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Mindfulness-Based Supportive Therapy (MBST): Proposing a Palliative Psychotherapy From a Conceptual Perspective to Address Suffering in Palliative Care

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Abstract

Objective: To develop a mindfulness-based palliative psychotherapy to address psychoexistential suffering in palliative care. **Conceptualization:** First, a theory of suffering was formulated by merging 2 models of suffering from 2 thematic analyses of 20 palliative care patients and 15 informal caregivers. Second, the results from a secondary thematic analysis of suffering caused by health care interactions were conceptualized into a psychotherapy framework. Third, principles of mindfulness were incorporated into the framework to form a mindfulness-based psychotherapy. **Results:** Mindfulness-based supportive therapy (MBST) was developed with the following 5 components of presence, listening, empathy, compassion, and boundary awareness. **Conclusion:** We believe that MBST is a potentially useful psychological intervention in palliative care, specifically designed to address psychoexistential suffering of terminally ill patients.

Keywords

suffering, mindfulness, palliative care, psychotherapy, psychosocial care, review

Introduction

Suffering is commonly defined as a state of severe distress associated with events that threaten the intactness of a person.[1,2] It occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person is restored in some other manner.[1] This widely accepted definition describes suffering as an interaction between a person and an event. The interaction is in the form of cognitive appraisals in which the significance of the event as a threat is judged, and the destruction of the integrity of the person is evaluated. A second definition, introducing the concept of coping evaluation, describes suffering as a threat to the integrity of the self, helplessness in the face of the threat, and the exhaustion of personal and psychosocial resources of coping.[3,4]

Comparing these 2 definitions of suffering to the Transactional Model of Stress and Coping,[5] transactions in the form of cognitive appraisals between the person and the event (stressor in the Transactional Model) were described in both stress and suffering, namely, the appraisal of threat and the appraisal of coping. In contrast to stress, the following additional points were noted in suffering: (1) suffering is a severe form of stress and (2) suffering involves an additional appraisal of destruction of personal integrity or damage to the whole person.[6] Therefore, the concept of the whole person with physical, psychological, social, and spiritual dimension is crucial in understanding suffering, that is, a form of "total pain."[7]

Despite current advances in medical science and technology, suffering has been reported to remain as high as 88% in patients with advanced cancer who attended an outpatient palliative clinic.[8] Of the 4 patients with end-of-life cancer of Dutch primary care, 1 reported unbearable suffering because of various physical and psychoexistential issues.[9] Psychoexistential suffering is defined as pain caused by loss of essential components that compose the being and the meaning of the self.[10] Common examples are loss of function, loss of control, burdening of family, unfinished business, problems in

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acceptance, hopelessness, meaninglessness, loneliness, absence of dignity, and concerns of death and dying.[9,11,12]

Traditional biomedical approaches that treat suffering as diseases are not only inadequate in managing suffering but are in fact contributing to the suffering of patients, in the form of health care-related suffering.[13-15] Therefore, in addressing suffering, biomedical approaches that deal with the threat; combined with cognitive methods that target the 3 cognitive appraisals of threat, damage, and coping, and whole person care or healing that assists patients in finding their new sense of integrity independent of illness, recovery, or death are necessary.[16] The need to reintegrate healing into the medical profession is urgent.[17] Medicine is incomplete when curing of disease is not complemented by healing and caring of the sick person. Particularly in palliative care, when the natural history of disease can no longer be modified with medical science, healing and caring should be continued to ameliorate suffering and to enhance quality of life of the whole person.

As far as psychotherapies are concerned, supportive psychotherapy, supportive-expressive group psychotherapy, psychodynamic psychotherapy, psychoeducational interventions, and cognitive-behavioral therapy can be useful for many types of psychological suffering in palliative care.[18-24] Interpersonal psychotherapy, couples therapy, and family-focused grief therapy can be applied to relieve various interpersonal and family suffering.[25-28] As for spiritual and existential suffering, dignity therapy, meaning-centered therapy, and narrative therapy are promising approaches.[29-34]

Nevertheless, delivering psychotherapy in palliative care is not without its challenges.[35] Patients can experience rapid changes in psychological distress, physical strength, or conscious level. The setting of treatment can change from hospital to hospice or home. Persons for psychotherapy can change from patients to families or friends. Even therapists need care to prevent burnout and compassion fatigue secondary to frequent exposure to death and dying. Ideally, palliative psychotherapy should subscribe to the following palliative care principles: a whole person approach taking into consideration physical, psychological, social, and spiritual issues; a whole family approach that helps the entire family; a whole team approach that emphasizes team work and professional self-care and a whole journey approach that underscores the importance of nonabandonment.[36-40]

Mindfulness and Its Potential to Reduce Suffering

Mindfulness is a moment-to-moment, nonjudgmental awareness, cultivated by paying attention in a particular way: on purpose, in the present moment, and as nonreactively, as nonjudgmentally, and as openheartedly as possible.[41,42] It concerns a noninterference with experience by allowing inputs to enter awareness in a simple noticing of what is taking place.[43] Currently, there is substantial evidence in the literature on mindfulness in reducing various forms of psychological stress. Mindfulness-based interventions, such as mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT), have been shown to improve pain acceptance, insomnia, stress, anxiety, depression, caregiver stress, and so on.[44-53]

Several mechanisms have been proposed to explain the effectiveness of mindfulness in reducing psychological stress. These mechanisms can be classified into 3 groups based on the above-mentioned definition of mindfulness: (1) Paying attention on purpose—attention regulation (orienting attention, alerting attention, and executive attention), (2) paying attention in the present moment—decreased rumination of past symptoms and decreased worry of future symptoms, and (3) paying attention nonreactively—this includes metacognitive awareness (the awareness of one's thoughts and feelings as mental events, rather than the self), decentering (the ability to observe one's thoughts and feelings as temporary, objective mental events), defusion (the ability to be aware of one's thoughts, feelings, and memories as passing events rather than "things" that are valid or invalid), and reperception (the ability to disidentify from the contents of consciousness, such as one's thoughts, feelings, and judgments and view one's moment-to-moment experience with greater clarity and objectivity).[54-59] These mechanisms may lead to a greater ability to stay with unpleasant experiences, a positive reappraisal of stressful situations, an enhanced emotional and self-regulation, and a greater degree of cognitive, emotional, and behavioral flexibility.

Despite the fact that mindfulness has been found to be useful in reducing various psychological stress, its usefulness in the palliative care setting remains relatively unexplored. Little is known about its effectiveness in alleviating psychoexistential suffering of terminally ill patients. Although the proposed mechanisms of mindfulness seem to have great potential in reducing proliferation of mental events in suffering, but palliative care patients who are suffering may be too sick to participate in any psychotherapy or too emotionally unstable to regulate their attention and reactivity. In this concept article, we intend to conceptualize a mindfulness-based palliative psychotherapy that focuses on the cultivation of therapist mindfulness to address suffering in palliative care, taking into consideration the previously mentioned challenges.

Conceptualization of a Mindfulness-Based Palliative Psychotherapy

The conceptualization was conducted in 3 phases. First, a theory of suffering was formulated by merging 2 models of suffering in palliative care. The 2 models are the existential–experiential model of suffering from a thematic analysis of 20 interview transcripts of palliative care patients, and the compassion model of suffering from another thematic analysis of 15 transcripts of palliative care informal caregivers.[60,61] This theory of suffering serves as a foundation for the psychotherapy. In this theory, the different types of suffering in palliative care were classified into dimensions and subdimensions. The subdimensions were further clarified with the results from the 2 thematic analyses.[60,61] Additionally, a set of open-ended questions were formulated from the

Table 1. Matching of Health Care-Related Suffering to Potential Solutions.

Suffering caused by interactions with health care providers	Psychotherapy framework
Suffering due to lack of attention from health care providers	Presence
Suffering due to lack of listening from health care providers	Listening
Suffering due to lack of understanding from health care providers	Empathy
Suffering due to lack of understanding of feelings	*Emotional empathy*
Suffering due to lack of understanding of thoughts	*Cognitive empathy*
Suffering due to lack of compassion from health care providers	Compassion
Suffering due to lack of communication from health care providers	*Compassionate communication*
Suffering due to lack of communication of medical information	*Compassionate communication of medical information*
Suffering due to lack of communication of empathy and hope	*Compassionate communication of empathy and hope*
Suffering due to lack of competence in caring	*Compassionate action*
Suffering due to lack of competence in palliative care	*Compassionate action in palliation of suffering*
Suffering due to boundary issues	Boundary awareness

theory of suffering to guide the assessment of suffering. Next, examples of palliations to address the different types of suffering were presented.

Second, drawing from the results of a secondary thematic analysis of 35 transcripts regarding suffering caused by interactions with health care providers, a framework of palliative psychotherapy was conceptualized by matching salient themes and subthemes from the study to potential solutions.[62] The matching was based on the concept of immediate inference in logic and was illuminated further in Table 1.[63,64]

Third, the principles of mindfulness were incorporated into the framework to form the application techniques of the psychotherapy. The landmark definition of mindfulness, that is, paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally, was conceptualized into 3 domains, deliberate attention (paying attention on purpose), present moment attention (paying attention in the present moment), and nonreactive attention (paying attention nonjudgmentally).[41] Based on these 3 domains, 3 techniques of directing attention, sustaining attention, and distraction monitoring were integrated into the psychotherapy framework.[65] These 3 techniques serve as a guide in the cultivation of the 3 domains of mindfulness in relation to the psychotherapy. The psychotherapy was given the name "mindfulness-based supportive therapy."

The 3 phases of conceptualization were done by the principal investigator, a palliative care physician. Another palliative care physician, 2 psychiatrists, and 1 psychologist were involved independently in the review of the psychotherapy. We believe that mindfulness-based supportive therapy (MBST) is a potentially useful psychological intervention in palliative care, specifically designed to address psychoexistential suffering of terminally ill patients. The foundation, framework, and application techniques of MBST will be elaborated subsequently.

The Foundation of MBST

The foundation of MBST, that is, the theory of suffering in palliative care, was formulated from merging of the existential–experiential model of suffering (patient based) and model of compassion suffering (family based) in palliative care, as in Figure 1. In the existential–experiential model, suffering arose from a complex interplay of various existential and experiential factors. These factors led to suffering when the suffering threshold was exceeded. Suffering threshold was defined as a unique, subjective, and dynamic point of beginning of suffering when events and experiences were perceived as suffering. When the suffering threshold was exceeded, existential events became existential suffering and existential experiences became experiential suffering. While existential suffering emphasized suffering seen from the perspective of existential events, experiential suffering emphasized suffering seen from the perspective of the inner experiences of the person. These existential events and existential experiences are shown at the top half of Figure 1.

Existential suffering was categorized into subdimensions of deprivational suffering and acquisitional suffering. Deprivational suffering, or suffering due to loss-related events, was further classified into subdimensions of differential suffering, dependent suffering, and empathic suffering. Differential suffering referred to suffering related to change and loss, such as loss of function, loss of independence, loss of job, change in quality of life, loss of hope, loss of confidence, and so on. These losses made patients dependent on their families. The perceived burdening of others, perceived uselessness, and embarrassment of receiving help were examples of dependent suffering. Empathic suffering occurred as a result of witnessing the stress and exhaustion of caregiving family members. On the other hand, acquisitional suffering, or suffering due to gain-related events, was categorized into subdimensions of terminal suffering, interactional suffering, and environmental suffering. Terminal suffering described suffering of gaining a terminal disease and facing dying. The sickness brought patients to seek treatment in the hospital and led to interactional suffering caused by unpleasant health care interactions and environmental suffering caused by disagreeable hospital stay.

For experiential suffering, the subdimensions were perceptual suffering and reactional suffering. The former referred to suffering related to sensory perceptions, and the latter referred to suffering related to emotions, thoughts, and unmet spiritual needs, corresponding to emotional suffering, cognitive

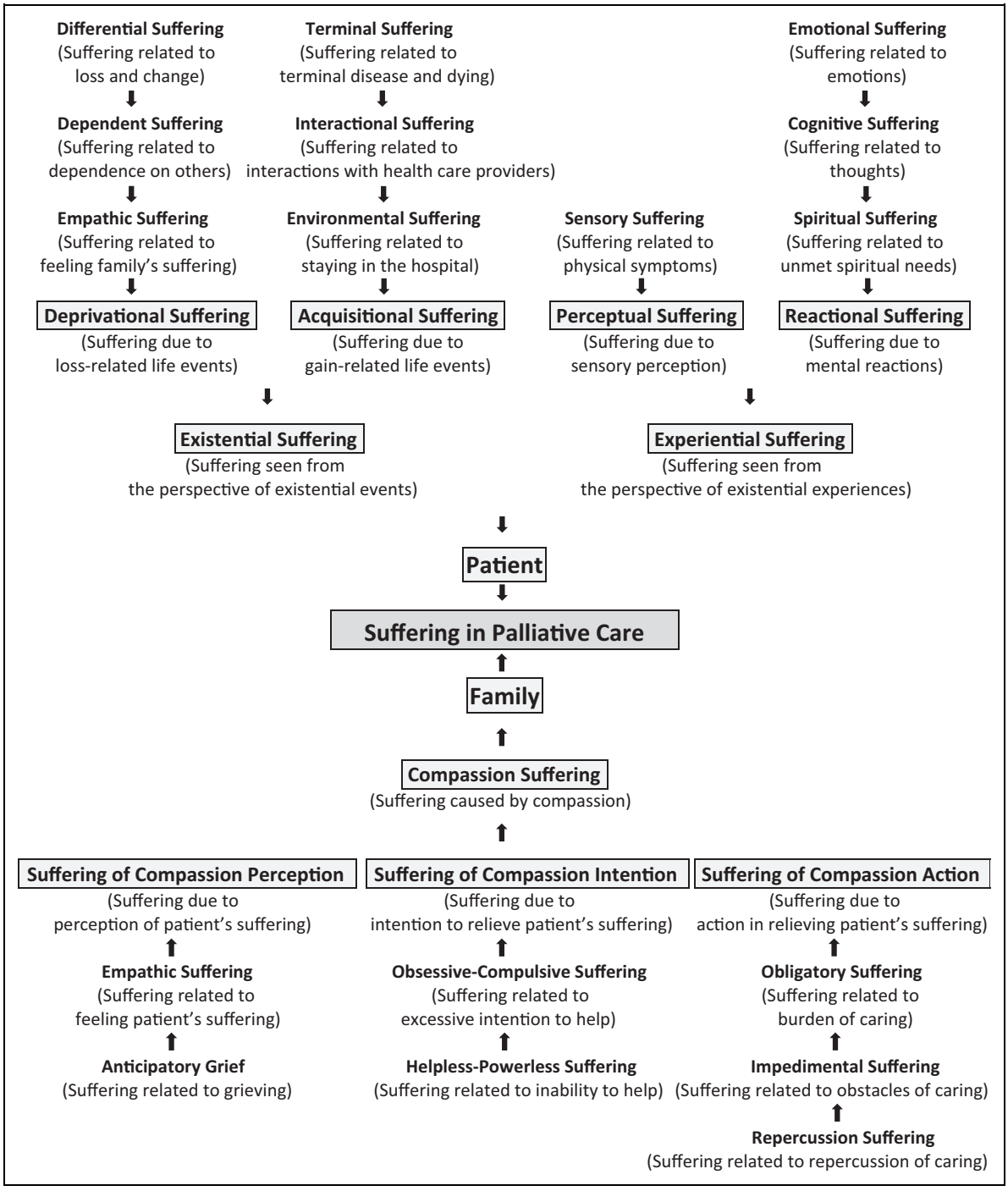

Figure 1. The theory of suffering in palliative care.

suffering, and spiritual suffering, respectively. Perceptual suffering was a crucial subdimension that represented the initial suffering caused by the contact between an existential event and the mind. Reactional suffering referred to "adventitious suffering" or "extrasuffering" created by the mind beyond the initial suffering, through emotional, cognitive, and spiritual reactions.

In the compassion model, suffering of palliative care informal caregivers was noted to be significantly different from that of the patients. Nevertheless, the suffering of patients and the suffering of caregivers were linked by compassion. Informal caregivers suffered by virtue of their compassion. Compassion suffering has 3 subdimensions, suffering of compassion perception due to perceiving patient's suffering, suffering of compassion intention due to the intention to relieve patient's suffering, and suffering of compassion action due to the action in relieving patient's suffering. Details of these 3 subdimensions are shown at the bottom half of Figure 1.

Table 2. Open-Ended Questions for the Assessment of Suffering.

General questions	
Patients	Caregivers
Can you tell me a little about your experience?	Can you tell me a little about your experience taking care of him?
How has this illness affected you physically?	How have you been affected physically?
What about your emotions?	What about your emotions?
How have your family been throughout your illness?	How have things changed in the family?
What about your friends?	What about your friends?
How do you find the doctors and nurses here?	How have the doctors and nurses been?
How is it like staying in the hospital?	How do you find the hospital?
What things do you believe in that are important to you now?	What things do you believe in that are important to you now?
Is there anything else that you would like to share with me about your experience?	Is there anything else that you would like to share with me about your experience taking care of him?

Specific questions (patients)	
Existential questions	Experiential questions
Differential suffering	Sensory suffering
Can you tell me a little about the changes in your life because of the sickness?	Tell me about your physical symptoms.
How has your routine changed?	How have your symptoms affected you?
Are there specific things that you are planning to do?	What are your concerns about the symptoms?
Dependent suffering	Emotional suffering
Tell me a little about your family support.	Tell me a little about your mood when you go through the sickness.
How about the support from your friends?	How are you affected by your emotions?
How do you feel about their care?	How do you deal with your emotions?
Empathic suffering	Cognitive suffering
What are your concerns for your family?	What are your beliefs regarding the sickness?
What are their routines now?	What are your hopes and expectations?
How is your family coping?	How do you come to terms with your sickness?
Terminal suffering	Spiritual suffering
What are your concerns regarding your sickness?	Are there things that you can't make sense when you experience the sickness?
What about your treatment?	How has your faith affected by the sickness?
What are your concerns about the future?	What support do you look for when life is difficult?
Interactional suffering	
How do you find the communication from doctors and nurses?	
How would you comment on the level of care you have received?	
What are your opinions regarding the knowledge and skills of doctors and nurses?	
Environmental suffering	
How do you find the hospital environment?	
How do you find the hospital food?	
What about the hospital facilities?	

Specific questions (caregivers)		
Compassion perception questions	Compassion intention questions	Compassion action questions
Empathic suffering	Obsessive–compulsive suffering	Obligatory suffering
Can you tell me a little about yourself when you see her getting sick?	Tell me about your expectations in taking care of him.	What are the things you do in caring of her?
What was it like for you when she talked about her sickness?	What about your hopes?	What else did you do in caring of her?
What are your concerns for her?	What are your priorities in taking care of him?	How do you cope with these duties?
Anticipatory grief	Helpless–powerless suffering	Impedimental suffering
How do you feel when you think about her sickness?	What do you think about the support from your family members?	What are your challenges in caring of her?
How was it like when you thought about her future?	How about the support from your friends?	How about challenges from the family?
Is there anything that you feel you cannot express in front of her?	What do you think about the support from the nurses and doctors?	What about challenges from the health care system?
		Repercussion suffering
		How are you affected by your involvement?
		What about your social life?
		How do you take care of yourself?

Table 3. Types of Suffering as a Guide in the Diagnosis of Suffering.

Suffering (patients)			
Existential suffering		Experiential suffering	
Deprivational suffering	Acquisitional suffering	Perceptual suffering	Reactional suffering
Differential suffering Loss of physical function Loss of independence Loss of freedom Loss of sense of control Loss of job and income Loss of role Loss of normality Loss of quality of life Loss of future Loss of hope Loss of confidence Loss of fighting spirit Anticipated loss Dependent suffering Dependence on family Dependence on friends Dependence on doctors/nurses Perceived burdening of others Perceived uselessness Embarrassment of dependence Loss of self-image because of dependence Anticipated dependence Empathic suffering Witnessing family stress Physical exhaustion Emotional exhaustion Helplessness Grief Lack of self-concern in family Concerns about family future	Terminal suffering Diagnosis of terminal illness Disease progression Multiple recurrence Multiple complications Fear of dying Fear of suffering Fear of the unknown Near-death experiences Short estimated life span Dying young Unfinished business Interactional suffering Lack of full attention Lack of immediate attention Lack of listening Lack of empathy Lack of information Different information from different teams Poor communication Hearing "nothing more can be done" Perceived lack of competency Lack of efficiency Lack of coordination of different teams Lack of consideration from medical students Environmental suffering Hospital confinement Mobility restriction because of lines and tubes Boredom in hospital Loneliness in hospital Noisy hospital environment Unpalatable hospital food Witnessing suffering of others Witnessing death	Sensory suffering Various physical symptoms Impact of symptoms Physical functions Mental functions Routines Social activities Employment Sleep Family Sense of impending death due to exacerbation of symptoms Desire to die due to refractory symptoms	Emotional suffering Shock Surprise Worry Fear Anger Frustration Boredom Sadness Loneliness Regret Cognitive suffering Acceptance-denial spectrum Complete nonacceptance Partial acceptance Choiceless acceptance Hope–hopelessness spectrum Hope for cure Hope for survival Hope for function Hope for comfort Hope for peace Hope for sooner death Hopelessness Spiritual suffering Unanswered questions Reason of having the disease Reason of having to suffer Reason of having to die Contribution of past actions Time of death The unknown after death Loss of faith Religious doubts Spiritual loneliness
Suffering (caregivers)			
Compassion suffering			
Suffering of compassion perception	Suffering of compassion intention	Suffering of compassion action	
Empathic suffering Empathic suffering from seeing Seeing suffering of patient Physical suffering Functional decline Emotional suffering Treatment-related suffering Death and dying Seeing family stress Tiredness in the family Sadness in the family Denial in the family Seeing suffering of other patients Abandonment by family	Obsessive–compulsive suffering Compassion obsession Obsession with giving the best care Obsession with giving 24-hour company Obsession with pleasing patient Obsession with motivating patient Ignoring career Ignoring job and income Ignoring own social life Ignoring own health Concealing own grief Concealing own exhaustion Avoidance of discussion of sickness in front of patient	Obligatory suffering Companionship burden 24-hour company Overnight company Final days company Final moments presence Functional burden Functional assistance Activities of daily living Instrumental activities Unfinished business Decision input Financial burden Expenses	

(continued)

Table 3. (continued)

Compassion suffering		
Suffering of compassion perception	Suffering of compassion intention	Suffering of compassion action
Empathic suffering from hearing	Avoidance of discussion of death and dying in front of patient	Treatment
Hearing bad news from doctors	Existential obsession	Hospitalization
Terminal diagnosis	Obsession with keeping patient alive	Medical equipment
Abnormal blood results	Seeking multiple medical opinions	Traditional medicine
Disease progression	Seeking alternative medicine	Daily necessities like milk and diapers
Additional chemotherapy	Seeking various nutritious food	Cheer-making burden
Coma	Pressurizing medical team to treat	Making patient happy
Short prognosis	Committing to do good	Family gatherings
Hearing expression of suffering or dying from patients	Performing life-prolonging rituals	Outdoor activities
Expression of unbearable suffering	Praying for miracle	Impedimental suffering
Expression of the desire to give up	Willingness to sacrifice own life	Patient-related obstacles
Expression of death and dying	Doing compulsion	Difficult circumstances
Empathic suffering from worrying	Compulsion to do something for patient	Excessive dependence
Worrying about patient	Not comfortable in doing nothing	Bad temper
Pain and suffering	Not comfortable in sitting down and cry	Conflict in opinion
Nutritional status	Doing something without knowing benefit	Desire to die
Complications	Doing something despite own exhaustion	Confusion state
Side effects of treatment	Helpless–powerless suffering	Withdrawal from external world
Prognosis	Lack of information	Lack of appreciation from patient
Worrying about other family members	Not knowing what to do	Complaints from patient
Grief in the family	When patient is getting weaker	Family-related obstacles
Anticipatory grief	When patient is dying	Family conflict
Perceived impending death of patient	When patient is not eating	Continuation versus stopping treatment
Perceptions	When patient is not talking	Conventional versus alternative treatment
Recognizing dying	When patient is restless	Different alternative medicine options
From knowing the incurability of sickness	When patient is in pain	Different levels of acceptance in the family
From discontinuation of treatment	When patient insists to go home	Different levels of involvement
Witnessing dying	Not knowing what to say	Different ways of caring
Seeing patient deteriorates	When patient expresses	Health care-related obstacles
Seeing patient eats less	Unbearable suffering	Information issues
Seeing patient talks less	Burdening of family	Lack of medical information
Seeing patient sleeps most of the time	Knowledge about their impending death	Disease
Seeing patient stops responding to call	Desire to give up	Complications
Cognitions	Desire to die	Side effects of treatment
Hopes for patient	Unwillingness to die	Updates on progress of patient
Hope for cure	Not knowing what to expect	Lack of opportunity to meet doctors
Hope for survival	Not knowing how long patient can live	Interaction issues
Hope for function	Lack of support	Poor communication
Hope for quality of life	Lack of support	Lack of listening
Hope for a good after-life	Assisting patient functionally	Lack of sensitivity
Hopelessness	Temporary relief	Lack of hope-giving
Hopes for oneself	Overnight relief	Lack of nonabandonment reassurance
Hope to return to a normal life	Home medical support	Being told “nothing much can be done”
Hope to be there during patient’s death	Home nursing support	Paternalistic communication
Beliefs	Difficulty to get support	Lack of empathy
Belief in staying positive	Everyone has own commitment	Lack of compassion
Belief in decision of God	Lack of leave during year end	Poor attitude
Denial	Dispute in scheduling care	Institution issues
Complete denial	Fear of troubling others	Long waiting time
Partial denial	Belief that help should be voluntary	Noisy hospital environment
Emotions	Dissatisfaction with support	Witnessing suffering of others
Shock	Nonsupportive family	Witnessing death
Fear	Family members are not doing enough	Repercussion suffering
Anxiety	Not talking to patient	Personal life repercussion
Sadness	Not motivating patient	Physical exhaustion
Frustration	Not cheering patient up	Psychological exhaustion
A mixture of emotions	Criticism from family and friends	Sadness
Perceived impending absence of patient	Criticism in the way of caring	Worry
Current absence	Criticism in sacrificing personal job to take care of patient	Rumination
Absence of company during daily activities		Guilt
		Regret

(continued)

Table 3. (continued)

Compassion suffering		
Suffering of compassion perception	Suffering of compassion intention	Suffering of compassion action
Absence of company at home		Fear
Absence of company for talking		Countertransferences
Absence of company for support		Fear of getting cancer
Role substitution		Fear of dying
Perceived absence when patient is noncommunicative		Fear of burdening family in the future
Future absence		Sleep disturbances
Anticipated loneliness		Loss of freedom
Anticipated quietness		Loss of personal time
Anticipated sadness		Spiritual suffering
Anticipated aimlessness		Questioning "why me?"
Anticipated supportlessness		Questioning God
Anticipated life changes		Social life repercussion
Concerns about new life		Loss of family life
		Loss of socialization with friends
		Loss of recreational activities
		Loss of promotion
		Loss of job

The suffering of compassion perception was further classified into subdimensions of empathic suffering and anticipatory grief. Empathic suffering occurred when caregivers were feeling patients' suffering. Anticipatory grief occurred when caregivers were anticipating impending loss of their loved ones. The suffering of compassion intention included obsessive–compulsive suffering related to the excessive intention to help and helpless–powerless suffering related to the incapacity to help. For the suffering of compassion action, the 3 subdimensions were obligatory suffering, impedimental suffering, and repercussion suffering. Obligatory suffering referred to the burdens of taking care of patients. Impedimental suffering referred to the obstacles of caring. Repercussion suffering referred to the disruption of caregivers' lives because of caregiving.

Based on this theory of suffering (Figure 1), open-ended questions were formulated to guide the assessment of suffering (Table 2). Types of suffering were tabulated to guide the diagnosis of suffering (Table 3). Additionally, examples of interventions were given to guide the palliation of suffering (Table 4).

Table 4. Examples of Interventions in the Palliation of Suffering.

Types of interventions (patients)
Existential interventions
Differential suffering—rehabilitation
Dependent suffering—mobilizing support and resources
Empathic suffering—care of caregivers
Terminal suffering—disease-modifying treatment
Interactional suffering—communication training of health care providers
Environmental suffering—patient-centered hospital design
Experiential interventions
Sensory suffering—symptom control
Emotional suffering—supportive listening, emotional processing and relaxation techniques
Cognitive suffering—supportive listening, cognitive restructuring and hope fostering
Spiritual suffering—spiritual support, pastoral care and nonabandonment
Types of interventions (caregivers)
Perception interventions
Empathic suffering—palliation of patient's suffering
Anticipatory grief—supportive listening
Intention interventions
Obsessive–compulsive suffering—self-care emphasis, supportive listening, and shift of curing to caring duties
Helpless–powerless suffering—information giving and mobilizing support
Action interventions
Obligatory suffering—mobilizing support and respite care
Impedimental suffering—conflict resolution, family meeting, and communication training of health care providers
Repercussion suffering—self-care emphasis and social connection encouragement

The Framework of MBST

A total of 12 relevant themes and subthemes of suffering caused by health care interactions were selected for the construction of a framework for psychotherapy through matching each item to its potential solution, as in Table 1. The framework consisted of 5 components, (1) presence, (2) listening, (3) empathy, (4) compassion, and (5) boundary awareness. These 5 components and its subcomponents were illustrated in Figure 2. The MBST framework is elaborated subsequently, together with relevant italicized narrative examples selected from the 35 transcripts.[62]

Presence

Presence is the first and foremost requisite for a therapeutic relationship. From the results of the secondary analysis of 35 transcripts regarding suffering caused by interactions with health care providers, presence was noted to be lacking when patients needed it most.[62] As 1 patient with metastatic breast cancer said, "*I need someone to just walk in, and talk to me, and teach me, and take away my fear. The fear is the one that I'm scared of. It's not helping me. So far nobody can help me except the*

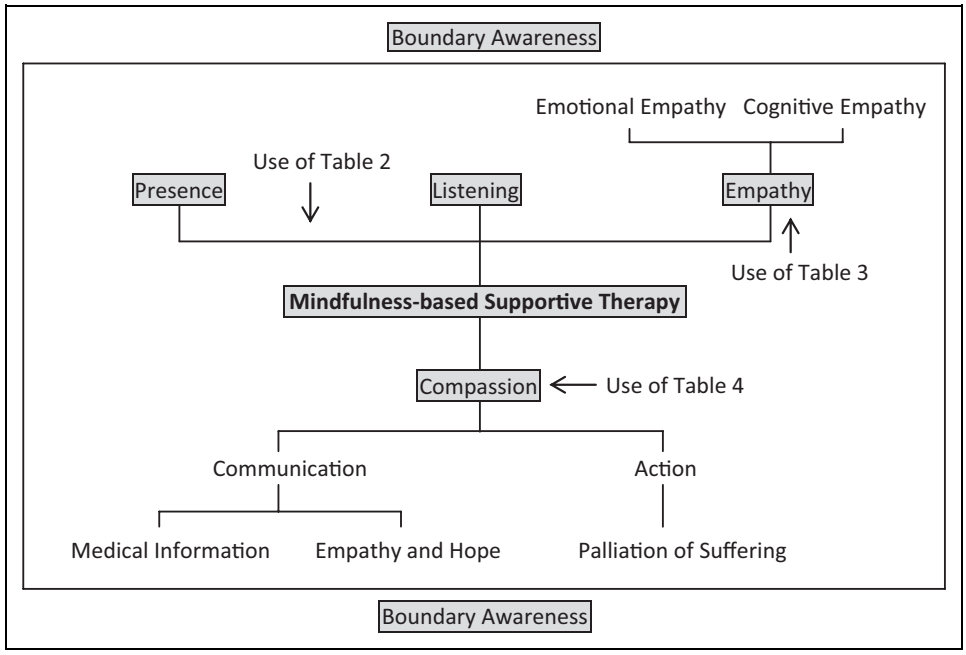

Figure 2. Conceptual framework of mindfulness-based supportive therapy.

medication. But then for the fear, every day, every day, every day I'm crying. The pain, I just don't know what to do about it. That's why I say, I just want to die now. I can't stand it any longer. This is it. I can't stand it any longer." Worst was when patients' calling were ignored, as described by a patient with renal cell carcinoma, "*I don't like staying in the hospital. I don't know why. I can tell you one thing. Once I was in a general ward, I told the nurse to lower down the bed. The second time I told her, 'Please lower down the bed a bit'. She still ignored me.*"

Sometimes patients remarked on the rush presence of health care providers, like "*Doctors being doctors, they have a short period of time. So, you are only going to get what is at the forefront of their mind. You are not going to get the entire picture."* At other times, presence was described as untimely, *"I don't want anybody to come when I want to sleep. If I'm tired, you come here. It's not the right timing.*"

Listening

Listening is a crucial component of communication skills. It requires the listeners to provide their undivided attention on the narratives of the speakers, free from any personal preoccupation, judgment, or distraction. The lack of listening from health care providers caused 1 caregiver to express his discontentment as followed, "*Okay, the nurses, there are some fundamental problems . . . They don't have the training. They don't have the attitude. They don't follow training. They don't listen and don't learn.*" Without listening, health care providers would not understand the underlying suffering of patients, like the words of a young leukemic girl, "*The most difficult thing about being sick is the feeling. It is very hard to describe it with words. It is very painful. It is full of suffering.*"

Without listening, the pain of her father would not be known, as in the following description, "*She is my only daughter. Do you know what she said? 'Papa, please give up on me. I can't stand the sixth round of chemotherapy already. Papa, if I go for the seventh, I will die.' She said, 'Papa, I'm telling you, I can't stand it anymore—the breathing, the chest pain. It's very painful. I can't stand it already. Papa, I want to die, Papa.' . . . I am looking for other way to cure my daughter. I will try my very best. I won't give up. I won't give up. I will find another way to save her life. Bad life, I don't believe. If you ask me, if I can sacrifice anything or do anything, I will do it. I can do anything for her. I mean not like robbing people, not that kind of things. But like parent giving kidney. If something can be taken out from my body to save her life, I will do it.*"

Empathy

Empathy is the ability to understand another's situation, perspective, and feelings.[66] Without putting ourselves in patients' shoes, it is difficult for us to understand what patients are going through, as expressed by a patient with breast cancer, "*Sometimes I feel lonely. No one knows my pain. Maybe they can see, they know, or see something, but they can't hundred percent understand what is happening inside me. They don't understand my actual experience. They don't know what is actually happening to me physically and emotionally. Maybe they know I'm upset, they know I'm in pain, but they can't understand, that is not their experience. They won't really feel it.*"

Due to the lack of empathy, health care providers were described by a caregiver as "emotion-less", *"I don't know about the nurses. They are human, right? So, I think, they have to deal with sick people every day. They can be quite 'emotion-*

less', or 'feeling-less'. I mean, imagine that every day you need to poke somebody, you need to do the job, and you need to do it fast; so, sometimes when my mother's crying in pain, they can't help it. They need to do it. There're so many patients." One patient with esophageal cancer commented, *"I argued with the doctor. She said, 'I have seen worse cases than yours.' You have seen many cases, but you haven't tried. Try not to eat 1 week and see what happens.*"

Without empathy, health care providers cannot understand the emotional experiences of patients, termed emotional empathy in this article. For example, 1 patient said, "*I am scared of a lot of things. I am scared of dying, scared of nobody going to take care of me because I am not married, scared of troubling people for taking care of me. So many things I am scared of. I am scared of needles. They are going to poke me. I don't know. I know this is the end of me. So, I hope it is fast, so that I don't have to suffer anymore. I don't want to suffer anymore. That's all.*"

Likewise, cognitive experiences of patients, such as beliefs, worries, and hopes, cannot be comprehended in the absence of empathy—termed cognitive empathy. Examples were (1) Belief—"*Suffering? I try to take it. I try to accept it because pain comes from God.*" (2) Worry—"*Of course I am worried. I worry about my future. If I cannot walk, then what can I do? How about my children? How long do I still need to depend on others?*" and (3) Hope—"*Of course the disease cannot be cured. But we can talk about prolonging. And then, prolonging, not just prolonging by hanging on drips and lying on hospital beds, but prolonging by making sure that there is still quality of life.*"

Compassion

Compassion is defined as the feeling that arises when witnessing another's suffering and that motivates a subsequent desire to help.[67] It comprises an intention to relieve another's suffering, coupled with the course of action taken in relieving it. Sometimes it is not the knowledge and skills of health care providers that are lacking but compassion. A caregiver said, "*The doctors are very good. But shall we say, some of them, or all of them could use a little bit more compassion perhaps. They are highly trained, you can see that they know what they do, they know precisely what to do but sometimes, they lack a little bit of compassion.*"

Compassion in communication and palliation of suffering were conceptualized as subcomponents of compassion (Table 1). Communication deficiencies included a lack of medical information as well as a lack of communication of empathy and hope. Regarding a lack of information, a caregiver commented, "*There's not a lot of patient information available. The only comments that you are going to get are verbal comments from the doctors and perhaps a limited amount of simple information.*"

Regarding empathic communication, health care providers were criticized of being too insensitive, as commented by the wife of a patient, "*He keeps on complaining that certain doctors are so direct in talking. They tell you right to the point of how many months you have left. I feel that they shouldn't tell right in front of him because having told him that he has cancer is already bad enough. And then you tell that he has how many more months to live. It's quite difficult for him to take it.*" Communication of hope was also lacking from the description of a caregiver who said, "*The doctor explained everything, and said, 'There is no more hope already', you know . . . But I still hope to find an alternative to cure my daughter.*"

As far as palliation of suffering is concerned, the lack of competence in palliating various physical and psychoexistential suffering was noted. One lady reported, "*I don't know how to express it. It was terrible. I had never felt such pain in my whole life before.*" Another girl said, "*First, you lose your hope. Then you lose your confidence. Then you feel like you've lost everything. You feel like you've lost everything because when you get this thing, maybe you'll die one day . . . Actually, I'm not scared of dying. How to say? It's like I haven't done many things, then I have to die. Do you understand this feeling? It's like I haven't done many things and I haven't tried many things in my life, then suddenly I've to die.*"

Boundary Awareness

Professional boundaries are defined as the mutually understood, unspoken, physical, and emotional limits of the relationship between the trusting patient and the caring physician or provider.[68] Although sometimes crossing boundaries can enhance compassionate care, boundary awareness is essential in order to avoid boundary issues that are deleterious to the therapeutic relationship. Common examples in palliative care include the request for futile treatment, extraordinary treatment, and the hastening of death as described in the following 3 narratives: "*I will try my best. Like, yesterday, my mother's blood pressure crashed to eighty-seven. So, it's quite worrying. I mean, I could just let go and wait for the time to come. But no, I will try. I told myself I will try my best. I called the nurse to make sure that everything else had been done." "We do some research. We scout out some options, and then we push them back to the doctors and say, 'Think about this. Can we look at doing this? Is it going to give us some benefit? Is it going to allow us to get in control of certain situations?' So we will push the doctors' boundaries because it may be stuff that they haven't actually done before." "I don't want others to take care of me until the end. I hope I can get better and I can deal with these problems myself. If one day I really cannot handle these problems, I wish doctors can help to relieve my suffering. That means to end my life.*"

The Application Techniques of MBST

In contrast to most mindfulness-based psychotherapies that require patients to cultivate the practice of mindfulness, MBST focuses on cultivation of therapist mindfulness. The 3 domains of mindfulness—deliberate attention, present moment attention, and nonreactive attention—can be cultivated through the 3 application techniques of directing attention, sustaining attention, and distraction monitoring, as

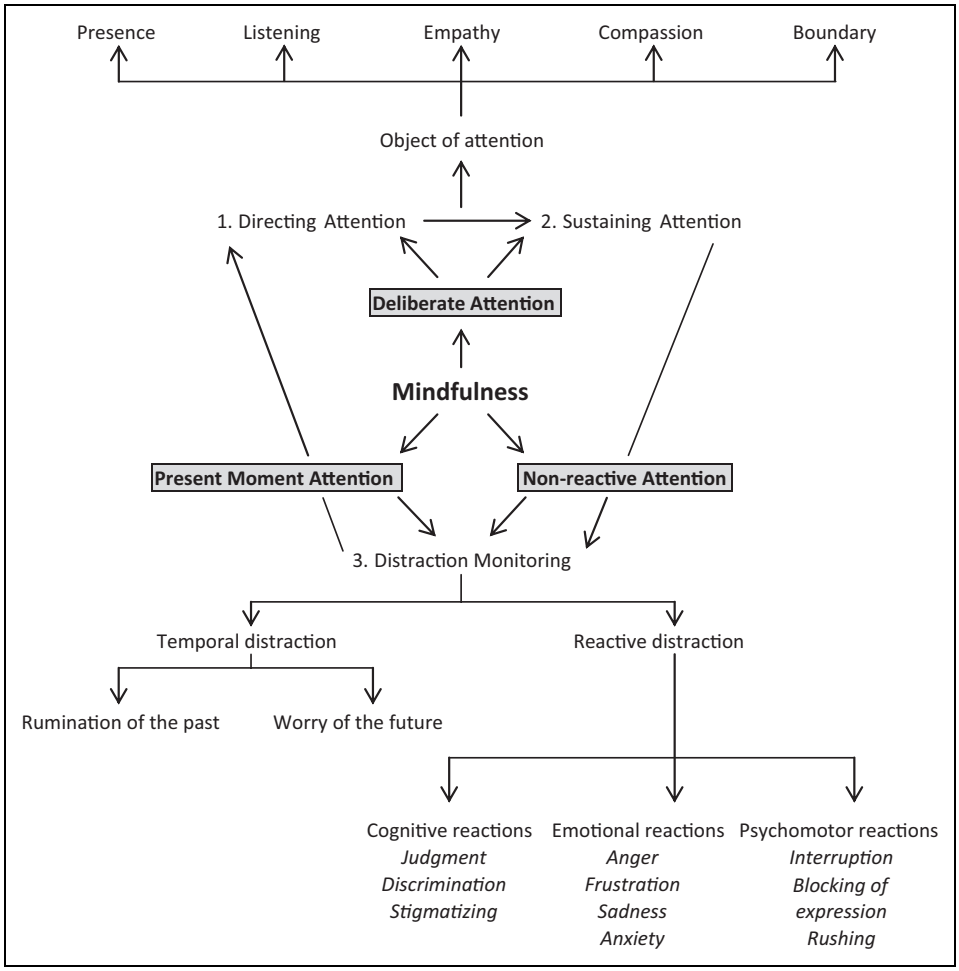

Figure 3. Application techniques of mindfulness-based supportive therapy.

shown in Figure 3. Directing attention involves the orienting of attention to any component of MBST. Sustaining attention involves maintaining the attention vigilantly. These 2 techniques are useful in the cultivation of deliberate attention. As for distraction monitoring, it is used to notice the 2 forms of distraction—temporal distraction (cultivation of present moment attention) and reactive distraction (cultivation of nonreactive attention). Temporal distractions include rumination of the past and worry of the future. Reactive distractions comprise cognitive reactions like judgment, discrimination, or stigmatization; emotional reactions like anger, frustration, sadness, or anxiety, and psychomotor reactions like interruption, blocking of expression or rushing, and so on. Once distraction is noticed, the cycle is repeated by gently redirecting one's attention back to the object of attention and resustaining the attention.

Although manualization of MBST is beyond the scope of this article, attempt was made to elaborate the application techniques of the 5 components of MBST in a systematic, stepwise fashion. Prior to this elaboration, we introduce mindful breathing as the fundamental practice that serves to anchor the 5 components of MBST together. Mindful breathing involves focusing our attention on the unmanipulated in and out breath and sustaining the attention. Once distraction is noticed, gently return our attention to the breath and start again without judging ourselves. Alternatively, we can repeat a silent verse in our mind before the practice: *Breathing in, I know I am breathing in. Breathing out, I know I am breathing out.*

Mindful Presence

Mindful presence is paying attention to presence, on purpose, in the present moment, and nonreactively. First, we begin with mindful breathing to center ourselves. As we breathe naturally, we bring our attention to rest gently on our in and out breath. We bring our mind and body together by resting our attention on our breath for a few times. Then, we direct our attention to presence deliberately. In mindful presence, we are completely aware of our own presence and the presence of others. We feel more alive by coming back to our senses, and we make others feel more alive too. We sustain our attention on this collective presence, just like we are there completely for patients. We are also mindful of maintaining our eye contact with the patients from moment to moment.

Mindful presence is an *unhurried presence*. Instead of thinking about the past or the future, we sustain our attention on

what is happening right now. Our only agenda is to offer our full presence for patients. If we notice any distractions, as when we are judging patient (cognitive reaction), feeling anxious (emotional reaction), or rushing (psychomotor reaction), we breathe and relax again into our presence. The practices of orienting our attention to presence, sustaining the attention, and noticing distraction before calmly returning the attention to presence constitute the practices of mindful presence. In the palliative care setting, sometimes our presence may be the only thing patients need from us.

Mindful Listening

Mindful listening is paying attention to listening, on purpose, in the present moment, and nonreactively. In the practice of mindful listening, we listen attentively to patients' narratives. We listen in a way as if we and the patient are the only persons in the world. Again, we use our breath as an anchor of our attention. Every time we remember we are breathing, we come back to ourselves from thinking about the past or future, and direct our attention to listening again. Sometimes patients suffer because no one is able to listen to them. When their suffering accumulates, it can become so unbearable that they desire to die sooner. Therefore, we must create a safe space for them to express their suffering and release their pain. We practise mindful listening to understand their experiences and bitterness. We pay attention to the verbal and nonverbal elements of their speeches. We pay attention to their facial expressions and body language. Additionally, we also pay attention to transference, the inappropriate reactions of patients to us and, countertransference, the totality of our psychological reactions to patients.

Mindful listening is a practice of *silent listening*. If we are distracted by our own psychological "noises," we breathe and accept them as they are, without reacting further to them. These "noises" include cognitive reactions like judgment and automatic thinking; emotional reactions like sadness, boredom, and frustration and psychomotor reactions like interruption, talking, and giving advices. If we really need to interrupt, we do so with the full awareness that we are interrupting as a necessary response rather than an automatic reaction. Similarly, communication facilitations such as head nodding, filler words, clarification, and paraphrasing are used only when it is necessary, with full awareness.

Mindful Empathy

Mindful empathy is paying attention to imagining oneself in another's perspective, on purpose, in the present moment, and nonreactively. Through listening to patients and observing their nonverbal cues, empathic imagination can be practiced to "enter into" the feelings and perspectives of patients. We begin the practice of mindful empathy by paying attention to our breath deliberately. After a few breaths, we direct our attention to imagining ourselves as patients. We pay attention to the existential and experiential descriptions of their suffering in order to understand their experiences without any distortion from our own views, opinions, or agendas. And we sustain the attention from moment to moment. Existentially, we imagine going through those lose-related and gain-related events narrated by patients. Experientially, we imagine the inner experiences triggered by those events, physically, cognitively, emotionally, and spiritually, as described by patients.

During empathic imagination of patients' inner experiences, it is crucial to differentiate those that are described by patients and those that are extrapolated by our imagination. Caution is made not to "overimagine," overgeneralize, or catastrophize the situations. Regarding the inner experiences, the volitional aspect of the cognitive experiences of patients need special attention, because it helps us to understand the hopes, wishes, expectations, and preferences of patients. In this way, we can then understand what patients want us to say or do for them.

Mindful empathy is a practice of *objective empathy*, where we observe the unfolding of the subjective empathic experiences objectively in our mind without adding any notions, ideas, judgments, or preconceptions of our own. Distractions in the form of judgment (cognitive reaction), vicarious emotion (emotional reaction), and blocking of expression (psychomotor reaction) are monitored. Once we notice any distraction, we let it be as it is without reacting further and gently return our attention to empathy. The practice of mindful empathy involves the conscious allowing of all cognitive, emotional, and behavioral reactions from patients without blocking it. The allowing can be in the form of silence, acknowledgment, validation, or normalization.

Mindful Compassion

Mindful compassion is paying attention to cultivation of the intention to help others and paying attention to the actual communication and actions in helping others, on purpose, in the present moment, and nonreactively. First, we practise mindful breathing to anchor our attention. Then we consciously cultivate the sincere motivation to alleviate patients' suffering. We may find it helpful to make the following vow silently in our mind: *Aware of your suffering caused by unpleasant events and experiences, I vow to cultivate compassion in order to relieve you from your suffering, and bring happiness and joy to you.* We pay attention to the thoughts and feelings of compassion that arise. And we let these thoughts and feelings manifest in our speech and action. With the aid of cognitive empathy, particularly the volitional aspect, we speak and act mindfully in consistence with the hopes, wishes, expectations, and preferences of patients. We remain cautious from moment to moment not to speak or act unwisely and add further suffering to patients.

Mindful compassion is a *process-orientated compassion*. It focuses on the process of compassion rather than the goal. Common distractions that can arise during the practice of mindful compassion include cognitive reactions like being judgmental, being obsessive with care, having excessive concern in fixing the suffering and excessive attachment to the goal

of relieving suffering; emotional reactions like excessive emotional involvement, the guilt of not doing enough and the feelings of helplessness and incompetence and psychomotor reactions like the compulsion to do something to relieve the suffering, excessive visits to patients due to positive countertransference or guilt of not doing enough, and avoidance of patients due to negative countertransference. Once we notice any distraction, we breathe and stop reacting, and gently bring our attention back to our breath, and then to compassion.

Mindfulness of Boundaries

Mindfulness of boundaries is paying attention to our professional boundaries, on purpose, in the present moment, and nonreactively. Paying attention to our breath gives us a focus point to return our awareness to the present moment and prevent ourselves from being lost in our habitual thoughts. Once we are centered and focused, we can direct our attention purposely on boundary issues that arise during our practices of presence, listening, empathy, and compassion. We consciously monitor our physical and emotional limits of the relationship between patients and us. We consciously maintain our awareness when boundaries are approached. After careful reflection, we cross boundaries consciously only if we are convinced that crossing boundary in a particular situation is beneficial to patient and the therapeutic relationship, without violating our professional conduct or compromising the equity of patient care.

Mindfulness of boundaries is a practice of *self-awareness*. It is a practice of simultaneously attend to the care of patients and the care of ourselves. Distractions can be in the form of cognitive reactions like judging patients for unreasonable requests, judging ourselves for failure to fulfill their requests; emotional reactions like guilt and helplessness and psychomotor reactions like the compulsion to cross boundaries and the avoidance of patients due to boundary issues. When we notice these automatic reactions, we breathe and stop reacting further. Sometimes, we may even need to bring these issues to the awareness of patients so that we can work through it together as thoughtful responses rather than habitual or impulsive reactions. Hence, mindfulness of boundaries protects us from burnout caused by various factors, such as work overload and time constraint (presence), distressing inappropriate transferences and countertransferences (listening), vicarious traumatization (empathy), and compassion fatigue (compassion).

Discussion

Mindfulness-based supportive therapy is a novel psychotherapy conceptualized to address psychoexistential suffering in palliative care. The theory of suffering in palliative care (Figure 1) provides a foundation for MBST in the assessment of suffering (Table 2), diagnosis of suffering (Table 3), and palliation of suffering (Table 4). Compared to most suffering assessment tools that apply quantitative methods in measuring suffering, the current article proposes a qualitative approach in the form of narratives in the assessment of suffering.[69,70] This approach can add further depth to our understanding of the unique suffering experiences of patients and their families. Furthermore, in contrast to most studies that classified suffering based on the biopsychosocial–spiritual/existential model, suffering was categorized into existential and experiential dimensions for patients and compassion perception, intention, and action dimensions for families.[60,61,71-73] For patients, this categorization allows the development of existential interventions that target threats or existential events, and experiential interventions that focus on the experiences of damage to the physical, emotional, cognitive, or spiritual integrity of the affected person. If the existential dimension of suffering is irremediable, greater attention can be put on the experiential dimension. If the perceptual component of experiential suffering is refractory to symptomatic treatment, then greater emphasis can be put on the reactional component—the ''adventitious suffering,'' ''extra-suffering,'' or ''unnecessary suffering,'' whichever term we use. For families, a triple approach that targets perception, intention, and action of compassion can be applied to support family caregivers throughout their journeying with patients.

The quality of the therapeutic relationship is crucial to positive outcomes across different psychotherapies.[74,75] Palliative care providers who are able to establish good therapeutic relationships are more likely to reduce suffering of patients and their families. The 5 components of MBST—presence, listening, empathy, compassion, and boundary awareness—provide palliative care professionals with a framework for the cultivation of a supportive relationship with patients and families. This supportive relationship is important in every palliative care encounter since supportive therapy was reported to be the mainstay of treatment of existential suffering for the terminally ill.[76] In a review, supportive–expressive group therapy was found to be the only probably efficacious treatment among various palliative psychotherapies.[77]

Presence has been described in the literature to be therapeutic in its own sense.[78-82] At times, presence can be the only reassurance patients need from us, as described by the following quote, ''*Suffering is not a question which demands an answer, it is not a problem which requires a solution, it is a mystery which demands a presence.*''[83] The physical presence of ''being there'' and the psychological presence of ''being with'' are crucial in the alleviation of suffering. No matter how knowledgeable or skilful palliative care providers are, if they cannot offer their presences during time of needs, it would be difficult to reduce the suffering of patients or their families. The practice of mindful presence reduces the tendency to rush during time-limited encounters and the discomfort of presence in difficult situations.

Although presence emphasizes ''being'' as opposed to ''doing,'' the second component of MBST highlights ''listening'' rather than ''talking.'' Listening is an integral part of whole person care. It is a form of treatment for psychoexistential suffering.[84-87] Although listening to medical cues is important to understand the biomedical aspect of suffering, understanding of suffering will be incomplete without listening to patients' emotions, beliefs, concerns, and preferences or their hopes, dreams, and passions.

Without listening, empathy that involves attuning ourselves to be in touch with the inner experiences of patients cannot be achieved. Furthermore, the practice of mindful listening can help to reduce the tendency to interrupt and prevent inappropriate countertransference reactions from listening.

Empathy is an important predictor of psychotherapy outcome.[88] It allows the therapists to see the world from the perspectives of patients. In this article, cognitive empathy refers to the capacity to understand another's perspective in terms of beliefs, concerns, and preferences; emotional empathy focuses on understanding the language of emotions of patients. The former helps us to understand how patients see their suffering, what are their worries, and what do they want us to do for their suffering. Each understanding of the cognitive experiences can be further consolidated by the latter emotional experiences of patients. Additionally, mindful empathy can facilitate the development of a witnessing consciousness likened to the observing self in psychodynamic therapy. This reduces personal interpretation of patients' experiences, projection of personal experiences on patients, and arising of vicarious emotional reactions.

Compassion is the cornerstone of all therapeutic relationships. Although most health care providers are genuinely compassionate, it is not uncommon for their compassion to gradually lessen with time due to various reasons, such as heavy workload, stressful organizational problems, difficult encounters, or repeated exposure to unresolvable suffering. The state of exhaustion and dysfunction as a result of prolonged exposure to the stress of caring is termed compassion fatigue.[89] The practice of mindful compassion enables health care providers to renew their compassionate motivation again and again during each MBST session. It allows health care providers to become fully aware of what to say and what not to (compassionate communication) and aware of what to do and what not to (compassionate action) in addressing suffering of patients and their families. It also helps to mitigate compassion fatigue due to the full engagement in the present moment in a nonreactive manner.

Boundary issues are common in palliative care. Examples are like receiving gifts from patients, giving out phone numbers to patients, socializing with patients outside of clinical settings, and revealing excessive personal information to patients.[90] Boundary awareness is absolutely important in all therapeutic encounters to avoid boundary crossings that are harmful to patients or health care providers. In relation to empathy, mindfulness of boundaries resonates with the description of exquisite empathy in the literature, the highly present, intimate connection with patients and caregivers without losing awareness of one's own professional boundary.[91] Similarly, when mindfulness of boundaries interfaces with the other 3 components of MBST, the results can be extrapolated as exquisite presence, exquisite listening, or exquisite compassion.

Directing attention, sustaining attention, and noticing distraction of MBST offer health care providers 3 simple steps in cultivating deliberate attention, present moment attention, and nonreactive attention of mindfulness. Compared to MBSR, an 8-week intensive program with a variety of formal and informal mindfulness practices,[92] MBST allows health care providers to practice mindfulness while addressing suffering of patients or caregivers. It is complementary to MBSR in the way that it allows health care providers to continue their practices of mindfulness during work.

In the prevention and alleviation of suffering, the practice of MBST helps health care providers to cultivate awareness of their automatic thoughts, speeches, and actions so that they can think, speak, and act mindfully to reduce suffering and enhance well-being of patients and caregivers. In terms of self-care, the practice of MBST can increase the capacity of health care providers to disrupt automatic mental reactions. This helps to reduce stress temporarily. The effect of stress reduction mediated by this disruption of automatic mental reactions wears off when health care providers stop practising MBST. With continued practice of MBST, health care providers may first develop conceptual insights into stressful mental events (sensations, cognitions, and emotions) with respect to temporariness (knowing that stressful mental events are temporary), conditionality (knowing that stressful mental events are determined by conscious and subconscious conditions), and stress formation (knowing the contribution of automatic negative reactions: cognitive, emotional, and psychomotor, to stress formation); followed by less conceptual and more experiential insights into the same 3 characteristics. These insights may produce a longer term effect on stress reduction in health care providers. This longer term effect is mediated by the capacity of health care providers to disidentify themselves from the contents of consciousness without reacting further and the capacity to intentionally replace stressful automatic reactions with thoughtful responses.

The MBST is a flexible psychotherapy with no restriction in time and session. It can be delivered by any health care providers to patients or caregivers or both at the same time. It can be applied to diagnose and palliate suffering simultaneously at various settings, such as hospital, home, or hospice. And it can be terminated at any time. It can also be a bridge to further psychotherapies based on the types of suffering encountered.

In conclusion, we believe that the practice of MBST—mindful presence, mindful listening, mindful empathy, mindful compassion, and mindfulness of boundaries—is useful to address suffering in palliative care. Concurrently, we postulate that the practice of MBST can produce "mindful health care providers" with qualities that are not only important for the therapeutic relationship but also beneficial for increasing equanimity and resilience of health care providers in facing stress in the palliative care setting. In the alleviation of suffering, we believe that we may search the whole world for the best method to realize that it is not so much about the method but how much love we dedicate in that particular method; and to truly love, we need to be there 100%, to listen with undivided attention, to understand deeply, and to speak and act compassionately, with full awareness of our personal and professional boundaries.

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