

Practice

Implementing Healing Touch Pilot in an Inpatient Rehabilitation Unit: Reductions in Pain and Anxiety

Pat Conway, PhD, MSW

Essentia Community Hospitals and Clinics, Essentia Health Duluth, MN, USA

Janet M. Tomaino, DNP, RN, AHN-BC, CCAP 

Earl E. Bakken Center for Spirituality & Healing, University of Minnesota, Minneapolis, MN, USA

Stacey Quade, CHTP/I, COTA, Herbalist

Essentia Health Miller-Dwan Rehabilitation, Essentia Health Duluth, MN, USA

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Energy-based therapies (EBT) are increasingly being used as comfort measures for hospitalized patients. This article describes the background and process of implementing an EBT healing touch (HT) pilot program in an inpatient rehabilitation unit. The pilot built on knowledge gained in a preliminary EBT pilot in two hospital units to improve rehabilitation patient outcomes and gather additional information to support a fully funded, sustainable rehabilitation EBT program. Thirty-five percent of the rehabilitation patients received HT, most commonly for pain and anxiety, by experienced HT practitioners over the 9-month pilot period. Both HT practitioners' and patients' ratings showed that patients' level of pain and anxiety decreased by approximately two points after the HT experience. Documented patient comments confirmed their positive experience, including comments describing a reduction in anxiety and increased sense of calm.

Keywords: *adult; older adults; nurses; pain and pain management; rehabilitation; energy-based therapies/energy work; healing touch; alternative/complimentary therapies*

Introduction

As health care organizations continually seek methods to provide comfort for patients without adding or increasing medications, some are implementing an integrative health approach (Mayo Clinic, n.d.; U.S. Department of Health and Human Services, n.d.) that emphasizes treating the whole person, not just an organ system. Holistic nursing promotes the use and evaluation of complementary and integrative health approaches (Thornton, 2019), an integrative health approach uses evidence-based practices that have not traditionally been a part of conventional medicine concurrently with conventional treatments. Examples of these practices, also known as complementary,

alternative, or integrative therapies, are aromatherapy, guided meditation, and energy-based therapies (EBT; Taking Charge of Your Health & Wellbeing, n.d. a). Revisions to the Joint Commission management standards in 2015 to include nonpharmacologic strategies provide added incentive to adopt an integrative health approach (Weeks, 2015). More recent Joint Commission revisions implemented in 2018 include even stronger language that *requires* nonpharmacologic methods to be used for pain management (The Joint Commission, 2017). EBT, such as healing touch (HT) and others, are recognized by the North American Nursing Diagnosis Association

Authors' Note: Janet Tomaino, 1902, Saint Louis Ave. #117, Duluth, MN 55802. e-mail: toma0131@umn.edu

(NANDA) as an intervention for “Imbalanced Energy Field” (American Holistic Nurses Association, 2017).

HT and therapeutic touch (TT) were both developed as nursing interventions and fit under the umbrella of EBT or biofield therapy, terms that are used interchangeably in the literature (Rubik et al., 2015). TT, developed by a nurse and natural healer in 1971, is thought to promote balance and well-being as trained practitioners use their hands to facilitate a process of universal energy exchange (Therapeutic Touch International Association, n.d.). Founded by registered nurse Janet Mentgen in 1989, HT uses standardized, gentle hand techniques and conscious intent to clear, energize, and balance a person’s human and environmental energy fields and support their ability to heal (Healing Beyond Borders, n.d.; Taking Charge of Your Health & Wellbeing, n.d. b).

Other EBT include Qigong, a practice with Chinese roots millennia old, and Reiki, a Japanese spiritual practice originating in the twentieth century by Mikao Usui (Miles, 2008). While EBT originate from different cultures and use varied techniques, these noninvasive therapies performed with either hands-on or hands-off the body are hypothesized to modulate the human biofield, biologically generated fields, or complex organizing energy fields with physical properties that have the capacity to influence cells and tissues (Hammerschlag et al., 2015). Data from the 2012 National Health Interview Survey found that more than 3.7 million U.S. adults had seen an energy medicine practitioner at some time and 1.6 million had received some form of biofield therapy in the past year (Jain et al., 2015).

The purpose of this pilot study is to describe the development of the EBT Initiative at a physical rehabilitation unit of a large healthcare organization in a metropolitan statistical area of midwestern United States, which offered HT to improve comfort and patient experience and to reduce patient’s pain. The study’s aims were:

1. To further develop the HT intervention, creating procedures for implementing it in the rehabilitation setting and
2. To evaluate processes and outcomes of the EBT Initiative, informing program development and contributing to sustainability of the intervention.

This article describes the corresponding holistic nursing theory; reviews relevant EBT (biofield) research; describes the development of a HT program in an inpatient rehabilitation setting; and presents the process and outcomes that contributed to development of the program. It concludes with recommendations for implementing HT in an inpatient rehabilitation setting.

Theoretical Framework

The use of holistic approaches in a supportive healing environment aligns with Jean Watson’s Theory of Caring (Watson Caring Science Institute, 2023). This theory is also one of the holistic nursing theories that serve as the foundation for the organization’s nursing professional practice model. Caring that embraces the whole person, body–mind–spirit in a supportive healing environment is central to nursing practice and is the heart of Watson’s theory. The Theory of Caring, operationalized by 10 Caritas Processes[®], provides a universal language for human caring: practicing loving-kindness with self and patients; being authentically present; honoring and cultivating spiritual practices; developing and maintaining caring relationships; authentically listening; using creative problem-solving; promoting teaching-learning within the caring relationship; creating and supporting a healing environment; sustaining human dignity by assisting with basic needs; and being open to existential, spiritual unknowns allowing for miracles. As the culture of healthcare has shifted from individual disciplines to interprofessional collaborations, this theory is relevant not only in nursing, but across other healthcare disciplines (Wei & Watson, 2019). While nurses did not deliver the EBT in our project, they were central to this pilot; the project lead, a nurse, consulted throughout, and nurses on the rehabilitation unit guided the patient’s care plan in which they promoted holistic patient-centered care in a healing environment. Providing symptom management and overall well-being for patients is much more than delivering medications. Promoting adjunct modalities such as EBT gives nurses more options with providing overall holistic patient care that honors the whole person.

Literature Review

Improving patients’ comfort is more than just decreasing pain; it is often reducing symptoms such

as anxiety and nausea. Results of our previous EBT pilot in an inpatient setting indicated this to be true, as evidenced by patients' and/or HT practitioners' positive statements. Biofield therapy has been studied for a variety of issues such as anxiety, quality of life, agitation, and hospital length of stay in a variety of settings and patient populations. Jain and Mills (2010) concluded that studies regarding effectiveness of symptom management for pain and cancer are the strongest and have been studied the most.

A 2010 systematic review of 66 studies concluded that biofield therapies showed moderate to strong evidence for decreasing pain intensity, moderate evidence for decreasing anxiety in hospitalized patients, and moderate evidence of decreasing agitated behaviors in dementia patients. Additionally, a small number of studies provided strong evidence that biofield therapies may improve the quality of life-rated physical functioning (Jain & Mills, 2010). Mueller et al. (2019) evaluated a randomized controlled pilot study of nurse-delivered TT on back pain in adults on a neurological unit. Fourteen patients in the control group were compared to fifteen patients who received 20–30 min TT treatments daily for 4 days. The TT group showed significant reductions in back pain and function using the German Quebec Back Pain Disability Scale (QBPDS) and a 0–10 numeric pain rating scale (NPRS). Additionally, the daily pretreatment NPRS values were reduced each day, indicating a long-term major effect of TT.

HT-specific research studies also indicated evidence of support for symptom management and quality of life. A randomized control trial of hospitalized coronary artery bypass patients showed decreased anxiety and hospital length of stay with HT given the day before, day of, and day after surgery (MacIntyre et al., 2008). HT length of sessions ranged from 20 to 60 min on 2 of the days and 60–90 min on the day of surgery. A 2001 study of 62 women receiving radiation therapy concluded that the HT group had a greater reduction in fatigue than the control group, in addition to more improvement in level of depression, anxiety, and anger (Cook et al., 2004). Additionally, a study of women with cervical cancer receiving HT after radiation therapy concluded that nurse-delivered HT had a positive effect on the immune response and depression, as compared to patients receiving relaxation or standard care (Hart et al., 2011).

A randomized control pilot study of 19 subjects with a diagnosis of osteoarthritis of the knee suggested that HT could be an effective nonpharmacological adjunct to the treatment of osteoarthritis (Lu et al., 2013). The experimental group received nurse-delivered HT sessions three times per week for 6 weeks as compared to the control group that received weekly nurse “friendly visits.” Key findings showed a significant reduction in severity of pain and interference with life activities in addition to improved knee joint function over time for the HT group as compared to the “friendly visit” group.

A quasi-experimental study of hospitalized bariatric surgery patients investigated outcomes in patients receiving nurse-delivered HT with a 7-minute technique daily during their inpatient stay (Anderson et al., 2015). It compared controls selected from the electronic health record ($n = 20$) to patients receiving HT ($n = 22$) and showed statistically significant decreases in pain, nausea, and anxiety in the HT group on postoperative days one and two using a 0–10 numeric rating scale (NRS). Significant decreases in pain and anxiety were also noted on day three using the same scale. Additionally, levels of anxiety and depressed mood, measured using the Hospital Anxiety and Depression Scale (HADS), significantly decreased from prehospital recruitment to discharge in the HT group.

Preliminary Study

Prior to this HT pilot, a team including nursing leadership, practice councils from a general medical unit and an oncology unit, the volunteer service department, local HT providers, and the research institute conducted a preliminary project in two acute-care medical inpatient units within the same hospital to determine the feasibility of implementing HT in the hospital setting. The lead HT practitioner was both a certified occupational therapy assistant (COTA) on the organization's rehabilitation unit and a HT practitioner with a private business. Prior to offering HT, the lead HT practitioner and clinical nursing leaders offered training sessions for nursing staff regarding EBT, short experiential sessions, the referral process, and the patient education information handout. Despite HT being chosen for the project, the overarching term EBT was used for education purposes

and for the potential use of other EBT modalities (i.e., Reiki) in the future.

Seven HT practitioners, including the lead HT practitioner, offered HT 3 hours a day, three days a week. HT was offered to patients who were referred for additional comfort measures by nurses. Two measures were completed prior to and at the conclusion of each session. HT practitioners invited patients to complete the Wong-Baker Faces Scale (Wong-Baker Faces Foundation, n.d.); HT practitioners completed the PAIN-AD scale (Warden et al., 2003). Nursing staff were invited to complete a brief electronic survey at the conclusion of the educational session and at the conclusion of the HT project. They rated their level of agreement with the statement, "Patients on my unit will benefit from receiving EBT" on a scale from 1 = strongly disagree to 5 = strongly agree. The average level of agreement was 3.95 (SD = .31, N = 39). Forty-one percent strongly agreed that patients on their unit would benefit from receiving EBT. After the HT sessions concluded, 47 staff rated their level of agreement with the statement, "Patients on my unit benefited from receiving EBT" (Mean = 4.22, SD = 1.09).

HT practitioners reported patient responses after HT sessions, indicating positive impact:

- Body was stiff, felt "very relaxed and peaceful" when done.
- Could go for hours, felt all tension going out legs.
- Anxiety down from 9 to 5, sleeping through session.
- Patient asleep, breathing less labored—more relaxed.
- Patient had some anxiety/overall discomfort and nausea at the beginning of the session, was peaceful, calm, and relaxed at the end of the session.

The preliminary project provided the opportunity to refine the process for rating pain, including the addition of prescoring, clarifying who completes which scale, and the importance of completing the pain scale scores on all patients. Additionally, the need to measure the impact on anxiety or stress was identified. Positive outcomes from both patients and staff led to the development of a second HT initiative implemented in the healthcare organization's inpatient rehabilitation unit.

The Physical Rehabilitation Unit HT Pilot Project

The Physical Rehabilitation Unit's HT pilot offered HT sessions to rehabilitation patients between July 1, 2016, and March 31, 2017. Its purpose was to investigate the impact that HT could have on improving patients' comfort and experience during hospitalization and to gather information to support institutionalization of this and other similar programs. An interdisciplinary team, including nursing staff, rehabilitation therapists (occupational, physical, speech, psychology therapists), HT practitioners, and researchers developed the project; they established a process for allowing external HT practitioners to provide services in the rehabilitation unit. Several education sessions for the rehabilitation therapists and nurses were offered, similar to previous sessions offered to staff in the preliminary project. Information on EBT was reviewed, short experiential HT sessions were offered, the referral process was described, and patient education handouts were reviewed. Nursing and therapy staff members were encouraged to review the HT handout included in the Rehabilitation Orientation Notebook with new patients during the admission process.

HT Practitioners

HT practitioners became EH volunteers; then, they were vetted to meet the minimum requirements as a HT practitioner for the study—a minimum competency of completion of the first two levels of HT coursework. Four of the five were fully certified HT practitioners (five levels completed) through Healing Beyond Borders (2020). Once vetted, HT practitioners were oriented to the rehabilitation unit and to the process of providing the treatments. The lead HT practitioner updated other HT practitioners and rehabilitation staff monthly regarding the progress of the HT Project.

Offering HT

Recruitment. The program was scheduled 3 days a week from 2 to 5 p.m., to avoid interfering with the heavy morning schedules most patients had with other rehabilitation interventions. Rehabilitation staff were asked to refer patients displaying pain,

problems with concentration, distractibility, depression, anxiety, nausea, and inability to tolerate scheduled daily rehabilitation therapies. Initially, the expectation was that rehabilitation staff would complete a brief referral form. It quickly became clear that the most effective means for recruiting patients to HT was personal communication between rehabilitation staff and the HT practitioner when the HT practitioner arrived on the unit. HT practitioners introduced themselves to patients and their family (if present), explained the HT project, how patients might benefit from HT, and what to expect from a session at the patient's level of understanding. Patients received an EBT educational handout designed to be understandable at a fifth-grade level; verbal conversations took into account patients' communication barriers. For instance, patients were commonly aphasic, requiring nonverbal communication. Verbal consent and acknowledgment of HT were obtained before sessions began.

HT intervention. The HT practitioner received patient referrals from a log kept on the rehabilitation unit, queried staff if there were other patients to add, and reviewed the rehabilitation unit's therapy schedule to determine the best time to see patients (see Figure 1). The HT practitioner then met with the patient or family to provide HT information, documented the pain and anxiety presurvey ratings on the iPad, and performed a HT session. Patients completed the postsurveys, again rating their level of pain and anxiety. Once the session ended, HT practitioners completed the PAIN-AD rating again and added their comments about the session and the patient and/or family. HT interventions ranged from 5 to 30 min; the length of sessions was determined by the HT practitioners' assessment of the patient's response to HT (appearing relaxed). Some sessions were shortened due to unplanned interruptions by

the health care team. The HT practitioner selected techniques from HT Levels 1 and 2 techniques (Anderson et al., 2017; see Table 1) based on each patient's needs.

Method for Evaluation of the HT Pilot Project

The evaluation of this HT pilot (<https://www.nccih.nih.gov/grants/nccih-research-framework>), a case study (Yin, 2017), employed multiple sources of data such as retrospective patient data from the organization's electronic health records (EHR), pain ratings, and staff surveys. The evaluation was guided by community-based participatory research principles (Wallerstein et al., 2017). The EBT team (researchers, HT practitioners, and rehabilitation staff) served as the project's evaluation workgroup. The workgroup provided oversight for the evaluation and dissemination of results.

Ethical Considerations

The organization's IRB approved the project, deeming it to be "minimal risk" and therefore "exempt" from IRB oversight. Data collected by HT practitioners were saved in a secure server to maintain confidentiality; results were aggregated to assure anonymity.

Sample

Between July 1, 2016, and March 31, 2017, five HT practitioners conducted 436 HT encounters with 111 adult rehabilitation patients; 55% were male; their average age was 67. Patients who received HT comprised 35% of the 318 adult patients that the

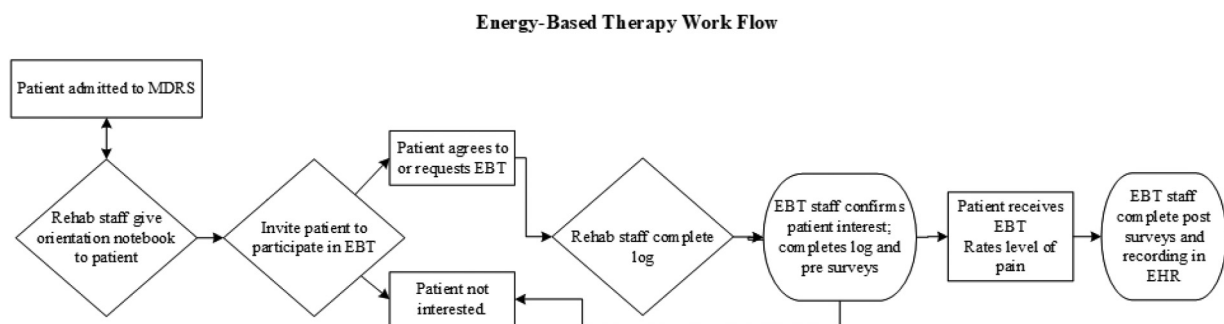


Figure 1. HT intervention workflow.

Table 1. Level 1 and Level 2 Techniques

Back and Neck sequence	A full body technique specific to the spinal column and vertebrae. Series of hand positions along the length of the spine and the chakras of the lower body and feet.
Chakra connection	A full body technique whereby the provider holds their hands over each chakra for a period of approximately 1 min
Chakra spread	Slow, gentle movements of provider's hands over each chakra in a spreading motion from head to toe following a specific series of repetitions and passes.
Field repatterning	<i>Hands moving</i> —hands are passed above the person's body in sweeping motions. <i>Hands still</i> —hands are held above or gently on the body.
Headache techniques	Series of hand placements using several techniques (hands still, hands in motion, ultrasound, and laser) in succession to address various headache presentations sinus, tension, etc.
Lasers	One or more fingers are held still over an area of pain or energy congestion.
Beak finger	Laser uses three fingers in a pinch position and rapid movements over the area to break up congestion.
Modified Mesmeric Clearing	Hands sweep above the body from head to toe with fingers spread and slightly curved. Multiple passes are completed to clear physical and emotional congestion.
Migraine technique (very different from other Headache tech)	Specific technique—uses pain ridge assessment, hands in motion, and (sometimes) siphon.
Noel's Mind clearing	A series of light fingers holds over the head, face, and neck, which balance energy flow to the brain.
Siphon	The provider's left hand is placed over an area of pain with the right hand downward to drain painful energy. The right hand is then held over the area with the left palm upward to infuse energy inward.
Pain ridge clearing	Hands are passed above the person's body in sweeping motions over an area of pain.
Spiral Chakra Connection	Variation of Chakra connection, hand placement is in different sequence.
Wound sealing	Hands are held palm downward above a wound or incision and moved from the outer aspect of the wound inward, then the palms are held still above the wound for approximately 1 min. This treatment is done without touching the person's body.

rehabilitation unit served during that year; patients who participated in HT were similar in age and sex to all rehabilitation patients during that timeframe. Rehabilitation patients were assigned to one of four therapy teams based on their diagnoses: traumatic brain injury, spinal cord injury, cerebral vascular accident, and general comprehensive patient. The average length of stay for all patients was 13.78 days.

Data Instrumentation and Collection

Rehabilitation patients' demographic data were retrieved from the EHR. HT practitioners recorded data regarding patient status prior to and at the conclusion of each HT intervention using an iPad, through a link to the study's Survey Monkey site. Tools with documented reliability and validity were selected to measure change prior to and after each HT session. Change in pain was measured by the PAIN-AD scale (Warden et al., 2003) completed by the HT practitioner and the Wong-Baker Faces Scale (Wong-Baker Faces Foundation, n.d.) rated by the patient. The PAIN-AD scale, originally

developed for use to measure pain experienced by adults with dementia, is completed by health care staff; it measures observed behaviors (breathing, vocalization, body language, and whether can be consoled). The Wong-Baker Faces Scale is a simple rating scale completed by patients at EH, across the US, and internationally. Change in anxiety was rated by patients using a 0–10 subjective units of distress (SUDS) rating scale (Molin, n.d.). This simple scale is rated similarly to the Wong-Baker Faces Scale. Based on experience in the preliminary project regarding factors that might influence HT outcomes, HT practitioners recorded whether a patient's cognition, physical impairment, communication barriers, and sleeping or decreased level of consciousness were present. At the completion of each session, HT practitioners recorded notes about the encounter and patient status.

Data Analysis

Data were downloaded from Survey Monkey in an Excel document, and then imported into SPSS for

analysis. Patient demographics were summarized using frequency (N , %) for the categorical variable (sex) and mean (SD) for the continuous variable (age). Reasons for participating were calculated using frequencies (N , %). Levels of pain and anxiety were calculated using mean and standard deviation. Pre and post-HT session changes in levels of pain and anxiety were calculated using t test. HT practitioner comments were categorized to complement the quantitative results regarding pain and anxiety.

Results

Nurses and rehabilitation staff referred patients to HT; patients also could request sessions. The most common reason for patients' referral to the program was the presence of both pain and anxiety/stress (39%); 28% were referred for pain only; and 11% were referred for anxiety only. The most common factors that might influence the outcomes of the intervention were impaired cognition (13%) and communication barriers (7%).

Level of pain. The average level of pain, as rated by HT practitioners prior to intervention using the PAIN-AD tool, was 1.15 (SD = 1.75); after the intervention, the average level of pain was rated as 0.19 (SD = .83; see Table 2). The level of pain rated by HT practitioners was statistically significantly lower after the HT experience ($t = 12.15$ [df = 373], $p < .001$). Ratings by HT practitioners were missing 10% of the time prior to the intervention, and 6% after the intervention. Fifty-one percent of HT practitioners' comments related to post scores noted that the patient was sleeping. The average level of pain,

as rated by patients, was lower after the HT intervention ($t = 14.22$ [df = 294], $p < .001$; $t = 13.16$ [df = 280], $p < .001$; see Figure 2), dropped from 4.36 (SD = 3.48) to 2.42 (SD = 2.8). Patient ratings of pain were missing 18% of the time prior to the intervention and 33% of the time after the intervention. Thirty-five percent of HT practitioners' comments noted that patients were asleep during and/or at the conclusion of sessions, which likely accounted for missing patient ratings. Patients' comments recorded by HT practitioners reflected change in physical discomfort and level of pain. Example of comments include:

- *Reports "stomach feels better."*
- *Right shoulder pain went down from 7 to 3; stated the session was amazing; that she feels so good all over.*
- *Nausea gone.*
- *It feels good, it does not hurt now, I will go to sleep now.*
- *Patient states she was skeptical at first but finds this therapy to relieve her pain.*

Level of anxiety. Patients' average level of anxiety prior to intervention was also lower based on the SUDS rating scale ($t = 13.16$ [df = 280], $p < .001$); the mean level of anxiety dropped from 3.99 (SD = 3.21) to 2.08 (SD = 2.01) after the HT intervention. Fourteen percent of the ratings were missing prior to the intervention, 32% after. Many of the patient comments or observations recorded by HT practitioners described a reduction in anxiety and increased sense of calm. Examples of comments include:

- *He was able to quiet and calm down; midway through session, stated it felt amazing and that he had not felt this good since he had been here; patient requested another session.*
- *Tensions completely resolved; client rates at zero (based on 0–10 scale).*
- *Patient stated that she felt much better; how amazed she was that she could get so relaxed.*
- *Pt progressively calmed and became more positive about his situation; talked about strategies and ways to cope during therapy tomorrow.*
- *Pt progressively calms and is sitting still at the end of the session; chooses to remain sitting in room versus going back to "pacing."*
- *Wonderful, I feel at complete peace, what a wonderful feeling!*

Table 2. HT Practitioner Pre and Postintervention Pain Ratings

PAIN-AD Score	Pre PAINAD		Post PAINAD	
	Frequency	Percent	Frequency	Percent
0	233	53.4	377	86.5
1	42	9.6	18	4.1
2	41	9.4	4	0.9
3	26	6.0	3	0.7
4	18	4.1	1	0.2
5	23	5.3	5	1.1
6	3	0.7	0	0.0
7	6	1.4	2	0.5
Missing	44	10.1	26	6.0
Total	436	100.0	436	100.0

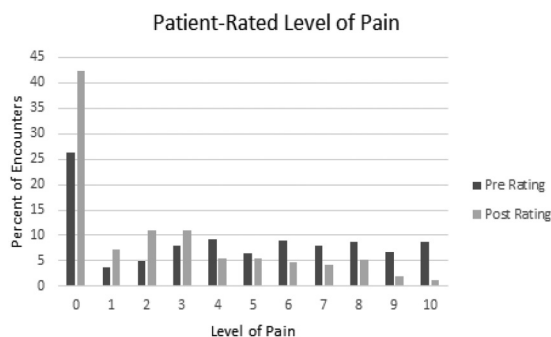


Figure 2. Patient-rated level of pain based on FACES scale.

Patients Also Commented on a General Sense of Feeling Better and Energized.

- *Feels invigorated and energized.*
- *I feel wow.*

Discussion

Patients' level of pain, as reported by both HT practitioners and patients, and level of anxiety reported by patients reduced after the HT sessions. Patient and HT practitioner comments confirmed patients' positive experience. While 35% of patients hospitalized during the EBT pilot received benefits of HT during their stay, it is noteworthy to look at challenges staff members acknowledged about the program. Some admitted they did not always have time to add patients to the referral list despite knowing the patients wanted HT. Although staff members were provided education on HT, including how to explain it to patients, some staff members expressed their discomfort or lack of confidence with how to describe it, which likely led to less referrals.

Despite this, the EBT pilot in the rehabilitation setting offered successful nuances that were not experienced in the previous EBT pilot in the acute medical inpatient settings. HT practitioners noticed that patients were more willing to receive HT in the rehabilitation setting; patients were also more accessible than those receiving HT on the acute inpatient units due to fewer interruptions for medical care and tests than those on the inpatient units, therefore allowing more time for HT sessions. A respected member of the rehabilitation therapy staff who had routinely used HT with their patients was the lead HT practitioner, another factor that likely increased participation in the study. This preexisting relationship may explain why other rehabilitation therapy

staff were more likely to refer patients for HT than were nursing staff. Additionally, the lead HT practitioner spent more time on the unit, both explaining and providing HT during their regular employed time as a therapist, thus increasing the number of patients receiving HT outside of the regularly scheduled EBT project days. Their success in this project highlights the need to employ HT practitioners in the rehabilitation setting.

Limitations of the study included barriers to measurement of change in level of pain. A sizable portion of patients were sleeping at the conclusion of the session, which precluded their rating of and comments about the level of pain and anxiety. Measurement bias resulted from the data collection process; individuals offering HT were also the individuals who recorded the results of the measures of change. Biological measures of change were not available to compare with scale ratings. Future EBT studies would benefit from using random assignment to HT or no HT and a more robust evaluation including biological measures to the intervention.

The Holistic Nursing Scope and Standards of Practice American Nurses Association (2019) recognizes that implementing holistic models in the current healthcare environment requires a paradigm shift for providers who practice a disease model of care. The EBT pilot fits nicely within the organization's practice model that is based on holistic nursing theories. Positive patient outcomes of HT witnessed by the unit's nursing and therapy staff increased awareness and acceptance of a holistic practice and added to the body of knowledge required for a paradigm shift. Regardless of the type of inpatient unit, nurses consistently try to provide comfort measures. Although a rehabilitation unit may provide an environment with less interruption for patients to receive EBT, the results of this pilot, in addition to the preliminary study, point to the generalization of EBT in all inpatient settings. An important question remains unanswered: how can an EBT pilot program that is successful in meeting the goal of improving patients' comfort and hospital experience be built into the culture of the organization? Upon completion of the pilot, some of the HT providers remained on as volunteers for up to nine months. They eventually left due to lack of compensation, time commitment, and lack of administrative support to sustain the EBT program. The only remaining HT provider after the grant-funded project concluded was the therapist who was already employed on the unit.

Recommendations

Success with the first EBT pilot in the acute inpatient setting provided the background and knowledge for the rehabilitation unit's EBT pilot. This second pilot increased the knowledge of advancing holistic healthcare, yet the organization's culture at the time was not ready to provide the support required for a sustainable EBT program. Despite positive results, lack of funding (from grants or inclusion in the unit budget) at the conclusion of this study led to the inability to continue offering HT. Lessons learned from this pilot led to several recommendations to guide organizations with developing a sustainable EBT program using HT or other EBT such as Reiki: investigate the organization's culture and potential funding sources at the initial planning stages; ensure a program facilitator who is familiar with the organization's culture is in place to oversee the EBT program and guide sustainability; ensure at least one experienced HT provider is a member of core staff to provide HT to patients and support for other trained staff to incorporate HT into their daily workflow; offer or encourage HT training for nurses and other core staff members; provide adequate training for staff to provide EBT education and information to patients with confidence; provide EBT information to all patients and their families upon admission to the unit; create a method for entering data into the EHR that supports clinical work and facilitates evaluation; and provide adequate training for nonstaff HT providers to document pre and post measures and access to EHR.

Conclusion

The EBT pilot was successful with creating procedures for implementing HT in a rehabilitation setting and evaluating the process and outcomes. Documented outcomes revealed how significant HT sessions were in providing added comfort in a healing environment. The pilot also provided insight on retaining a sustainable program. Although the EBT pilot was not successful with sustaining HT therapies for patients in this organization at the time, it is hopeful that the information conveyed in this paper will help this and other organizations to develop a sustainable EBT program in the future.

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Conflicts of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

ORCID iD

Janet M. Tomaino  <https://orcid.org/0000-0002-6239-0492>

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- Pat Conway**, PhD, MSW, Senior Research Scientist, Essentia Institute of Rural Health, Duluth, MN, conducts research at Essentia Health and with community partners in Wisconsin, Minnesota, and North Dakota. Current work focuses on evaluation of projects to reduce and treat opioid use disorder through integrated care and community networks; pain management is a key component of this work.
- Janet M. Tomaino**, DNP, RN, AHN-BC, CCAP, retired from Essentia Health, Duluth, MN as a Nursing Professional Development Specialist where she implemented energy-based therapy pilots and an aromatherapy program. She is a Reiki Master and integrative health nurse consultant/educator specializing in aromatherapy, founder of NurseScents, and faculty member in the Earl E. Bakken Center for Spirituality &

Healing at the University of Minnesota. She is a founding board member of the Aromatic Research Quality Appraisal Taskforce (ARQAT).

Stacey Quade, COTA/L, CHTP/I, Herbalist, has maintained a private practice in Healing Touch and Herbal Medicine since 2002 in Duluth, MN. She retired in 2021 as a Certified Occupational Therapy Assistant at Essentia Health Miller

Dwan Rehabilitation where she specialized in traumatic brain injury and was a leader and practitioner in energy-based therapy research and a member of the Integrative Health Advisory Committee. She teaches classes on a variety of wellness topics, including energetic principles, diet/nutritional basics, and herbalism. She currently serves on the board of North Central Healing Touch Community (NCHTC), and on the professional development committee for Healing Beyond Borders (HBB).