Chapter 1

THE STORY OF THE HEARTS PROCESS

Marianne Tavares interviews Ann Carter

Question 1. Why was there a need for HEARTS?

As a therapeutic intervention, HEARTS did not start out with a name of any kind; the name that is based on the acronym came later. When I started working at the Neil Cliffe Centre for cancer care in Manchester in 1992, it soon became clear that my training in massage and aromatherapy was not sufficiently flexible. For me to work effectively with people who had a life-threatening illness, my practice had to change to meet the needs of patients who had a wide variety of existing problems. From the onset of working in cancer care, I encountered difficulties; sometimes, for example, a patient's skin was very friable or resistant to absorbing a lubricant; the lubricant was typically grape seed oil, chosen for its ability to moisturise dry skin and facilitate a smooth glide during effleurage. For very poorly patients, positioning and creating comfort on a massage couch could be difficult. There were also body image issues, sometimes not verbally expressed, which surfaced when a patient was asked to remove even a minimal amount of clothing to receive a massage. Additionally, many patients, often those living with fatigue and the side effects of medication, were unable to accept a session that was scheduled to last an hour, although the hands-on work lasted only for a maximum of 40 minutes.

The day centre in which I was working as a complementary therapist was adjacent to a hospital ward. At that time, an oncology consultant who was linked with the day centre gave permission for therapists to work with in-patients when time was available. This amazing opportunity was an 'on the edge' experience, and it quickly became apparent that the treatment had to be adapted so it was acceptable to both the patient and the body posture of the therapist.

Treatments were usually offered to patients who were supported by pillows, and who were in either a seated or supine position. Therapists who were working in the centre needed to become familiar with the mechanics of hospital beds, and the need to remove bed ends for easier access to the patient. Additionally, there were complications of medical paraphernalia, such as intravenous lines, drainage catheters, oxygen masks and often-cluttered bed tables.

We needed to do something with our intention to help, using the complementary skills that we had. We all wanted to optimise this wonderful opportunity to make a difference to the wellbeing of vulnerable patients. Massage was not always appropriate, and neither was the use of essential oils. A gentle approach to reflexology was (and continues to be) very useful for patients as they do not need to disrobe and the feet are often easily accessible. However, for some patients, attention to the feet was not welcomed, and reflexology was not offered where there was local infection, altered sensation or where limbs were missing. Additionally, some patients requested attention to other areas of the body. The dilemma was to find a flexible approach that we could integrate safely and comfortably into our existing practice of complementary therapies. Whatever we did, the approach would need to meet the many challenges that arise when working in cancer care.

Question 2. So what influenced the development of HEARTS?

Possibly, the first major turning point was my visit to a Mind, Body, Spirit festival in London where I was helping on a stand sponsored by the (then) International Society of Professional Aromatherapists (ISPA). I was fascinated by how many of the therapies that were being demonstrated involved the skilful use of touch. The most significant therapies I noticed that involved kind, well-intentioned touch were shiatsu, the Metamorphic technique, Indian-style head massage and spiritual healing. (This doesn't mean to say that there weren't others, but these were the ones that had the most significance for me.) I noticed three things. First, members of the public who were receiving a short 'treatment' did not have to remove clothing. Second, amidst the loud noise of the crowds, and the continual variety of announcements over the speaker system, the giver and receiver of the therapy somehow created their own 'bubble of tranquillity'. This 'bubble' was obvious, although the giver and receiver were being observed by as many as 30 people. Third, the

receiver was demonstrating signs of being in a relaxed state, despite being surrounded by observers. One woman, who was receiving Indian-style head massage, was so relaxed that she was visibly dribbling! In addition, she was leaning to one side of the chair, which had no arms, and I wondered if she would manage to remain seated! Potential distractions were overcome by what appeared to be a deepening 'connection' between the giver and receiver. Both parties were totally engaged; the giver was clearly absorbed in what s/he was doing and the receiver appeared to have willingly accepted the process.

For me, these three observable elements were important principles that triggered some reflective thoughts about my own touch-based practice. The massage I had learned required a lubricant that was applied to the receiver's skin. The approach was very much directed towards treating private clients, usually paying for one-hour sessions, or working in a gym or a beauty salon. As a trainee therapist, I had learned a set routine for the massage process, which formed the basis for the final practical assessment. However, in the hospice and cancer care context in which I was now working, I needed to revise and enhance my skill level. I felt it was important to make the best use of the time allocated, and to offer an effective and resourceful treatment for a patient or carer.

Question 3. How did these insights affect your evolving practice in cancer care?

When reviewing and revising my touch-based work, I took the principles I had learned at the festival and applied them to my work at the centre. First, a complementary therapy could be offered at the bedside in a busy ward environment and, in spite of the noise, relaxation and calm could still be achieved. We could create a therapeutic space around the bed. Second, if touch could be offered through fabric (clothes or covers) then patients would feel less exposed and less vulnerable. This would give us options which would create opportunities for patients with more complex needs. The third factor which influenced my practice was the versatility of touch techniques I had observed through watching a variety of approaches to body work. There were many ways in which skilful touch could be used which was not restricted to basic massage strokes.

Around this time I had been attending some short courses where gentle touch techniques were involved. I started adapting some of

the techniques for use with clothed patients and was very pleased with the outcomes and the feedback. The 'adapted' techniques were empathic, gentle and effective, and it was these approaches that became central to the HEARTS Process.

In the first instance, I offered treatments using the touch techniques to some very vulnerable patients who were covered with large towels throughout the treatment. The responses from patients and their carers, who often sat in on the sessions, were positive and encouraging. So, with the permission of the oncology consultant and a GP who was also involved with the centre, I began integrating these approaches regularly within my practice.

Question 4. Why did you feel it necessary to introduce the use of sound?

As I provided more and more treatments using adapted touch techniques, it became clear to me that there was still a missing component. Most patients wanted to access a state of relaxation or at least a state of calm. Some patients had difficulty in achieving this state with touch therapies alone. The hands-on work was enjoyed and regarded as pleasurable, but for some patients it wasn't enough to calm the 'chattering thoughts'. I noticed that some patients wanted to chat throughout the whole treatment, or they would relax for a short while, and then start to chat again. Frequently, patients talked about having 'overactive and sometimes intrusive thoughts' so they weren't able to 'switch off'. It seemed easier for patients to disengage from the relaxation process, as they did not have a resourceful strategy for coping with internal chatter. I needed to add something that would engage their thoughts and offer an easily accessible solution. Music was an obvious option, but in some situations there was no access to a CD player, so another approach had to be devised. Some patients asked for a technique that they could learn and practise at home, so different methods had to be created that involved the patient in some way. If the patient was cognitively able, it would be something s/he could use to help 'self soothe' when a therapist was not present. (I describe these processes in detail in Chapter 7 on 'Sound'.)

As a result of practising a combination of well-intentioned touch and different methods to 'quieten the chattering mind', the patient's key healthcare workers at the hospice and cancer care centre asked me if I would give 'what I was doing' a name, so that patients could be referred specifically for this therapeutic package.

Question 5. How did you arrive at the name of 'HEARTS'?

One afternoon, the complementary therapy coordinator (who had been involved in the development of the approach) and myself sat down with flipchart paper and pens. Our aim was to devise a name for the collection of processes with which we had become very familiar. We isolated each component of the total approach and our first attempt produced the mnemonic 'HERTS' (Hands-on, Empathy, Relaxation, Textures and Sound). This was not a good title; no healthcare worker would want to refer a patient for an intervention by a name that suggests pain! It was at that point that we agreed to include aromatherapy, although we were aware that only qualified aromatherapists could prescribe essential oils. Since these early stages, 'Aromatherapy' has been modified to be included as 'Aromas', which gives all therapists using 'HEARTS' an additional therapeutic approach. The methods have been modified so that guided imagery involving aromas can be devised in a way that involves the patient. These are further described in Chapter 8.

Question 6. What has encouraged you to continue with the development of HEARTS?

There are many reasons. Principally, it was the benefits to the patients; it was like finding a 'missing link'. The feedback from the key workers and nurses about the effective outcomes for patients and carers was excellent, and the growing number of positive case histories was very heart warming. HEARTS was something that could be used almost anywhere, in any situation, and which could be effective in short periods of time. As a therapist, I also enjoyed using HEARTS in the challenging area of hospice and cancer care; I loved its flexibility and I came to regard HEARTS as an art form as well as one that had a scientific basis. The words that really offered inspiration and that I still quote at the start of every course I teach, are from Alfred, Lord Tennyson's poem, 'Break, Break, Break':

> But O for the touch of a vanish'd hand,
> And the sound of a voice that is still!
>
> (quoted in Autton 1989, p.108)

This is the essence of what HEARTS is all about.

Question 7. What response have you had from sharing and teaching HEARTS with complementary therapists?

Complementary therapists are always very keen to learn new skills that will enhance their practice and importantly support their patients. HEARTS has been greeted with enthusiasm on all of the courses. By the end of the workshops many of the therapists are thinking of patients for whom it would be suitable. Sometimes, I continue to meet therapists who were trained in the early days, which is now over 20 years ago. They are always keen to tell me that they are still using HEARTS, and how useful and effective it is.

Question 8. What evaluations have you done?

I think that most complementary therapists are aware of the need for evaluation, monitoring and audit. Much positive feedback has been obtained from listening to comments from patients, carers, complementary therapists and healthcare professionals. However, this feedback is informal and has a major qualitative element, and little has been done to obtain quantitative data. After a two-day course in HEARTS, I offer a HEARTS practitioner certificate. To complete the certificate, participants write up two case histories, which aim to demonstrate the competent use of different aspects of HEARTS. If the case histories demonstrate good reflective practice, a practitioner certificate is awarded. I always send the individual some feedback on their work and therapists are aware that the certificate is not a qualification; it is an acknowledgement that they are prepared to go further in the context of developing their skills in using HEARTS. There has been an enormous amount of useful information about the value and application of HEARTS in these case histories, and I hope therapists have also found my feedback helpful. In 2017, I circulated a questionnaire and the results are discussed in Chapter 12. The content gives some information about how therapists use HEARTS and their perceptions of its value to themselves, their patients and carers.

Question 9. In your experience, how has HEARTS helped patients in the earlier stages of palliative care?

I have found that patients and carers have benefited from HEARTS at all stages of cancer. Sometimes there is a misconception that HEARTS is only for patients with advanced illness and end of life,

whereas it is suitable for patients and carers at any stage of the cancer journey.

Its main advantages for patients who are receiving palliative care are:

- Patients don't need to remove clothing, so it can be practised in a variety of situations.
- There is no lubricant, set techniques or routines. Once the basic principles have been learned, HEARTS is largely intuitive and carers find this helpful.
- Treatments can last for around 5 minutes as a minimum; it doesn't take long for HEARTS to be 'quietly effective'.
- HEARTS can be incorporated into other complementary therapies at any stage of the treatment.
- HEARTS can also be used in conjunction with medical treatments and clinical procedures.
- In some situations, HEARTS has been used to restore physical contact between family members where this interaction has lessened, or been limited, through illness and disability.
- HEARTS is easy to learn – the approach and pressure used are no more than we would use for stroking a baby, a cat or a dog. It is a very gentle and rhythmic therapeutic approach.

Question 10. How can families benefit from HEARTS at end of life?

Healthcare staff and families will often look forward to the patient's treatment with a complementary therapist; they appreciate the benefits that can be experienced through receiving a touch-based therapy. However, a therapist may not be available when required, such as during the night, or when a patient is distressed or unable to sleep. It is in these situations where HEARTS comes into its own; the process gives the family options and something in which they, too, can be involved.

One of the features of HEARTS is that there is an option for two therapists (or two people) to work simultaneously with a patient. A carer (or carers) can easily learn some hands-on approaches that can be offered when a therapist isn't present. The easiest way for a carer to learn some HEARTS approaches is for him/her to work

alongside a therapist. Observing, then copying, how a therapist is working can lead to building confidence and any safety aspects can be discussed. Providing the patient is well enough, some approaches from HEARTS can be given to the carer in return. This may be a welcome option. Sometimes a patient feels that s/he is receiving 'all the attention' and their loved ones are 'missing out'. Being able to offer 'reciprocal' touch may help to restore relationships as the patient feels that the receiving of care is not all in one direction.

Many carers have reported how HEARTS has helped them to feel that they could do something for their family member or friend in the last hours of life. They have also described an opportunity to create a resourceful, lasting memory where the family was involved in saying farewell to a loved one.

Question 11. What is the future for HEARTS?

I would like to see HEARTS more widely used in a variety of healthcare settings, so I am training experienced therapists to run HEARTS courses in different parts of the country. I don't see HEARTS as another 'complementary therapy' – there is no professional body, no final exams and no assessments. I see HEARTS as being a therapeutic process that can be integrated into patient care. Some of the case histories in the book will illustrate its versatility and effectiveness…and will help to capture the essence of HEARTS and its potential uses.

Ideally, I would like there to be more criteria for entry into teacher training. At present, I know personally the therapists who want to do the training course. I remain in touch with them and the ones who are able to run HEARTS courses are meeting the challenges with professionalism and enthusiasm – and they are enjoying the teaching, which is really important.

Question 12. Is there anything else you would like to add?

This feels like a 'post script' or an 'epilogue'. Through writing this book I have come to realise two principles. First, although HEARTS is a pleasure to demonstrate and learn, the anatomy and physiology that brings about the positive outcomes is very complex. Even more surprising is that the nervous system could be processing the sensations of touch, the sound of music (or the human voice) and aromatic sensations all at the same time! This is

amazing physiology and we take it for granted. Second, from all the case histories, the existing evidence base and the HEARTS questionnaire results, I believe that we totally under-estimate the inherent properties of body and mind to make a positive change of some kind. This potential is always there, no matter how ill or troubled someone might be. We just need to find the right key to help unlock this potential for an individual. So many therapists, healthcare professionals, familial carers and caregivers have found HEARTS to be an inspiration and a resource in promoting a positive quality of life. I hope that this book will provide both an inspiration and a resource for its readers.