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Behind the care: emotional struggles, burnout, and denial in kazakhstan's professional palliative care workforce

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Abstract

Background This exploratory study investigates the emotional impact of palliative care provision among healthcare professionals in resource-limited settings, specifically in Kazakhstan. As a middle-income country with a growing burden of chronic diseases, the palliative care sector in Kazakhstan faces increasing challenges to address burnout.

Methods Due to limited existing knowledge, an exploratory design was adopted, employing grounded theory approach to discover professionals' understanding of their experiences, emotional stressors, and burnout development. In-depth qualitative interviews were conducted with 60 palliative care professionals (41 nurses, 19 physicians) from 4 hospices, 2 PCUs of cancer centers, and 1 nursing department from diverse geographical locations within Kazakhstan. The data collection phase was carried out between May 2021 and July 2022. Analysis focused on identifying stressors leading to burnout and coping mechanisms used by palliative care professionals.

Results The study identifies key stressors, including emotional involvement with patients, communication challenges with relatives, witnessing patient frailty and death, lack of personal accomplishment, and emotional labor. A unique finding is the widespread denial of emotional impact among participants, expressed through normalization of work-related stress and suppression of emotions. Through analysis, four key themes were identified as central to the findings: (1) stressors contributing to burnout, (2) denial of emotional impact, (3) coping mechanisms, and (4) attitudes towards seeking psychological help.

Conclusions The present study has revealed that the denial of emotional impact, along with the downplaying or dismissal of the impact of stress, is a recurring pattern among healthcare workers providing palliative care to terminally ill patients in Kazakhstan. The findings of this study underscore the need for tailored training to address the specific emotional needs of palliative care workers, focusing on effective communication, techniques for emotional regulation, stress management, and self-care practices to help professionals cope with the emotional demands of their work.

Keywords Palliative care, Emotional impact, Burnout, Stressors, Normalization of stress, End-of-life care, Denial of emotional impact, Workplace stress, Low-resource settings

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Background

Palliative care professionals experience significant emotional challenges due to the nature of their work, including repeated exposure to suffering, ethical dilemmas, and frequent confrontation with death and dying. These challenges contribute to high levels of burnout, psychological distress, and emotional trauma globally, with work conditions, coping mechanisms, and healthcare infrastructure playing key roles in shaping these outcomes. Research has highlighted broad patterns of distress among palliative care workers, but studies specific to low-resource settings, particularly in Central Asia, remain limited.

The role of palliative care is critical in middle-income countries (MICs) like Kazakhstan, where healthcare systems are often transitioning between resource limitations and ambitious reforms aimed at improving care quality. In MICs, the burden of non-communicable diseases such as cancer, cardiovascular conditions, and chronic respiratory diseases is rising rapidly, creating a growing demand for palliative care services to manage symptoms and improve the quality of life for patients and their families [1]. In Kazakhstan, palliative care remains underdeveloped despite increasing recognition of its value. Barriers such as insufficient access to opioids for pain management, a lack of specialized training for healthcare providers, and cultural stigmas surrounding end-of-life conversations hinder both patients' access to care and professionals' ability to deliver it effectively [2, 3]. Moreover, palliative care is often not integrated into existing healthcare systems, placing an immense emotional and logistical burden on healthcare workers tasked with bridging the gaps between patient needs and systemic limitations.

The overall prevalence of job burnout among nurses and physicians worldwide are at high endemic levels [4–6]. Burnout prevalence is higher for palliative care clinical professionals, where clinical demands and frustrations are elevated due to death and dying patients and where institutional supporting resources have greater scarcity than in most other healthcare settings [7, 8]. A systematic review of 59 studies [9] found that professional palliative care provider burnout prevalence varied, with burnout prevalence as high as 66%. Resource shortages, organizational challenges, communications challenges, lack of education and training, and heavy workloads were found to exacerbate palliative caregiver job-related stresses [10, 11]. Despite heightened vulnerability for palliative care professionals in developing job burnout, currently there are few organizational or institutional programs to prevent burnout from happening for these caregivers in this setting [9].

The bulk of current burnout research for professional palliative care providers is focused on identifying the prevalence and risk factors of burnout [7, 12–14] and assessing organizational-level interventions to reduce or manage burnout [10]. Reported interventions include palliative care education and training, workload reductions, mindfulness practice, meditation, yoga, acupuncture, gratitude journaling, coaching, and peer networks [15], for which most interventions require additional organizational resources. However, there is a sparsity of published research on characterizations of personal coping mechanisms utilized by professional palliative caregivers.

Palliative care services, especially in resource-limited settings, lack organizational and institutional programs designed to prevent and attenuate job burnout [9]. The failure of many palliative care organizations and institutions to address this need places greater importance on personal strategies chosen by individual palliative care providers to cope with burnout or choosing to be in denial of burnout. These coping mechanisms are not well understood and lack full characterization. Denial of job burnout is especially concerning, given that denial has been associated with higher levels of emotional exhaustion and depersonalization scores [16]. Denial is considered a maladaptive coping strategy for work stress, which is associated with increased likelihood of anxiety and depression [17] and shares underlying characteristics with dissociative coping strategies [18].

There is a dearth of published research literature characterizing and assessing palliative care professionals' coping mechanisms for job burnout. As a middle-income country with a growing burden of chronic diseases, the palliative care sector in Kazakhstan faces increasing challenges to address burnout.

A study of palliative care job burnout coping mechanisms informs the design of interventions to improve the care of patients and their families, to retain professionals in palliative care, and ultimately to support and protect the well-being of these caregivers. Our qualitative study was designed to address this knowledge gap by exploring the following research objectives:

1) To characterize key stressors associated with work burnout among palliative healthcare professionals as perceived by these professionals in a resource-limited setting.
2) To characterize the impact of work stress and burnout on the provision of palliative care services as perceived by these healthcare professionals working in such environments.
3) To identify the coping strategies and support systems, that are most effective in mitigating feelings of burnout among palliative care workforce.

Methods

Setting

Our research, a national study characterizing palliative care coping mechanisms, was conducted in the resource-limited setting of Kazakhstan, a Central Asian middle-income country. Kazakhstan currently lacks adequate palliative care professional education and training, where the limited palliative care training and education that is provided does not meet international standards. Kazakhstan's palliative care services is at a preliminary stage of integration into mainstream healthcare services [19]. The legal framework for this nascent palliative care system was only finalized over a little more than a decade, with the introduction of the Public Health Code 2009 (Code of the Republic of Kazakhstan No. 193-IV ZRK, 2009) and the adoption of the Kazakhstan National Cancer Control Program 2012–2016 (Decree of the Government of the Republic of Kazakhstan No. 366, 2012) [20].

Design

The philosophical approach underpinning this research is grounded in an interpretivist (social constructivist) paradigm, which holds that social reality and knowledge are co-constructed by individuals and researchers rather than existing as a single objective truth [21]. In this view, emotional stress, burnout and coping are not abstract measures but lived, context-dependent phenomena shaped by personal and professional backgrounds. Grounded theory is well-aligned with this paradigm. It uses an inductive, flexible approach to develop theory grounded in participants' own accounts [21]. This inductive process matches the interpretivist emphasis on generating understanding from context-specific data.

This study adopted an exploratory design due to the limited knowledge on the emotional impact of palliative care provision among healthcare professionals in resource-limited settings such as Kazakhstan. Grounded theory framework was employed to explore the palliative care professionals' understanding of their professional experiences, emotional stressors, and the impact on burnout development [22].

Recruitment and procedure

Permission to conduct the study was granted by the Ministry of Health of the Republic of Kazakhstan, and ethical approval was provided by the Nazarbayev University Institutional Research Ethics Committee (NU-IREC-407/13052021). Following this, official invitation letters detailing the research were sent to hospital and hospice heads. Out of the 10 hospitals and hospices invited, 3 hospices and 3 hospitals (2 PCUs of cancer centers and 1 nursing department in a general hospital) accepted the invitation to participate in the study. Administrative permissions were obtained for each site. Only those institutions that consented were included.

In each participating institution, a designated contact person, who was a staff member at the institution, liaised with the research team and provided a list of workers with their contact details for participation. In this way, we used purposive sampling of adult professionals (nurses, physicians, administrators) currently employed in palliative care units. The research team members conducted interviews with individuals who met the following inclusion criteria: adults aged 18 and over and currently employed in a palliative care facility. These criteria were established to ensure that our sample accurately represented the perspectives of professionals actively engaged in palliative care provision.

The research team members conducted the interviews. Participants were initially contacted via phone call or WhatsApp messenger by the research team members and invited to participate in the interview. During this initial interaction, previously trained interviewers introduced themselves, provided information about the research and participation conditions, and obtained consent from potential participants. If the person agreed to participate, the interview date and time were scheduled.

The interviews were audio recorded with the interviewee's permission, anonymized, and transcribed verbatim. They were conducted in Russian and Kazakh languages, and the verbatim transcriptions were later translated into English for final analysis.

Participants and data collection

An interview guide was developed to explore the psycho-emotional aspects of interactions between terminally ill patients and healthcare professionals, their impact on the healthcare professionals, and stress management strategies, addressing gaps identified in the literature review. The semi-structured guide was pilot-tested. Before the main study, a pretest was conducted with several experienced palliative-care professionals. This helped to verify that questions were understandable and flowed naturally. Consistent with published recommendations, pilot testing "ensures that interview questions are interpreted as intended and allows for adjustments to improve clarity and flow" [23]. Based on the feedback, confusing probes were removed.

In-depth qualitative interviews were conducted with 60 palliative care professionals (41 nurses, 19 physicians) from 4 hospices, 2 PCUs of cancer centers, and 1 nursing department from diverse geographical locations within Kazakhstan. The data collection phase was carried out between May 2021 and July 2022, involving medical personnel from seven facilities geographically dispersed across seven cities and villages in Kazakhstan (Table 1). Due to COVID-19 measures, most interviews were

Table 1 Sociodemographic and professional characteristics of the participants

Participant characteristics	*n*	%
Nurses		
Sex		
Female	39	95.12
Male	2	4.87
Education		
Specialized secondary education	35	85.37
Higher education	6	14.63
Organization type		
Hospice	30	73.17
PCU, Oncological dispensary	10	24.39
Nursing department, Hospital	1	2.44
Job title		
Nurse	30	73.17
Chief nurse	11	26.83
Palliative care experience (years)	Median = 5 Interquartile Range = 7.5	
Physicians		
Sex		
Female	18	94.74
Male	1	5.26
Education		
Higher education	19	100
Organization type		
Hospice	15	78.95
PCU, Oncological dispensary	2	10.53
Nursing department, Hospital	2	10.53
Job title		
Head/Deputy Head of PCU/Hospice*	8	41.11
Physician	9	47.34
Attendant physician	2	10.53
Palliative care experience (years)	Median = 5 Interquartile Range = 9	

*Concurrently, they also work as physicians

*Specialized secondary education in Kazakhstan refers to a vocational training program (2–4 years after Grade 9) leading to a diploma for mid-level medical specialists (e.g. nurse or feldsher). *Higher education is the standard university degree [27]

conducted online via Zoom and WhatsApp mobile applications. From May 16, 2022, to May 19, 2022, due to the relaxation of COVID-19 measures nationally and globally, some interviews were conducted face-to-face among healthcare workers of the same hospice on-site.

Data analysis

Firstly, interview transcripts were translated from the original languages (Kazakh or Russian) into English and thoroughly reviewed. Interviews were translated by the same researchers, who led the interviews and who possess both language fluency and a strong background in qualitative methodologies. To maintain the accuracy of translation, back-translation was carried out as part of the verification process.

Translated transcripts were then uploaded into the NVivo software for further coding management. Two investigators independently coded the transcripts, engaging in discussions and cross-referencing codes after each analyzed interview transcript to ensure consistency and relevance. The codes were organized into themes and sub-themes based on conceptual similarities [24].

Throughout the coding process, transcripts were analyzed using the constant comparative approach to address similarities and disparities in perceptions until data saturation was reached, at which point no new themes or sub-themes emerged. By employing the constant comparative method, the researchers iteratively refined their understanding of the stressors and coping mechanisms, ensuring that the emerging theory was well-grounded in the data. This approach maintained the inductive nature of grounded theory while allowing for a targeted exploration of the research interests.

To enhance the rigor of the analysis, the themes and sub-themes were refined through discussions and literature reviews. The final list of themes and sub-themes was discussed and finalized in consultation with the principal investigators (Table 2). Throughout the process reflexivity was maintained, with the researchers regularly reflecting on their own perspectives and biases to minimize their influence on the analysis and ensure the integrity of findings. We continued sampling until data saturation was achieved, meaning no new themes emerged from additional interviews [25, 26]. The analysis specifically focused on identifying stressors that may lead to burnout and the coping mechanisms employed by palliative care professionals.

Results

Table 1 presents a summary of participant demographics and professional roles. Table 2 outlines the four major themes, and 12 subthemes identified through thematic analysis, which structure the findings discussed below.

Stressors that May lead to burnout

Palliative care professionals in Kazakhstan encounter a range of emotional, interpersonal, and systemic stressors that contribute to work-related burnout. These stressors are deeply intertwined with the nature of end-of-life care, where prolonged exposure to suffering, death, and complex family dynamics creates a high emotional burden. Interviewees identified several distinct yet overlapping sources of distress that affect their well-being and professional functioning. The subthemes below outline these key stressors as experienced by palliative care professionals.

Table 2 Themes, sub-themes, and categories derived from interview data

Themes	Sub-themes	Categories
1. Stressors that may lead to burnout	1.1. Emotional involvement with patients	
	1.2. Challenges in communication with relatives	
		1.2.1. Breaking bad news to relatives
		1.2.2. Disclosure issues
	1.3. Seeing patients dying	
	1.4. Lack of personal accomplishment	
	1.5. Emotional labor	
2. Denial of emotional impact	2.1. Perception of stress and burnout	
	2.2. Suppressing emotions	
3. Coping mechanisms	3.1. Support from colleagues	
	3.2. Family support	
	3.3. Individual self-care practices	
	3.4. Psychological help to staff	
	3.5. Job satisfaction	
4. Attitudes towards seeking psychological help		

Emotional involvement with patients

About a third of the people who took part felt an emotional connection to the patients akin to that of family or friends. Some of the healthcare personnel who were questioned spoke of shedding tears of compassion for the patients and their families, highlighting the heavy emotional load they bear. The emotional connection, according to another respondent, goes beyond one's duty as a professional.

> *"It's not just like you come and do your work here, we get emotionally attached to these patients….". Physician 6, hospice.*
> *"Sometimes I cry, I feel so sorry for patients. There was a boy, he wanted me to be his mother. We try not to overwhelm ourselves with emotions but still feel very sorry for everyone. I try to think that this is such a job, such a life, and nothing can be done." Nurse 32, hospice.*

The participants' accounts of their deep connections with terminally ill patients suggest that the professional relationship evolves into a more personal one when the patient undergoes recurrent admissions, which go beyond simply addressing the illness:

> *"Cancer patients might be admitted a few times. To the extent that you get used to them like a family member. You treat the whole person, not only the disease. And they understand it.". Nurse 7, PCU.*
> *Our nurses are the ones who get emotionally attached. They say that it is not right to get attached, if the person dies, it gets very hard emotionally." Physician 8, hospice.*

These quotes collectively highlight the emotionally charged nature of working with palliative patients in Kazakhstan, revealing that some professionals develop deep emotional bonds with their patients.

Challenges in communicating with relatives

In exploring the emotional dynamics between the healthcare professionals and patients' relatives, the quote analysis has revealed the challenges faced when dealing with different prognostic perspectives. The emotional strain in healthcare workers intensifies when relatives shift blame from the disease or the patient's condition to the healthcare staff:

> *"Sometimes relatives think it is not the disease that is to blame, not the condition of the person, but the employees and, the hospice in general, are to blame." Physician 2, hospice.*

Another finding underscores the difficulty that the palliative care workers encounter when relatives remain optimistic about the patient's recovery despite the reality of incurable or difficult conditions. In such cases, blame may be unfairly directed towards the healthcare team, creating a challenging work environment:

> *"It is very difficult to talk with relatives of patients who are confident that the patient will become better…It is difficult to work in such a case." Physician 12, hospice.*
> *"On the one hand, it's understandable why the family members feel this way. You know, they're in a state where they want to help somehow, but there's really not much they can do. Sometimes, they try to find someone to blame. Not everyone understands that there's no one at fault here. They still want to*

> *take the patient somewhere else, maybe for treatment abroad or to some other place."* Physician 4, PCU.

Breaking bad news to relatives

Some healthcare professionals admitted the difficulty of informing relatives about a patient's death, revealing the emotional weight carried by them. The immediate emotional response from grieving family members induces a sense of personal responsibility and self-blame, complicating an already challenging task:

> *"It has always been hard for me to call the relatives of the patient and tell them about the death of their close one. I call and they immediately start crying. And I start to think it's all my fault. I don't like upsetting people, so it can be hard."* Nurse 30, hospice.

Non-disclosure/truth-telling issues

Some quotes stress the delicate balance between maintaining hope and providing realistic expectations. The reluctance of relatives to share information creates difficult environment for the staff, who must navigate the patient's expectations and potential unfavorable outcomes:

> *"Some believe patients should not know their diagnosis, and if relatives request nondisclosure, we comply. But after that, the patient is in some kind of aggression, because it seems to him that we are not treating him correctly. As a result, it is more difficult for doctors and nurses to work with such patients."* Physician 12, hospice.
>
> *"We primarily treat patients with oncological conditions. Many patients believe in the efficacy of their treatments and anticipate significant support from us, but sometimes there are fatal outcomes. When relatives ask us, 'Don't tell them, don't explain anything,' the patients persist in clinging to hope for a cure. Working in such circumstances is exceptionally challenging."* Physician 17, hospice.

Seeing patients dying

Witnessing patients in the advanced stage of terminal illness accentuates the profound emotional burden inherent in delivering end-of-life care.

> *"when patients approach the last minute of their lives we are being next to them. They hold our hand and look at us as if asking for help. Psychologically it is very difficult for us."* Nurse 9, hospice.

Participants described how they may experience distress when pain relief efforts are ineffective, which adds a sense of helplessness and emotional strain. As admitted by the interviewees, the unrelieved pain in patients may have a psychological impact on palliative care workers.

> *"It is difficult when the patients' pain remains unrelieved, even with opioid analgesia. Witnessing patients in such a terminal stage is emotionally difficult."* Nurse 26, hospice.

Lack of personal accomplishment

The study revealed that about one sixth of the interviewees experience feeling of inactivity coupled with an inability to make a sustained positive impact on the well-being of patients when they see that patients' physical state does not improve:

> *"There are cases when we discharge a patient and see that things have not gotten better, that we have not been able to help, unfortunately. Patient leaves and there is such a feeling that it is as if something has not been completed."* Physician 4, PCU.
>
> *"There is a feeling that I am not doing enough. I might not be used to working with this particular category of patients. There is a feeling of inactivity, as if I am doing nothing to improve the patient's condition."* Physician 13, hospice.

Emotional labor

Almost half of the interviewed healthcare workers described how they try to conceal their sad emotions, emphasizing the importance of maintaining calmness and emotional resilience when interacting with patients:

"Usually, I try not to show emotions at work" Physician 13, hospice.

Emotional control and resilience are also expected from the peers among healthcare staff to protect patients from the emotional distress:

> *"There are medical/nursing students who begin to cry, we begin to calm them down and ask them not to show their tears to the patient."* Physician 18, hospice.
>
> *"Sometimes I even scold the staff so that they leave home problems at home and come to work with a bright head…"* Nurse 33, hospice.

Denial of emotional impact

In addition to direct stressors, the study uncovered a recurring pattern of emotional denial among healthcare professionals. Rather than acknowledging or addressing emotional strain, many participants described suppressing their emotions or normalizing the distress as part of the job. This theme explores how denial operates as both an individual coping strategy and a workplace norm, potentially masking deeper emotional needs and increasing vulnerability to burnout over time.

The present study has revealed that the denial of emotional impact, along with the downplaying or dismissal of the impact of stress, is a recurring pattern among healthcare workers providing palliative care to terminally ill patients in Kazakhstan. We found that about half of participants underestimated or denied the extent of emotional stress caused by their interactions with patients. Analysis showed participants framing denial primarily as an individual adaptive coping mechanism– normalizing stress and suppressing emotions to continue functioning. Denial, while serving an immediate coping function, is likely influenced by workplace culture and remains an area for future study.

Perception of stress

Despite indications of stress and fatigue, there is a recurring theme of adaptation and normalization, or downplaying or denying the existence of emotional stress. To a question if they feel stressed at work, one sixth of the interviewees replied that they had already gotten used to stress and framed it as a routine and manageable aspect of work:

> *"You know, I am already used to working like this." Nurse 14, hospice.*
> *"By virtue of experience, we no longer experience burnout, it is difficult for young people, but of course in general we all get tired." Nurse 39, hospice.*

Some participants attribute their stress to the nature of their profession, implying its normalization:

> *"Initially, I was stressed. But there is no stress now. We have such a profession. The stress was at the first experience, as it happens with everyone." Physician 10, hospice.*

Suppressing emotions

About one sixth of respondents tend to suppress their negative emotions and ignore emotional exhaustion. The acknowledgment that a busy schedule and lack of time in the workplace leave little to no room for addressing stress suggests that stress is perceived as a secondary concern, unworthy of attention or reflection.

"I don't even have time for stress." Physician 10, hospice.

Some interviewees shared how they tend to suppress stress by forcing themselves to think positively.

> *"You need to think less about it, you need to think only about the good things." Nurse 20, PCU.*

In another statement, the interview participant indicated that they continue to work despite stress, which suggests that some healthcare workers may often prioritize duties over their personal well-being.

"We work, work and work. You survive and you move on." Nurse 11, PCU.

Coping mechanisms

The coping mechanisms reported in the interviews often include readily accessible resources at work, such as seeking support from colleagues, consulting with staff psychologists, or engaging in hobbies.

Support from colleagues

Approximately one third of participants articulate a reliance on mutual support from colleagues, engaging in reciprocal assistance as a coping strategy when confronted with stress and burnout.

> *"We try to cheer each other up and support each other." Nurse 20, PCU.*
> *"When I notice that someone is going through a hard time, I try to help, engage in conversation and cheer them up." Nurse 21, PCU.*

Individual self-care practices

Besides social relationships as coping, one-sixth of participants reported practicing various self-care strategies such as meditation, listening to music, yoga, active sports, and others as a means of mitigating the impact of stress and burnout.

> *"To prevent burnout, maintaining an active lifestyle after work is crucial. We try to go for walks as a means of coping." Physician 19, hospice.*
> *"I take a moment to sit in silence, reflect, and it slowly passes." Chief Nurse 13, hospice.*

Psychological help to staff

Some participants reported psychological support from the staff psychologists as one of the instruments to cope with stress at work.

> *"When I encounter challenges or find tasks overwhelming, I seek guidance from our staff psychologist." Physician 9, hospice.*

More than half of respondents refer to the availability of a psychologist at their institution, who facilitates group stress-relief sessions and periodically assesses the emotional and psychological well-being of staff. However, according to some interviewees, the support from staff psychologists often falls short of their needs, expressing a desire for greater attention and more frequent psychological support.

> *"Mostly, a psychologist works with patients. Of course, she can talk with employees, but she mainly works with patients." Nurse 9, hospice.*
> *"The psychologist visits us and conducts group sessions and takes surveys from time to time… However, we would like more attention…. Personally, I believe we need the psychologist to work with us more often." Nurse 12, PCU.*

Some interviewees expressed reluctance to seek psychological support, citing concerns about unethical behaviour by staff psychologists. One participant shared their experience, emphasizing a breach of trust that deterred them from seeking necessary emotional and mental health support:

> *"No, I don't want to go to our psychologist. He disclosed confidential personal information, it's unethical." Physician 14, hospice.*

This concern highlights a potential systematic barrier to accessing mental health resources leaving the emotional stress among palliative care professionals unaddressed.

Job satisfaction

For some participants, seeing the results and impact of palliative care workers' effort to improve and sustain patients' physical and emotional well-being contributes to job satisfaction:

> *"Well, I've been working for 4 years now. In the beginning, I thought about leaving my job, but now I like my job. I console myself with the fact that I am helping these people, that there is some help from me." Nurse 25, hospice.*
> *"When you ease the patient's condition, it becomes easier. In palliative care, we support people in their final stage of life by relieving their pain and suffering. From the fact that we help patients, there is also satisfaction." Physician 4, hospice.*

Family support

One-tenth participants find their family as a valuable means of alleviating the emotional burden associated with working with palliative patients.

> *"I have a child at home, so when I return, I am completely distracted. We enjoy cooking together, exercising, and going for walks." Chief Nurse 12, PCU.*

Attitudes towards seeking psychological help

The present study also identified a reluctance among some healthcare workers to seek psychological support, with several participants preferring to manage stress on their own. Despite occasional encouragement from colleagues to seek professional help, some declined, often citing time constraints, concerns about stigma, or fear of being perceived as mentally ill.

> *"I don't visit psychologists. I try to manage stress on my own. He always conducts surveys. When I come to work, I forget about household chores. And when I leave work, I leave everything here." Nurse 35, hospice.*
> *"I rarely take consultations from a psychologist. The workload is big, I am too busy for that…" Physician 13, hospice.*

Another participant admitted that cultural attitudes may play a significant role in this reluctance, noting that the Kazakh mentality can discourage seeking professional psychological assistance.

> *"From my point of view, our mentality does not allow us to turn to a psychologist in Kazakhstan." Physician 19, hospice.*

Furthermore, even when stress is evident, some staff members hesitate to seek help, questioning whether they truly need psychological support and feeling that doing so implies something is inherently wrong with them. This reflects a deeper stigma surrounding mental health care in the workplace:

> *"If a member of staff starts having problems, dissatisfaction, or starts to get tired, then we suggest the help of a psychologist. But in most cases they refuse to accept this help and usually you can hear such questions: "No, I don't need it. Is there something wrong with me?" Nurse 31, hospice.*

Discussion

Overall, the findings reveal the stressors experienced by the interviewees that potentially contribute to and exacerbate burnout among palliative care workers. These stressors include emotional involvement with patients, challenges in communication with relatives, witnessing patients' frailty and death, lack of personal accomplishment, and emotional labor. A striking and unique finding of this study is the widespread denial of emotional impact among the interviewees, expressed through normalization of work-related stress, disregard of their own emotional state, and deliberate suppression of emotions.

Literature consistently identifies emotional suppression as a prevalent coping mechanism among palliative care professionals, driven by workplace norms and cultural expectations, but there is limited direct focus on denial of emotional impact through normalization of stress, disregard of personal emotional states, or deliberate suppression as explicit, systemic behaviors [28–31].

As this study and previous research has shown, providing care to patients with serious or terminal illnesses generates significant emotional challenges for palliative care professionals, who frequently encounter grief, loss, and moral distress in their daily work. Coping with these challenges often involves emotion regulation strategies, including emotional suppression, psychological distancing, and normalization of work-related stress [28–31]. While these mechanisms may serve to mitigate immediate distress, they are implicated in harmful long-term outcomes, such as emotional exhaustion, compassion fatigue, and burnout. A growing body of literature examines the coping mechanisms of palliative care professionals, yet the topic of denial of emotional impact, through normalization of stress, disregard of personal emotional states, and/or deliberate emotional suppression, remains underexplored from a systemic and mechanistic perspective.

Several studies touch on aspects of these mechanisms. Research on normalization of stress highlights cultural and systemic influences that perpetuate internalized narratives framing emotional distress as an unavoidable and acceptable part of the job [28–31]. For instance, Ingebretsen and Sagbakken [28] describe how hospice nurses normalize emotional control using techniques such as “technical busyness” to suppress emotional responses and focus on professional tasks. Similarly, Arantzamendi et al. [32] explore how novice professionals internalize emotional restraint as a workplace expectation, though such norms may evolve with experience and increased emotional competence. These findings indicate that normalization is both culturally reinforced and institutionalized within palliative care teams; however, few studies explicitly conceptualize it as a form of emotional denial.

Emotional suppression has been widely documented as a deliberate strategy to maintain professionalism in palliative care settings [28, 31, 33, 34]. Nurses and other caregivers report suppressing grief or distress to appear calm and competent in front of patients and colleagues, often as part of the emotional labour required by their roles [31]. However, studies such as those by Testoni et al. [29] and Funk et al. [31] link this suppression to emotional dissonance, depersonalization, and long-term stress accumulation. Emotional suppression is thus recognized as both a workplace-enforced behavior and a maladaptive coping mechanism, although its relationship to systemic and organizational factors remains insufficiently explored.

The disregard of personal emotional states is less explicitly studied but emerges indirectly through findings on self-neglect and insufficient reflective practices. For example, professionals often lack structured opportunities to process their feelings, and systemic barriers perpetuate avoidance of self-awareness [35]. Emotional disengagement is also associated with cognitive dissonance, as professionals struggle to reconcile their caregiving roles with ignored personal vulnerabilities [29, 30]. While some studies emphasize the importance of self-care and emotional openness [32, 35], discussions of overlooked emotional states are frequently framed as individual shortcomings rather than symptoms of systemic denial.

Despite recognizing the psychological and physical consequences of these coping mechanisms, which include burnout, moral distress, and reduced empathic engagement [28–30, 34], the available research largely focuses on descriptive accounts of emotional regulation strategies rather than systemic investigations of denial processes. For instance, while Fisher et al. [30] identify emotional suppression and lack of self-care as unhelpful stress responses, the mechanisms through which these behaviors are normalized remain underexamined. Furthermore, few studies address interventions or organizational approaches to reframe normalization and suppression into adaptive coping practices [34, 35].

This therefore highlights substantial gaps in the research literature on how systemic denial of emotional impact shapes the emotional well-being of palliative care professionals. While emotional suppression, normalization of stress, and disregard of personal emotional states are prevalent themes, they are rarely interrogated as interconnected mechanisms of denial. Addressing these gaps will require greater emphasis on cultural and institutional factors that reinforce these behaviors, alongside research into interventions that allow for healthier emotional processing and professional sustainability. A key gap in the literature, and one underscored by this study, is the lack of attention to healthcare professionals’ attitudes toward seeking psychological help. Kazakhstan’s cultural attitudes toward emotion and help-seeking are not well studied. While our qualitative design did not directly assess cultural norms, we now call this out as an important direction for future research. The only study directly examining both cultural norms/attitudes toward seeking psychological help and coping strategies among healthcare professionals in Kazakhstan is a small qualitative study of frontline COVID-19 workers, which found reliance on religious faith, professional duty, and informal social support, but overall, there is a critical lack of quantitative or large-scale research specifically assessing cultural barriers or help-seeking behaviors in this group [36].

The findings of our current study have several important implications for palliative care practice, particularly in resource-limited settings like Kazakhstan. Firstly, the widespread denial of emotional impact among healthcare professionals highlights the need for targeted training programs. These programs should focus on recognizing and addressing emotional stressors, normalizing discussions about emotional well-being, and providing strategies for managing stress and preventing burnout.

Developing emotional resilience is crucial for palliative care workers. Training should include techniques for emotional regulation, stress management, and self-care practices to help professionals cope with the emotional demands of their work. Additionally, effective communication with patients and their families is essential. Training programs should emphasize the development of communication skills to handle difficult conversations, deliver bad news, and manage conflicts with relatives, which can reduce stress and improve job satisfaction [8].

Establishing robust support systems within healthcare institutions can help mitigate the emotional burden on palliative care workers. This includes regular debriefing sessions, peer support groups, and access to mental health professionals who can provide counselling and support. Healthcare organizations should recognize the emotional challenges faced by palliative care workers and implement policies that promote a supportive work environment [9–11]. This could involve reducing workload, ensuring adequate staffing levels, and providing opportunities for professional development and emotional support.

The unique finding of denial of emotional impact underscores the need for further research to understand this phenomenon better. Raising awareness about the emotional challenges in palliative care can lead to more comprehensive support systems and interventions tailored to the specific needs of healthcare professionals in this field. Integrating psychological care into palliative care teams can enhance the overall well-being of both patients and healthcare providers [9–11]. Psychologists and other mental health professionals can play a vital role in addressing the emotional and psychological needs of palliative care workers.

By addressing these implications, healthcare systems can improve the quality of palliative care, enhance the well-being of healthcare professionals, and ultimately provide better support for patients and their families.

Conclusion

The findings of this study have important implications for palliative care policy and workforce development in Kazakhstan and similar resource-constrained settings. Understanding individual coping mechanisms can inform the creation of low-cost, scalable interventions—such as peer-support networks or tailored mental health resources—that do not rely on intensive institutional infrastructure. Furthermore, the insights into maladaptive strategies like denial highlight the urgency of integrating mental health literacy into palliative care training programs. Policymakers and health administrators should prioritize institutional strategies for caregiver support to reduce burnout and improve service sustainability. Future research should further explore the cultural and systemic factors contributing to denial of emotional impact and develop tailored support systems to enhance the mental health of palliative care professionals.

Strengths and limitations

To our knowledge, this is the first study to explore emotional impact and burnout determinants among palliative care professionals in Kazakhstan, addressing significant gap in literature. The adoption of a grounded theory approach which ensured that findings were directly informed by the perspectives of participants, enhancing the study's authenticity and relevance.

While this study provides valuable insights into the emotional challenges faced by palliative care professionals in Kazakhstan, several limitations should be noted. For our participant pool, we attempted to contact all the palliative healthcare professionals in the country; however, certain palliative healthcare sites declined to accept our invitation, and some healthcare professionals chose not to provide consent to participate- healthcare professionals that were not participating in the study may have had different perspectives and experiences than those participating in the study. In addition, the large majority of physicians and nurses working in palliative healthcare in Kazakhstan are women. As a result, our professional healthcare study participants, both nurses and physicians, were nearly all women. In our study we had no opportunity to distinguish differences in perceptions and attitudes concerning work stress, burnout and coping methods between male and female healthcare professionals.

Additionally, as a qualitative study, the findings are based on self-reported experiences which may be subject to recall bias and social desirability bias. Participants may have underreported or overemphasized certain aspects of their emotional experiences. However, we believe that due to confidential settings of the interview, we ensured that participants felt comfortable to discuss their emotional challenges. Our interviewers used probing questions to gain deeper insights and reduce the likelihood of superficial or biased responses.

The study was conducted in Kazakhstan, a country with unique cultural and healthcare system characteristics. While the findings provide valuable insights into the emotional aspects of palliative care professionals in resource-limited settings, they may not be fully generalizable to other regions with different healthcare infrastructures, cultural attitudes, and palliative care policies.

Furthermore, while the study highlights the phenomenon of emotional denial and suppression, it does not quantitatively measure burnout levels or compare them with those in other healthcare settings. A mixed-methods approach incorporating validated psychological assessments could provide a more robust understanding of burnout prevalence and severity.

Finally, due to pandemic-related constraints, many interviews were conducted remotely via Zoom and WhatsApp. While this allowed for broader participation, it may have influenced the depth and openness of responses compared to face-to-face interviews. However, to maintain interview quality participants were given flexibility in scheduling, allowing for comfortable and uninterrupted discussions.

Future study directions

Building on the insights gained from this study, future research should pursue several directions. First, quantitative studies are needed to validate and further explore the prevalence of burnout and the impact of identified stressors across different palliative care settings. Second, given the observed gender skew, research should systematically examine gender differences in emotional burdens and coping strategies among healthcare professionals. Additionally, expanding the geographic scope to include other resource-limited settings would provide comparative insights and enhance the generalizability of the findings. Finally, longitudinal studies are recommended to evaluate the long-term effects of targeted interventions designed to mitigate burnout, thereby informing evidence-based policy reforms and best practices in palliative care.

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Author contributions

BC: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation Methodology, Project administration, Resources, Software, Supervision, Validation, Visualization, Writing– original draft, Writing– review & editing MA: Data curation, formal analysis, methodology, project administration, resources, writing– original draft, writing– review and editing PA: Data curation, formal analysis, methodology, project administration, resources, writing– original draft, writing– review and editing FF: Conceptualization, Data curation, Investigation, Supervision, Writing– review & editing KD: Data curation, Investigation, Project administration, Writing– original draftWriting– review & editing AC: Conceptualization, Data curation, Investigation, Supervision, Writing– review & editing LT: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Supervision, Validation Visualization, Writing– original draft, Writing– review & editing All authors read and approved the final manuscript.

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Data availability

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval of this study was provided by the Nazarbayev University Institutional Research Ethics Committee (NU-IREC-407/13052021). This is a qualitative study and does not involve experiments on humans or human tissue.

Consent for publication

Not applicable.

Informed consent

Has been obtained from all participants.

Competing interests

The authors declare no competing interests.

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References

1. World Health Organization. Noncommunicable diseases country profiles 2018 [Internet]. Geneva: World Health Organization. 2018 [cited 2025 May 1]. Available from: https://iris.who.int/handle/10665/274512
2. Hannon B, Zimmermann C, Knaul FM, Powell RA, Mwangi-Powell FN, Rodin G. Provision of palliative care in Low- and Middle-Income countries: overcoming Obstacles for effective treatment delivery. J Clin Oncol Off J Am Soc Clin Oncol. 2016;34:62–8.
3. Seow H, Bainbridge D. The development of specialized palliative care in the community: A qualitative study of the evolution of 15 teams. Palliat Med. 2018;32:1255–66.
4. Williams ES, Rathert C, Buttigieg SC. The personal and professional consequences of physician burnout: A systematic review of the literature. Med Care Res Rev. 2020;77:371–86.
5. Zhang Y-Y, Han W-L, Qin W, Yin H-X, Zhang C-F, Kong C, et al. Extent of compassion satisfaction, compassion fatigue and burnout in nursing: A meta-analysis. J Nurs Manag. 2018;26:810–9.
6. Woo T, Ho R, Tang A, Tam W. Global prevalence of burnout symptoms among nurses: A systematic review and meta-analysis. J Psychiatr Res. 2020;123:9–20.
7. Gómez-Urquiza JL, Albendín-García L, Velando-Soriano A, Ortega-Campos E, Ramírez-Baena L, Membrive-Jiménez MJ, et al. Burnout in palliative care nurses, prevalence and risk factors: A systematic review with Meta-Analysis. Int J Environ Res Public Health. 2020;17:7672.
8. Martins Pereira S, Fonseca AM, Sofia Carvalho A. Burnout in palliative care: A systematic review. Nurs Ethics. 2011;18:317–26.
9. Dijxhoorn A-FQ, Brom L, Van Der Linden YM, Leget C, Raijmakers NJ. Prevalence of burnout in healthcare professionals providing palliative care and the effect of interventions to reduce symptoms: A systematic literature review. Palliat Med. 2021;35:6–26.
10. Beng TS, Chin LE, Guan NC, Yee A, Wu C, Pathmawathi S, et al. The experiences of stress of palliative care providers in malaysia: A thematic analysis. Am J Hosp Palliat Med. 2015;32:15–28.
11. Nevin M, Hynes G, Smith V. Healthcare providers' views and experiences of non-specialist palliative care in hospitals: A qualitative systematic review and thematic synthesis. Palliat Med. 2020;34:605–18.

12. Reddy SK, Yennu S, Tanco K, Anderson AE, Guzman D, Ali Naqvi SM, et al. Frequency of burnout among palliative care physicians participating in a continuing medical education course. J Pain Symptom Manage. 2020;60:80–e862.
13. Wang C, Grassau P, Lawlor PG, Webber C, Bush SH, Gagnon B, et al. Burnout and resilience among Canadian palliative care physicians. BMC Palliat Care. 2020;19:169.
14. Dijxhoorn A-FQ, Brom L, Van Der Linden YM, Leget C, Raijmakers NJ. Healthcare professionals' Work-Related stress in palliative care: A Cross-Sectional survey. J Pain Symptom Manage. 2021;62:e38–45.
15. Cohen C, Pignata S, Bezak E, Tie M, Childs J. Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: a systematic review. BMJ Open. 2023;13:e071203.
16. Doolittle BR, Windish DM, Seelig CB. Burnout, coping, and spirituality among internal medicine resident physicians. J Grad Med Educ. 2013;5:257–61.
17. Taylor DM, Pallant JF, Crook HD, Cameron PA. The psychological health of emergency physicians in Australasia. Emerg Med Australas EMA. 2004;16:21–7.
18. Tsouvelas G, Kalaitzaki A, Tamiolaki A, Rovithis M, Konstantakopoulos G. Secondary traumatic stress and dissociative coping strategies in nurses during the COVID-19 pandemic: the protective role of resilience. Arch Psychiatr Nurs. 2022;41:264–70.
19. Clark D, Baur N, Clelland D, Garralda E, López-Fidalgo J, Connor S, et al. Mapping levels of palliative care development in 198 countries: the situation in 2017. J Pain Symptom Manage. 2020;59:794–e8074.
20. Crape B, Akhmetova M, Akhmetniyaz P, Foster F, Nadyrov K, Toleubekova L. Number of palliative care nurse home visits and duration of palliative care associated with domains of the good death inventory: A National survey of bereaved family caregivers in a middle income country. Int J Nurs Stud Adv. 2024;7:100217.
21. Sebastian K. Distinguishing between the strains grounded theory: classical, interpretive and constructivist. J Soc Thought. 2019;3.
22. Noble H, Mitchell G. What is grounded theory? Evid Based Nurs. 2016;19:34–5.
23. Majid MAA, Othman M, Mohamad SF, Lim SAH, Yusof A. Piloting for Interviews in Qualitative Research: Operationalization and Lessons Learnt. Int J Acad Res Bus Soc Sci [Internet]. 2017 [cited 2025 May 1];7. Available from: http://hrmars.com/index.php/journals/papers/IJARBSS/v7-i4/2916
24. Polit DF, Beck CT. Essentials of nursing research: appraising evidence for nursing practice. Ninth edition. Philadelphia Baltimore New York London Buenos Aires Hong Kong Sydney Tokyo: Wolters Kluwer; 2018.
25. Guest G, Bunce A, Johnson L. How many interviews are enough?? An experiment with data saturation and variability. Field Methods. 2006;18:59–82.
26. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52:1893–907.
27. Ministry of Justice of the Republic of Kazakhstan. The Law of the Republic of Kazakhstan On Education [Internet]. 319–III. Available from: https://adilet.zan.kz/eng/docs/Z070000319_
28. Ingebretsen LP, Sagbakken M. Hospice nurses' emotional challenges in their encounters with the dying. Int J Qual Stud Health Well-Being. 2016;11:31170.
29. Testoni I, Carafa ML, Bottacin M, Zamperini A, Galgani M. [The nursing hospice care: critical incidents in managing the relationship with patients and their families]. Prof Inferm. 2018;71:151–9.
30. Fisher S, Gillanders D, Ferreira N. The experiences of palliative care professionals and their responses to work-related stress: A qualitative study. Br J Health Psychol. 2022;27:605–22.
31. Funk LM, Peters S, Roger KS. The emotional labor of personal grief in palliative care: balancing caring and professional identities. Qual Health Res. 2017;27:2211–21.
32. Arantzamendi M, Sapeta P, Belar A, Centeno C. How palliative care professionals develop coping competence through their career: A grounded theory. Palliat Med. 2024;38:284–96.
33. Erel BN, Tural Büyük E. The effect of emotional labor levels on the attitudes of neonatal intensive care nurses towards palliative care. J Med Palliat Care. 2021;2:40–6.
34. Ugarova A. Emotional management of healthcare professionals in palliative care settings. J Soc Policy Stud. 2022;20:313–22.
35. Dijxhoorn A-F, Raijmakers N, Van Der Linden Y, Leget C, Brom L. Clinicians' perceptions of the emotional impact of providing palliative care: A qualitative interview study. Palliat Support Care. 2023;21:843–9.
36. Foster F, Kanderzhanova A, Umbetkulova S, Stolyarova V, Sarria-Santamera A, Cobb-Zygadlo D. Who else if not us: an Exploratory-Descriptive qualitative study of Kazakhstani frontline professionals' experience and perceptions during the coronavirus disease 2019 pandemic. Qual Health Res. 2024;34:507–16.

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