SPEAKER: I have the privilege and honor today to introduce a speaker. Robert Benzo is a pulmonologist by training here at Mayo. He's a founding director of the Mindful Breathing Laboratory at Mayo Clinic. This laboratory, which is funded by the National Institutes of Health, develops and tests interventions that promote self-awareness and mindfulness in the context of chronic disease.

His focus is on compassion, mindful communication, behavior change, and these are also research targets of this laboratory. It might seem challenging to imagine how is it that the care of patients with chronic conditions should involve that such domains until you realize that patients with chronic conditions live through their condition their lives, and it is an issue of constantly reframing, and reinterpreting, and refocusing their lives and their conditions and how in doing that such reframes may affect their outcomes.

And Dr. Benzo's area of work is in fact focused on improving outcomes as defined by the patient's perspective through the mechanisms that are already inherent in the patient's capacity. He co-leads the COPD Clinic also at Mayo, and he's director of the Mindfulness and Meditation Program at the Mayo Clinic Wellness Center.

It is therefore a great privilege for all of us to have the opportunity to listen this afternoon to Dr. Roberto Benzo. Thank you.

ROBERTO BENZO: Thank you very much. I agree. I feel honored that I'm able to share a little bit of what I do in my laboratory with you.

I think that we're-- I'm going to be talking about self-care and self-management. I want to just show that in the chronic care model self-management support is important. And so I think it's important target that we all need to be aware of and work that is pretty much-- start saying that while I'm just using COPD in a very broad audience like you-- just do something-- in a very broad audience like you, I'm speaking of COPD, and perhaps it doesn't really matter for many of you, because you don't see COPD.

But COPD is in a chronic-- in the context of chronic disease is one of the-- they're more affected by depression and more affected by complication. It would be the third reason for being for death by 2020 and also is the disease in which self-management, self-care deficits are most significant, and that's I wanted to show this paper that was published in *Patient Education and Counseling* that pretty much, I think I have it here, yeah, comparing to cardiovascular disease and diabetes. This [INAUDIBLE] of COPD are much more significant. They have the lowest level of physical health, more depression, and lower educational level. So I would say it's a good example to actually talk about what self-management is about, what self-care is about.

I would like to start also with this important skill or exercise. I won't you to think about you, I mean, about self-care of yourself. I mean, because we sometimes we are in this observational situation in which we see that people need to actually change or need to actually exercise, or need to do this, or need to do that. And for this actually 45 minutes or whatever the time you're talking about, think about you.

How am I myself doing with actually making changes in my own life? I will just start with one of the completions of my talk that every intervention that we do depends totally on the status of the intervenor. So the state of mind you has everything to do with the success ending of any intervention you do. So it's is much more than delivering a recipe, a go beyond a kitchen table recipe. So that's a very important concept to keep in mind.

Self-management are a skill and confidence in managing health problems. The goal of self-management support, which is what we saw in the chronic care model icon, is to change patient behavior, increasing the patient's self-efficacy. So it means confidence and knowledge to improve functioning and quality of life. And the quality of life makes it seem like a soft concept. But quality of life is about answering the question, how you doing? How do you feel right now?

It's a very, very big, big outcome that it has everything to do with every other outcome, although some of the time we have kind of biases at looking at just hospitalization or just the people that are paying with money. But it's a very big outcome that we could pay attention to.

Self-management in COPD started with this paper. In 2003, a group in Canada actually randomized people into giving what is called an action plan, an emergency plan, and people taking antibiotics and prednisone when they have a flare up, and they decrease hospitalization by 40%. So that would be the difference between-- this is the probability of not being hospitalized, and people in the intervention have much less probability of being hospitalized over time compared to people that actually did not receive the intervention, which is this self-written action plan.

One of the situations that happen-- so everybody got very, very excited. So we got the situation-- we got something-- in our culture, once we have something that it seems to work that it's ABC, oh, we got it. So this is an action plan. I mean, this is what we use in Mayo Clinic, and so when people have more symptoms more than usual, they use their immediate action medication, which is the nebulizer in COPD. So for me, this is just too much in my specialty. But it's kind of where it is.

And the thing is either people are not better by using their rescue inhaler, actually, they take antibiotics and prednisone. By themselves, we are calling anybody. You And this kind of treatment shows in particular study that they decreased hospitalization by 40%.

But there was one thing that happened in that study I think is merit to actually be said. That study, improve hospitalization by 40% according [INAUDIBLE] did not improve. So that was something that actually was a little bit disconcerting, because I mean, you explained that when you improve that outcome that is so important for such a margin, do you [INAUDIBLE] two people, because you are feeling.

So as I said before, when I actually-- when we got these-- when we got these papers, we said, oh, we got it. We have a kitchen table thing, and then if we do this recipe 40% of the-- I mean, we will increase hospitalization by 40%, something that is very important, because in COPD, hospitalization is the main, I guess, focus of expense. So for the government, that is critical and [INAUDIBLE] I mean, if we actually are doing an intervention to the increased hospitalization.

So the problem is that, of course, that was the first study. And a study that actually came over the years did not show the same effects. Actually, people were in, and they were randomized in a much more organized health care system, which is like in England. And they were randomized to this action plan to our control. And they found no difference.

You can see here percent of people with the event. The event is hospitalization from the randomization, and you see the two lines are more different between each other. So what is going on? But he same analysis of this study show something that is also very tremendous. It was that people actually were able to monitor their symptoms, and to write them down, and actually to use the intervention when they actually were supposed to. They actually made a difference.

So in the people that were successful, if you will self-managers, actually they found a significant difference. So percent of event, so unsuccessful self-management, they have a higher percent of hospitalization at a given time. So the issue is there is something on the patient side, on the actual behavior of the patient, that actually has to do with improving the outcome. So it's not just writing an action plan to actually make a difference.

So we started to think about after that. We actually really started to think about what we aim, really to behavior change, which is not a simple thing. So we still carry-- if you will, we carry that question. We still carry that.

I just want to bring Pascal to this conversation with you. I'd like you to read this. "People are generally better persuaded by the reason-- they have themselves discovered than by those which have come to the mind by others."

So the thing is this, the first part that I will believe in behavior change is that we don't convince people to do anything-- pretty much that. People are convinced by their own thinking, by their own reflective inner process that this is good for me. And that's actually kind of fuel a line of work of-- let me just go back up the moment and say that based on what we said before is that self-management, it may not be for everyone.

But the thing is that one thing that when we look at the studies in COPD that actually have shown improvement within management. What happens is that when people have support, they actually make a difference. So in the studies that has been done more negative, there were less phone calls or less dedicated care with them. So the human factor is just critical.

This is just to show-- I mean, just-- so one thing that we do in our culture is that when we need the support, we need to actually make them do something, let's get to the computer. Let's get the iPad in the home. Let's get the telemonitor and call them up, kidn of measuring their blood pressure.

So there is a bunch of studies doing that. And the recent meta-analysis on all of them in COPD didn't really show a difference. So it's not a technical thing only that actually makes a difference on the outcome of the people. It seems that the human factor-- everything started to coalesce.

One of the thing that we're learning as management research, or self-care research, is the fact that this human factor is critical. This banding connection between interventions and the people can be easily replaceable. So this is kind of the forest plot. You can see that-- I mean if-- sorry about that. Over Come back.

So if the study may favor, telemonitoring will be on that side. You can see none of the studies actually mean-- and this is-- here is all the-- you can see all the outcomes measure in this meta-analysis here. They didn't show a difference. Most of the outcome, I mean, actually didn't really make a difference.

So there is nothing that goes in one to the other. So the thing is that I guess that the rationale of this, the moral of this, is that just technology is not enough. Just technology is not enough. So how do we engage a patient? How do we make them pay attention?

Yeah, one of the important things that I said in the beginning is the fact that-- the embracement of the intervention from the person that do it is everything and also the capacity of paying attention from the person that is doing the intervention is critical too. So in a way, we're learning there is a lot of homework on the people that are actually doing their the research like myself. I do coaching. I coach people myself.

So we came across a few years ago to this way of guiding people. We call it motivational interviewing that is actually aimed to change behavior. But it's doing it by a special type of communication. The one thing that I wanted to say to you, because again, once you read this previous slide, you said, we got it. Let's get all training and motivation interviewing.

What do we need? Two-day training? Three-day training? What is that? Why is that necessary? Again, it doesn't go that way. The developers are very, very, very defined, actually, it was last year just talking with us I think in one of these grand rounds that is not a technique or a set of techniques that are applied, or worse, used in people.

The spirit of motivational interviewing has been updated right now and involves four important things-- why people are willing to change, why people want to do it, evocation. Accept them where they are, actually, why they are where they are, where they do or decide not to do.

In my case though, they decided not to stop smoking, which is the typical situation in my Mayo Clinic. They may not be ready for that. This is an important, accept [INAUDIBLE] needs to be said with your mouth, but need to be said with your body.

Collaboration, which is a big thing, that means that kind of chipping in into what is the next step. But probably the directed way that we usually have been trained to, or at least I've been trained in medical school. Do this. Write that. I mean do take this. I mean, do that. Do so many minutes of exercise, which usually ends up in no behavioral change.

And what works out in the latest edition after 30 years of research is the compassion. Compassion is-- compassion is a willingness from your own heart to the other person suffer less. And that, again, is something that goes beyond words. And that is part-- and that can be translated not only in, of course, in person, but also on the phone.

I have people working with me. I have said that people that actually help doing the phones call from my laboratory, they feel that compassion over the phone. So it's something that can be done. That means I want you to suffer less, decrease that suffering, even if I cannot do anything.

And this I cannot do anything. It's very important, because when you talk of people that are actually happening-- who suffer a very bad thing, a very bad thing, they don't get relief from these people and say, oh, it's going to be just fine. Don't worry about it. They get the biggest relief from people that are just there standing by.

So that compassion can be and could be trained. By the way, very famous, if you will, places like Google get in their training of their people compassion training, because they work better. They do better. So it's a very solitary-- very, I think, joyful and great thing that motivates you into having compassion in their spirit, because it may just even go beyond this technique, and we understand that this is not really a technique.

All right, OK. The very, very rudimentary skills for motivational interviewing that are just skills are open questions. That means that we ask questions that we get asked if we have an answer, yes or no. Affirmation of what now is good, it's this deliberate effort of finding the good in the other person when actually you are talking to them. That creates a sense of self-efficacy and confidence that people say, well, I can do something. I'm worth something.

Reflective listening means-- I usually try to put listening, but I think that reflective listening means give-- I want to just leave it, because it would give the-- give the active part of the receiving. That means you. That means me. Listening is-- I mean, they said that listening is listening to what is being said and by those words not being said.

When you embrace somebody in such a way that you listen with your whole being, you embrace what is being said and what is not being said, everything. That's why this body language thing really is important. So reflective listening, that means that you actually are soaking in what is coming and then processing or not processing. You are just bringing them back saying, I pay attention to you.

So that's why you totally understand that this is something that, even if you do the best 24-hour program with-- anybody that is the best in the world for MI is not for motivation, and you won't do it. You need to actually practice. And it's a very handy practice to use in the most difficult situations like home environment

I'll summarize this and put it all together. So this actually creates conditions for change. So again, going back, change doesn't happen by forcing. It happens by creating condition, like having a go around where things actually start to pop up or not.

So the practice of listening, I think that this is not projecting. But this guy that I usually use in the mindfulness program that we do with the patient actually is hammering, hammering all the time this nail here. And this nail is not going in. And the guy is hammering anyway, even when the nail is not going in, and that is actually the practice.

I mean, in learning to listen, you do it, even when you don't feel like you are getting anywhere. That is a very important part of the listening training. I want to just bring your attention and just go over this paper in *New England* that just came two weeks ago. It's about dying in the ICU and about care. But I think it has everything to do with engaging the patient. And I'd like to burn a few moments of actually going into it. So it's called "The ABC of Dignity-Conserving Care."

Let me just read that, "Attitudes and Assumptions that Can Affect practice. Reflect on How Your Own Life Experience Affect the Way in which You Provide Care." So again, as I said in the beginning, the status of the intervenor has everything to do with how the intervention goes.

"Be Aware of [INAUDIBLE] Clinicians Attitudes and Assumptions That Can Affect Their Approach to Patients. Teach the Learner to be Mindful of How their Perspectives and Presumptions Can Shape Behaviors. Behaviors that Always Enhance Patient Dignity. Demonstrating with a Number of Methods how Patients and Their Families are Important to You."

That's why you can see this a lot for us here. It's a lot for actually for preparation to actually create conditions for this dignity-conserving care, for this actually engaging the patient. Engaging a patient is an active thing from here. It's not a technique. Do not rush. Sit down. Make eye contact when talking with patients and their families.

This is a paper this week in *Patient Education and Counseling* that they put a software in which they-- actually, they were able to see for how long the doctors are looking at the computer. They said relation between this time and the satisfaction of the patient and the effectiveness of care.

"Turn Off Digital Devices." That cannot be said enough. "Avoid Jargon." Compassion is Sensitivity to the Suffering of Another and the Desire to Relieve It," even if you cannot do it.

And people that are suffering, let me say this, people are suffering, they have this insincerity meter inside. They know when that people are coming in cheerful to them without actually meaning that. So meaning that is very important, and it's very well read. It's very well read from the body of behavior, even from the voice.

I mean, how many times you are talking to somebody that [INAUDIBLE] say, yeah, and you realize that he is reading an email or something like that? He's not with you. "Acknowledge the Effect of Sickness on the Patient's Broader Life Experience. What is the Effect on Other People?" Relieve suffering. "Explore Values That Are Most Important to the Patient."

When you get there, you get to engage when you actually are able to dip and soak what is important for people. You have the time to listen. You don't want to rush into whatever script you have and where you want to get. One of the things that we learn in our own research is that we don't need to go to a goal.

We don't need to get to the goal of actually moving more. Sometimes it's just connection. Sometimes it's just being there. That's why you engage. Then you get this credibility and this acceptance, people are actually asking you.

Ask who else should be involved to help your patients through difficult times. The caregiver is-- awareness of the caregiver is critical. In research on COPD, people that were living alone, they do much poorer. People that don't have anybody-- in our research on COPD, people that are actually independent, particularly end up in the ER, is actually living alone-- social isolation.

Because why is that? Because in the moment of constraint, they don't have anybody. They don't ask anybody. They just go, and they call 911, and they end up in the hospital. So all those issues has to do with wellness and important outcomes.

As I said before, this [INAUDIBLE] giving a recipe may not improve quality of life of people. So one of the things that we did in the laboratory is to actually study other factors that have to do with self-care, with self-management, with taking care of ourself. We'll be more healthy.

So one thing I want to just back up to say this. What is health? We usually-- I need to fix this. I need to get my coronaries plumbed, or I need to actually to get a new hip, or the World Health Organization is very clear on that. It's something that is not known by everybody.

It's the fact that health is a balance. It's just not merely the answer for absence of disease. We go beyond that . Many people that actually come to see me and with a very bad lung function, and we ask this question on everybody. How will you rate your health? Excellent? Very good? Good? Fair? Or poor?

Many people with, again, lung function was 20%, they said, oh, very good. I'm doing very well. So this today-- the answer to how are you doing? It may not be just the amount of, I guess, lack of lung function in my case or lack A1C in the case of Victor when he asked about people with diabetes.

It's about the balance, about the balance on your emotions, your balance with your body, and the social balance. Social balance is your environment, number one, an environment that we all have are mine, number one environment. Then who surrounds us?

Then another environment where we read, where we're watching TV or the lack of any awareness of the environment like what do we drink? What do we eat? So the social balance is a very big thing. So when we talk about health and being healthy and self-management for health, so this is a bigger awareness of what health is that we need to pay attention to.

And I don't say-- I mean, so feel free to don't believe anything I say. Feel free. Just kind of go into this thinking about this and to make your own-- but these guys, I guess, are trustable [INAUDIBLE] or trust to actually believe that this is the way, the whole way to kind of call what health is.

Health comes from the word whole, W-H-O-L-E, the big thing, working with every day that we have, every day. That's health. However we cope and work with everything there is, all this stuff, all this stuff. We all have stuff. There's nobody in this room that doesn't have stuff. All right?

So health is to deal with the stuff. And that stuff is being a diabetic, or having COPD, or needing a lung transplant, or something like that. It's a bigger thing about when we talk about health. So we measure self-management with a very big question, only 300 people. So somebody in my laboratory took the deliberate and the job to actually-- got 300 people in COPD and asking what self-care is for you, and we use a very well, I guess, defined health care tool to measures self-management.

That involves a subdomain, so it's a big domain of self-care, a maximal global score, but those are subscores like taking initiative, investment behavior, taking initiative what do you do, actually, what is the energy you have to do something? Investment behavior, we all actually look what kind of effort you put to actually be more social, be more close to your people, do things that you like, how many things you do, how many things you can do. What is the confidence of doing what you do and the positive frame of mind?

And this is the core of this lecture. So I think that I want you to pay attention with me to that. So this is in the [INAUDIBLE]. So this is a lot of numbers I want to work with you. So forgive me about so many numbers. But this is self-management behavior so the ability to actually take care of yourself, considering that that's six domains.

The first thing I want to-- all these numbers are a correlation coefficient. They go from 0 to 1. 0 means no correlation. There's no association between the two. 1, perfect association. The first thing I want to say is the assumption that we kind of have the gut feeling for.

All the measures, all the measure of lung function and severity of COPD-- this ADO index means age, dyspnea, shortness of breath, and obstruction in the airway. They don't correlate with the ability of self-management. Pretty much there's no correlation.

So you can be very severe, and you can still, if you will, take care of yourself. Or meaningful things, approaching people, feeling well, feeling confident of what you, like the patient that I have who got COPD, and every day they walk their dog, because they love the dogs, and they actually do that.

So age is not an impediment. You can be 88, and then be able to actually take care of yourself. Then we start to look at other-- so self-management is totally related. Also it has a good correlation where the total quality of life measured with a good tool that measures quality of life in COPD with emotional domains, with the ability to do things, with a level of fatigue, and you can see the numbers. The highest domain in which the quality that was related to self-management is the emotional domain.

And this capacity of self-management is not directly related to the degree of shortness of breath. So you can be very limited, but you still can have the ability to do things for you. That is a very important concept that we learn that I want you to just bring with you. So the thing is not limiting people, because of the limitation of the disease.

They can still do things for it. And as far as we're living, the idea is to live meaningfully, so to be able to do something that works for us, and that is the actual objective of the coach. What is that that actually move you every day? The essence of depression is the lack of purpose. And this ruminating machine here, this circuitry of rumination, you cannot do it, you cannot do it, you cannot work.

So all those things are coming in the coaching in the hall. But to our dismay, or actually-- worl-- you can see depression here, 0.39 correlation, resilience, the ability to come out of a hardship, 0.33. But we found that the biggest correlations were related to emotional factors, mainly with positive thinking and with emotional intelligence.

And that's why I wanted-- the second thing I wanted is to bring to this gathering is the fact of this novel outcome that perhaps we need to pay attention more in our willingness of actually connecting with people, engaging people, and create conditions for them to actually move forward, move forward means doing something that is meaningful for them and can be good for their outcomes and their health care outcomes.

So the other thing is that we did-- so we-- let me just back up. So we need motivated models to find out, OK, I mean, give me something that actually matters in COPD. Well, the quality of life. The number one independent predictor of quality of life in COPD, the number one, was emotional intelligence-- not FEV1, not gait speed. It was dealing with their emotion. We'll talk more about that in a moment.

So in a way, I mean, so 20% of the variance of these phenomena of quality of life has to do with understanding their emotions. So it's something that sounds too touchy feely, but it has now, or it has some ways in which we can approach that.

So we learned also so emotionally intelligence, positive thinking, and functioning capacity are the most meaningful determinant of how we actually set care. Functional capacity, of course, people actually were able-- we measured gait speed on them, on every one of them. And so people actually were able to be above the frailty index. About the point 8 meters per second they did better on the self-care, of course.

But they were not the number one predictors. And the severity of the disease is not an impediment for self-care. That's an important thing, this idea of worthiness. So people, even when they are very sick, they can do stuff for them.

Emotional intelligence, as I said before, is an independent predictor of quality of life, which is a key outcome. At the end of the day, we actually do things for people to feel better. From the self-management domains, two things were the most important.

Number one, investment behavior, how much you get out of your way to do things that matters to you, visit a friend, doing an activity you like, how much you go out of the way, and then this is the confidence that you have in yourself, self-efficacy. That goes with the Bandura theory of behavioral change. So things start to coalesce.

But these are very much the fine targets for any self-management program. We are taking it from COPD, but I think it can be used in anything-- diabetes, heart failure, anything. You name it.

"How to test positive affect and emotional intelligence." Let me just name it what it is. "Emotional intelligence is the ability to notice feelings and emotions in ourselves and in others," the number one station is ourself, "and use this knowledge to guide our actions," easy to say. The good thing of emotional intelligence is that we can train ourself into it. We can train about being more aware of our thoughts. And again, it's not an easy road, but it's doable.

The component of the pathway of emotional intelligence is number one, awareness, self-awareness for self-management, number one are-- and then social awareness, and they start to cross here with the idea of compassion. Compassion is starting here with myself, with my issues of how I suffer, and they start to see the suffering in another.

This sounds touchy feely, but it is totally-- I mean, when you start into a frank conversation, those kind of things has to come in. How to train emotional intelligence-- how to train in awareness, which is the main source of emotional intelligence is practicing mindfulness.

Mindfulness is a purposeful way-- it's the kind of awareness to the attention to be here, even when I perhaps don't like what you see here. So it's going away from liking or disliking. How can I be here in the context of this hardship, in the context of this disease, how can I be here?

And it comes to your mind, the idea of health, being able to deal with wholeness. It's not labelling the experience good or bad. It's a different way of coping that encourages engagement, turning away.

Where is that mindfulness thus? And then, again, this is again at the core of not-- this has nothing to do with anything religious. I mean, Google has a program called search inside yourself, but every engineer in Google needs to do it, that the foundation for emotional intelligence trained there is mindfulness, so it's what we're talking here.

And then what we're talking that in here, because it was the number one predictor of quality of life in COPD. That's why. And I think that this is the way to get to the-- problem solving, you don't need to go with the idea of solution in mind. You need to see-- we need to be open to what is that may be a way.

We found this by actually doing the 300 patients and found that no kidding, this is the independent predictor of that. This attention, this mindfulness, allows our emotional status to see our emotions in greater detail. That means getting the automatic pilot. We are all most of the time on automatic pilot.

That means this particular approach or way of being in front of a situation. Getting out of that trap is difficult.

So in order to deeply train emotional intelligence, we actually process-- we kind of foster this what is called thought awareness. It's a process by which you observe your thoughts and become aware of what is going on through your head. And I want to say-- I mean, we usually for training people in thought awareness, we start with very simple things, like breathing awareness, because it's going to [INAUDIBLE] it can be difficult. It can be-- nobody is going to do it.

Actually, if you get to *Science,* this week, this week, read the paper in which people that were left in a room of different cultures or different educational level left in a room 15 minutes to do nothing. Did you read it? To do nothing and being with their thoughts. They did that with 300 people, and most of them didn't like it.

From a subgroup of people that were in that 300, I mean, of being alone, there were a group of them in which they were able to-- they received electric shocks. [SHOCK SOUND] And then from those people that they asked them, listen, would you pay not to have this electric shock?

Yes. So those people that would be able to pay $5 not to have the electric shock, they were into a new set of research in which they were alone with their thoughts. What happened? 25% of the people or the men-- sorry, 25% of the women and 40% of the men actually pushed the button to have the electric shock, because they couldn't tolerate to be with their thoughts. That's tough.

I mean, the thing is just being with ourself, I'm just saying, [INAUDIBLE] sounds very good. Let's do it. It's not an easy road. That's why when we start to train in mindfulness, we start to try in very simple things, just breath in and out, or we just move, and this here creates awareness of the movement.

That's pretty handy when you're running a race or something like that. So how this is a typical graph that we can use for training awareness. People are starting to actually-- these are three levels in which we progress people-- negative thought, rational thought, and positive thought.

I mean, negative thought-- monitor your negative thinking. Document stressful events. Then once you do that enough, then you go to rational thinking. That means that you go to your negative thought and said is this reasonable that I'm thinking this? With my colleague, or my friend, or my mentor would agree with this negative thought I have?

If it is a substance, use something, but many times, there's no substance to be so negative. And then once you do that, you go into the next level, which is positive thinking, which is the affirmation of what is here. Gratitude may help great.

And usually write down in the present moment, when you going to this, you write this positive thought in the present moment, which is actually right now good. It may be a lot of things that we will label, where is the good? And that way the positive thing is starting to emerge.

So training emotional intelligence is possible. I take a route why it's possible. A major problem with negative thought is that it tends to flit, and tend to go into your consciousness, and do the damage, and flit back again until you actually start to go down the pipe. We just have to think that this negative thought is true. That's the problem with negative thought.

The most important positive thinking practice is smile. Smile means us not laughing. Smile is just what you are doing right now. That means 300 muscles on the face are telling the brain, yes, I'm willing to be here. I am going to be here. No matter what, I'm going to be here.

So mindfulness, what it does is actually help is us in this working. And mindfulness just means presence of the heart. It's be more hurtful, more the gut feeling of what a feeling to be then. That's what mindfulness is. So this Chinese character means presence, and this is means heart. So mindfulness is presence of the heart. Heartfulness in what we do.

With the mindfulness training with patients every week, twice a week, and we actually go into breathing awareness, mindful movement, the smiling practice, and the gratitude practice. So this you can say, this is the more positive thinking practice that we do. And this is kind of the introductory to kind of just being here.

I wish we can be so simple like this guy. I learned all this not only by thinking. Thinking is a problem, you know? It's good to be more into-- it's good to be more into the sensing, what is actually going on? Instead of what is actually going on. The thinking can be a problem.

The whole network that we have is thinking, thinking, thinking, but there is another network in which we actually are more aware, and that is what is necessary in the coaching call. In any encounter, let's just be here.

These are the experts. I learned a lot from them, a lot from them. Yeah. I wish to say more about them, but I don't have time. These experts in a qualitative study said that mindfulness helped them with breathing better, with moving better, and with committing with life, freedom from accepting, and it's a different way of seeing.

So for everyone practicing mindfulness, it's exciting. It's do nothing for 15 minutes a day, just breathe, be friend with your body. Find the positive in everything you encounter. That is big time. And the idea is to take notice. Don't react.

True silence comes from non-reacting. Through silence of the mind. It doesn't have to come from anything in the mind. It comes from none reacting. I have this bad thing. How about if I actually let it be here and keep with my life, keep moving.

I mean, when you find-- when you are in front of somebody that suffers, those things start to kind of populate and make sense. So the emotional intelligence training can go into-- so again, we're talking about a determinant of self-care and how to train for them.

What are the aims? Less reacting. That's true silence, recognizing and naming emotion, the negative thinking that we actually were documenting. You've seen the gut feeling that you're making. What do I really feel needs to be done? Not what I think is the right thing to do.

Where is your gut feeling? It's when the [INAUDIBLE]. And developing listening skills-- number one, listen skills to ourself, then listening to other people. Listens skills to other people is it too easy and is a pathway of compassion.

I like to finish with just this guy was-- was a critic of movies. But he wrote something before he died I like too much, and I'd like to share with you. "Kindness covers my political beliefs. No need to spell them out. I believe that if at the end according to our abilities, we have something to make others a little happier and something to make ourself a little happier, that is about the best we can do.

To make others less happy is a crime. To make ourselves unhappy is where all crime starts. We must try to contribute joy to the world. That is true, no matter our problems, our health, our circumstances. We must try it. I didn't always know this, and I am happy I live long enough to find it out."

And I want you to kind of recover this idea of where [INAUDIBLE] start. So the intervenor needs to start to actually create an intervention that works, that actually creates joy.

Health about balance. And when we talk about the goals and what are you going to be doing, it looks like over time it's kind of a physical activity, how many minutes I want to run. How about what brings you balance? What do you need? Those are very, very meaningful conversations actually when you-- and you need listen, and you need silence to get there. If you're rushing, I have 15 minutes on this call, oh, my god, then it won't work.

Usually, the calls don't last that much. It's interesting. When you go with a friend, you just need a site, and just a few comments, and easy enough to mention everything. The same happened with patients when you develop a true relationship.

So let me finish. This is my last slide, I think. I have this balance, emotional intelligence, positive affect, positive thinking, self-compassion. We talk so much about it, but it's kind of looking at your suffering yourself and yourself first. Be friends with actually with this actually difficult [INAUDIBLE].

And functional capacity are important in terms of actually going into this balance, self-care. The effect of any intervention depends on the status, internal status of the intervenor. I will repeat that 1,000 times. Telemedicine is just a tool, but the real core is the people. And the severity of the disease is not an impediment for self-care.

I like to recognize the people in my lab that I will be ever able to learn everything I learn if I don't have the people that scramble with me every day when I change decisions, I change question, or I change-- everything I change. But you know, this is the way it happens with clinical research.

And by the way, I'm grateful for the people that work with me. The love of my lab means that this wellness guy. And this circle means that everything that is necessary is here is finding meaning of what is here right now. Thank you very much.

[APPLAUSE]