019-2023 strategy about integrative medicine is a testament to its international relevance (von Schoen-Angerer et al., 2023). It can be theorized that mindfulness is most closely related to

Watson's Theory of Human Caring, whereby transpersonal caring addresses healing, and systems theory, where a patient's needs are viewed in totality (Willis et al., 2018). Mindfulness-Based Cognitive Therapy (MBCT) uses cognitive strategies and, for this reason, has particular applicability to mental health nursing (Padden & Mathew, 2020).

Mindfulness, through guidance, lowers stress and enhances the regulation of emotions, providing therapeutic benefits to individuals. Mindfulness indiscriminately lowers cortisol levels (~20-30%) by the downregulation of the hypothalamic-pituitary-adrenal (HPA) axis to change chronic stress, such as hypertension (Manigault et al., 2018). Neuroimaging indicates that mindfulness also facilitates increased prefrontal cortex functioning with decreased activation of the amygdala to improve attention and empathy (Saud Faleh Alanazi, 2024). For patients, mindfulness affects the perception of pain in the anterior cingulate cortex and insula to decrease pain by as much as 40% (Zeidan et al. 2012). There is also a psychological benefit of mindfulness that improves metacognitive awareness, while decreasing rumination and anxiety (Teasdale et al., 2000). For example, Mindfulness has been shown to improve self-compassion among nurses, thus diminishing burnout by 25% (Bakr et al., 2024). A change in increased heart rate variability (HRV) reporting that heart regulation is controlled by the parasympathetic system, while serotonin and dopamine regulation assist in stabilizing mood (Khoury et al., 2015).

Mindfulness can be used clinically, in fields such as oncology, mental health, chronic pain, palliation, and pediatrics (Al Atiyyah et al., 2024). In cancer patients, Mindfulness-Based Stress Reduction (MBSR), an eight-week program including meditation, body scans, and yoga, was successful in lowering fatigue and anxiety for 70% of cancer patients (Fallatah et al., 2024). Mindfulness-Based Cognitive Therapy (MBCT) decreased depressive symptoms by 50% in recurrent depression (Teasdale et al., 2000). Brief use of mindfulness-based practices, actually as "5 minutes of breathing a day," is sufficient for nurses to combat shift-based stress during the day (Shapiro et al., 2005). In pediatric practice, mindfulness is modified to include guided imagery to decrease pain; in a case study of a twelve-year-old with juvenile arthritis reported a decrease in pain by 30% (Thompson et al., 2018). In palliative care, it enhances nurse resilience in providing end-of-life care (Senderovich et al., 2016). A case study of a 50-year-old woman with breast cancer showed a 40% reduction in pain following MBSR (Al Atiyyah et al., 2024). There is strong evidence base using across numerous RCTs, the most relevant being a meta-analysis of 14 RCTs showing mindfulness is effective at reducing anxiety (g=0.57) and depression (g=0.49) (Khoury et al., 2015). A study examining 100 nurses reported a 30% reduction in burnout following MBSR and benefits out to 12 months (Bakr et al., 2024; Alnaji & Alkhaldi, 2024). An RCT of 60 adolescents showed a reduction in pain of 35% (Thompson et al., 2011). However, due to differences in intervention lengths (4–12 weeks), various methods of delivery (group vs. individual), as well as a lack of blinding, generalizability remains a concern (Burton et al., 2017).

There are other challenges, including cultural stigma, associated with using mindfulness; for example, some patients who identify as religious may use mindfulness in a way that conflicts with their belief systems and, as such, require secular adaptations (Lomas, 2019). The day-to-day constraints of time that arise in high-pressure settings have proved problematic, as has the fact that well over 30% of physicians do not believe what they do is efficacious (Alruqi, 2025; Burton, 2017). Additional concerns

exist regarding the cost of training ($500 - $2000), and the time commitment is demanding in itself (Abdu Asiri et al. 2025).

Nurse training occurs through organized programs, for example, MBSR certification (8 weeks) or MBCT workshops, through universities such as the University of Massachusetts or the Oxford Mindfulness Centre (Padden & Mathew, 2020). The AHNA offers continuing education credits for mindfulness courses (McLaughlin, 2025). A California hospital's 50-nurse MBSR program reduced turnover by 25% after 6 weeks (Agostinho et al., 2023). Scalable, virtual training models are needed to increase accessibility (Khoury et al., 2015). Mindfulness can enrich the holistic nurse, leading to better patient outcomes and resilience in nurses, but with protocols and continued support and commitment from healthcare institutions, we can reduce barriers and maximize our impact.

**Aromatherapy in Nursing**

Aromatherapy is the therapeutic application of essential oils originating from plants. It is a major holistic nursing intervention that positively influences a person's psychological and physical well-being (Buckle, 2016). Aromatherapy is rooted in ancient civilizations in the use of medicinal plants as early as 3000 BCE in Egypt and China. Although aromatherapy has existed for a long time, Marguerite Maury was the first to write about aromatherapy from a nursing perspective in the 1950s, developing methods for topical and inhalation uses of essential oils (Buckle, 2016). Aromatherapy aligns with holistic nursing in that it brings together a person's mind, body and spirit, an important concept within holistic nursing (McLaughlin, 2025) and therapeutic nurse-patient relationship, while its sensory engagement aligns with Watson's Theory of Human Caring, a model that is based on holistic and environmental aspects of a nurse-patient relationship, as well as systems theory, which recognizes the patient as a totality (Willis et al., 2018). The World Health Organization's (2019) strategy has expedited worldwide use. It is better incorporated into the hospital's protocols in the UK and Australia (von Schoen-Angerer et al., 2023). Its presence in nursing has increased, such as in the case of palliative care in the UK in the 1980s and American Hospitals in the 2000s, implicated at the time that over 30% of US hospitals used aromatherapy (Smith & Kyle, 2009; Alruqi, 2025). Its rise in nursing is attributed to ever-increasing evidence of a broader theme of patients wanting non-pharmacological interventions as an alternative to medications.

Aromatherapy interacts with the part of the brain involved in olfaction and limbic regulation of emotion and stress response - a relatively new understanding of how the olfactory system works (Herz, 2021). Linalool, a primary component of Lavender oil, has anxiolytic properties by acting as a GABA receptor agonist. Linalool reduces heart rate and feelings of anxiety by approximately 15-20%, revealing parasympathetic activation based on polyvagal theory (Karadag et al., 2017). Menthol, the primary component of peppermint oil, stimulates trigeminal nerve endings in the nasal cavity, inhibiting nausea in the brainstem (Tayarani-Najaran et al., 2013). Chamomile - apigenin - stimulates sedation by acting on benzodiazepine receptors (Lillehei et al, 2016). Practitioners also apply loads of oils topically, some with terpenes, which absorb into the bloodstream and have anti-inflammatory effects (Peana et al., 2002). There is also the complete sense of smell; the act of smelling little bits of calming memories, for example, being calm when smelling lavender (Herz, 2021).

In clinical settings, aromatherapy is appropriate in palliative care, labor settings, postoperative recovery,

mental health (low mood, anxiety), and critical care (Smith & Kyle, 2008). In a pre-operative context, nurses could apply lavender oil by inhalation to decrease anxiety and alleviate anxiety before surgery. Nurses use peppermint oil to alleviate nausea related to chemotherapy (Tayarani-Najaran et al., 2013). The use of aromatherapy in healthcare has been found to have beneficial effects on patients and acute pain, according to some studies. Lavender essential oil vaporization resulted in a decrease in anxiety and an increase in sleep in a 65-year-old cancer patient (Lillehei et al., 2015). Lavender and rose essential oils significantly reduce labor pain, with a pain reduction of at least 25%, as evidenced in a case study of a 30-year-old nulliparous woman (Yazdkhasti & Pirak, 2016). In a randomized controlled trial, peppermint essential oil significantly reduced postoperative nausea in 80% of patients (Hines et al., 2018). In the area of mental health, chamomile and bergamot essential oils can be effective in managing anxiety. In ICUs, low-dose vaporization of essential oils, such as lavender, produces a mild aroma in the surroundings and prevents patients from becoming overstimulated (Karadag et al., 2017).

Although the evidence base for using aromatherapy in healthcare is strong, there are limitations due to how the studies were conducted (design). A systematic review of aromatherapy in palliative care found that the use of lavender essential oil improved sleep in 70% of hospitalized patients (Lillehei et al., 2015). Randomized controlled trials indicate that lavender essential oil can decrease labor pain by 25% (Yazdkhasti & Pirak, 2016) and decrease anxiety in cardiac patients by 20% (Karadag et al., 2017). A control group of patients receiving peppermint in a randomized controlled trial for postoperative nausea found that it worked better than the control group (Hines et al., 2018). A case study of a 55-year-old cardiac patient inhaling lavender after cardiovascular surgery found a 30% decrease in anxiety (Karadag et al., 2017). A meta-analysis found that aromatherapy is beneficial for 65% of palliative care patients (Smith & Kyle, 2008). However, due to variability in essential oil quality and dilution when administered (1-10%) and placebo effects (as much as 30% of the outcome), the findings are difficult to interpret (Farrar & Farrar, 2020; Hines et al., 2018).

Challenges include a lack of standardized protocols, with inconsistent dosages hindering replication (Farrar & Farrar, 2020). Allergic reactions (1-5% of patients) necessitate screening (Ali et al., 2015). Skepticism (25% of physicians) and lack of reimbursement limit adoption (Alruqi, 2025; Snyder & Lindquist, 2010). Time constraints in busy settings and cultural perceptions as “alternative” require education (Abdu Asiri et al., 2025; Lomas, 2019). Safety guidelines state the oil must be diluted by 1-5% and must be tested for patch testing to minimize irritation (Lewis, 2020). Course certifications require training. Though it varies, AHNA's Clinical Aromatherapy Certification is from 100-200 hours, which teaches pharmacological knowledge and application of aromatic substances (Buckle, 2016). In a sample of nurses undergoing training to reduce risk for errors and increase safety (Agostinho et al, 2023). In a 2018 study, Johns Hopkins found an increase in satisfaction of 20%, although costs to train employees, ranging from $300-$1000, can make it difficult to scale up. Alternatively, a train-the-trainer model may alleviate costs (Tisserand & Young, 2014). Training nurses in aromatherapy will add to the concept of holistic nursing; knowledge must become standardized, and institutional-wide support is necessary to decrease barriers to patient improvement.

**Therapeutic Touch in Nursing**

Therapeutic Touch has its origins in 1975 when nurse Dolores Krieger developed these techniques in

collaboration with clairvoyant Dora Kunz. Therapeutic Touch asserts that living entities are infused with a biofield that can influence the energy exchange in the people whose biofield is engaging with the practitioner (Wiederkehr, 2021). Therapeutic Touch practice emerged amidst the 1970s holistic health movement as it draws on ancient practices of qigong, while giving weight to holistic nursing and healthcare views (Fletcher et al., 2022). Therapeutic Touch was formally formed in association with New York University and encourages the practitioner to engage with the energy being exchanged to restore a biofield disturbed by physical and emotional stress, which aligns with holistic nursing's client/patient care across body, mind, and spirit (McLaughlin, 2025). Theoretical perspectives to Therapeutic Touch are twofold; it is based on Martha Rogers' Science of Unitary Human Beings, which views patients as energy fields, and Jean Watson's Theory of Human Caring as it pertains to transpersonal human healing (Rivera et al., 2024). TT has become part of palliative practice in Canada and Australia, and as such is reflective of international trends in the field of integrative medicine. Its introduction and development during the 1980s in oncology and hospice care was expedited by Healing Touch International's steps to provide education and training; nevertheless, there was significant controversy about the actual mechanisms (Mendes et al, 2022; Yalcinkaya & Gozuyesil, 2024).

There has been an ongoing debate about the mechanisms of action for TT, and compared to energy as a social interaction influenced by the context and intention of the interactions and practitioners, it is more likely to rely on biological explanations (Yalcinkaya & Gozuyesil, 2024). Practitioners believed that hand movements, performed 2-6 inches off the body surface, balance the energy fields to encourage homeostasis (Wiederkehr, 2021). The effects of TT are clear if they stemmed from a relaxation response or based on a placebo response; however, increased heart rate variability (HRV) showed activation plural activation of the parasympathetic nerve responses to immunity. TT to minimize the perceptions of pain and anxiety may be mediated by the release of endorphins and by the modulation of the autonomic nervous system.

A 2010 study indicated TT resulted in a 15% reduction in cortisol levels in patients with cancer (Alruwaytie, 2025; Senderovich et al., 2016).TT may enhance the outcomes of the practitioner's presence; the nurse's intent and compassionate presence can further enhance outcomes, as a patient-practioner trust may contribute to greater effects, however, critics explain the benefits of a nurse and TT to be a non-specific effect of 'hands on' or 'hands off' without manipulating energy (Ernst, 2019). While the bioelectromagnetic theory for TT is at a preliminary stage of theorizing, there is limited evidence to demonstrate that the movements of the practitioner's hands might influence preference, physiology, and outcomes (Jain & Mills, 2010).

TT is used in practice for wounds, anxiety, end-of-life care, and pediatrics (Mendes et al, 2022). In the case of wounds, 10–15-minute treatment sessions increase circulation, as demonstrated in a case study demonstrating 20% faster healing for a 60-year-old man with diabetic ulcers (Stein, 2021). In hospice, TT has meaning-making social connection elements whereby the use of TT helped reduce anxiety in a 70-year-old lung cancer patient (Senderovich et al, 2016). In oncology, TT is also used to reduce anxiety with the administration of chemotherapy. In pediatrics, a gentle TT treatment program reduced the anxiety of an 8-year-old boy with leukemia by 30% (post- White et al, 2003; Thompson et al, 2011). In a qualitative study, 80% of patients noted they were closer to nurses using

TT, which contributed to satisfaction with their care (Stein, 2021).

TT has a weaker evidence base than similar holistic interventions. This is primarily due to the design of the studies. Robinson and colleagues (2007) completed a systematic review and meta-analysis of 15 studies where TT was effective in reducing pain in 60% of cases (d=0.45) with arthritis and postoperative pain. Randomized controlled trials have noted TT was effective in reducing anxiety (25% for cancer patients) and improving quality of life in hospice care (65%) (Alruwaytie, 2025; Senderovich et al, 2016). An example from a case study of TT with a 55-year-old woman with breast cancer found that pain diminished 30% (Mendes et al, 2022).

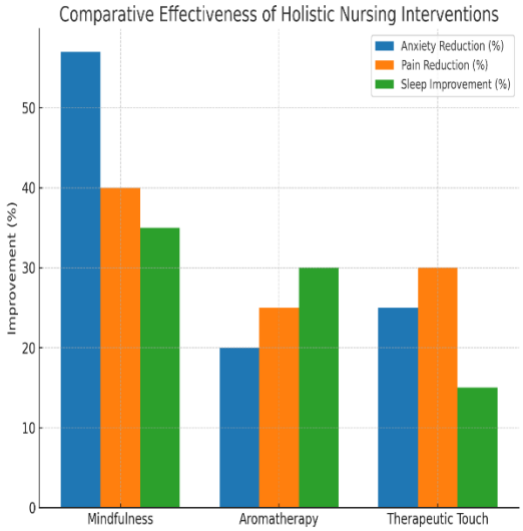
Several weaknesses of the studies included a small sample size (n=20-50) and no blinding. It is also important to note that the protocols for TT were also not consistent, and while critics have pointed out that the therapeutic touch may have non-specific effects (Ernst, 2019). A 1998 study that examined biofield detection provides additional support for skepticism (Rosa et al., 1998). Barriers to widespread use and acceptance include skepticism (Alruqi, 2025). 30% of physicians do not believe that TT is a legitimate practice; instead, they see it as pseudoscience. Additionally, there are the high costs to become a certified clinical trainer ($500-$2000) as well as a time commitment when using services in increasingly busy environments (Abdu Asiri et al., 2025). Among nurses, only 10% have used TT regularly after their training, partly because of time constraints.

Cultural resistance is another barrier to overcome, especially in biomedical-centered regions, requiring education from nurses originally from the regions of North America to advocate for TT acceptance (Lomas, 2019). Initial training is important for TT, in which the minimum amount of training is similar to the Healing Touch Program (100-150 hours), which signifies competence via a client assessment and energy assessment for ethical practice (Wiederkehr, 2021). A 2019 research study program evaluated TT implementation across 47 hospice programs throughout Canada and trained 40 nurses. Cuando 40 nurses used TT, there was a 15% increase in patient satisfaction (Senderovich et al., 2016). Recently, TT was being used in online modules but contact and demonstration are also critical (Hammerschlag et al., 2014). While TT does enhance holistic nursing, barriers will need to be addressed (e.g., conduct valid studies and train TT at the lowest possible cost). Table 1 and Figure 2 discuss the comparison of the three approaches across important dimensions.

**Table 1. The comparison of the three approaches across important dimensions.**

| Approach | Mechanism | Primary Outcomes | Clinical Settings | Evidence Strength |
|---|---|---|---|---|
| Mindfulness | Modulates the HPA axis, enhances prefrontal cortex activity, and reduces amygdala reactivity | Reduced anxiety, depression, pain; improved sleep, empathy | Oncology, mental health, chronic pain, palliative care | Strong (meta-analyses, RCTs, neuroimaging) |
| Aromatherapy | Limbic system activation via olfactory pathways, parasympathetic stimulation | Improved sleep, reduced nausea, anxiety, and pain | Palliative care, labor, postoperative, and mental health | Moderate (RCTs, systematic reviews, protocol variability) |
| Therapeutic Touch | Hypothesized biofield energy balancing, relaxation response, and placebo effects | Reduced pain, anxiety, and improved patient trust | Wound care, end-of-life care, and anxiety management | Weak (limited mechanistic evidence, methodological issues) |

**Figure 2. The comparison of the three approaches across important dimensions.**




## 8. Conclusion

Holistic nursing/holistic care can involve mindfulness, aromatherapy, and therapeutic touch and provides a paradigm shift in healthcare that considers the physical, emotional, psychological, and spiritual health of patients and nurses (Asseri et al., 2024). This literature review confirms that these therapies improve patient outcomes and nurse health and align with the mission of the American Holistic Nurses Association to heal the whole person. Mindfulness is well-supported by evidence; it reduces anxiety (g=0.57) and burnout by 30% because of neuroplastic changes and HPA axis modulation. Aromatherapy, specifically lavender and peppermint, impacts sleep, pain, and nausea in 70-80% of cases because they spark limbic system activities. Therapeutic touch has modest to moderate evidence for pain and anxiety relief and promotes emotional connection among patients and family members at the end-of-life or in an oncology setting.

Challenges exist to holistic nursing/holistic care, including a lack of standardized evaluations of efficacy and application, skepticism, and limited resources. Our findings have policy implications.

Hospitals should provide protocols for nurses to receive holistic training, similar to the Cleveland Clinic, which states that they have observed 15% higher patient satisfaction. Reimbursement must follow to encourage and cover these types of cost-saving therapies to eliminate readmissions. More long-term studies, standardized protocols, and combining therapies are warranted (e.g., mindfulness and aromatherapy). Culturally responsive adaptations are also needed to address barriers to this type of nursing practice (e.g., mindfulness and therapeutic touch).

The holistic nursing vision includes incorporating these practices into standard care with interdisciplinary support and educational programs. Holistic nursing can address the challenges facing healthcare systems around the world, including nurse burnout and the global burden of chronic disease, and prevent issues from growing into crises and failing healthcare systems. Ongoing funding for research, education, and policy changes will demonstrate the healing potential of mindfulness, aromatherapy, and touch therapy and will transform nursing practice.

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