Proceedings of the 6th International Conference on Biological Engineering and Medical Science
DOI: 10.54254/2753-8818/2026.36829

Construction of Psychological Resilience among Palliative Care Practitioners

Yanxin Wang

College of Arts and Sciences, The Ohio State University, Columbus, USA
wang.16157@osu.edu

Abstract. Palliative care is important care for the advanced cancer and end-stage chronic diseases. The goal of such care is to prolong the lives of patients but also to alleviate their suffering, enhance their quality of life and maintain their dignity. However, palliative care professionals are expected to approach patient distress and loss of life and family bereavement and are vulnerable to burnout, compassion fatigue, emotional exhaustion and secondary traumatic stress. Psychological resilience is regarded as a significant psychological resource that practitioners use to manage their occupational stress, to maintain their mental health and to provide quality care. This review examines pathways to develop psychological resilience for palliative care practitioners such as practice of mindfulness, self-care, cognitive behavioral therapy, peer support and organizational support measures. Based on previous studies in this field, it is assumed that these interventions will contribute to the regulation of emotions, restoration of psychological resources, reduction of negative thoughts and increase in team support on various levels. Current studies have many limitations, including short-term follow-up, low patient numbers, and lack of long-term evidence. Future research can build on the existing research, especially regarding the sustainability of interventions in real work settings and how interventions directed to individual palliative care practitioners, teams and institutions can be better combined to give palliative care practitioners more stable psychological assistance.

Keywords: Palliative care, Psychological resilience, Palliative care practitioners, Burnout, Self-care

1. Introduction

Given the growing incidence of chronic diseases, the demands of patients with advanced cancer, diabetes and other end-stage chronic diseases are also on the rise. Usually, these patients are very difficult to treat through curative treatment, and traditional treatments such as chemotherapy have very limited effects in such patients. This has led to a change of focus in clinical medicine, now not only concerned with the extension of life but also with patients' feelings, such as symptom control, emotional well-being, life quality and dignity. Palliative care has become very much in the limelight in recent years. Palliative care and other palliative interventions can help to enhance the quality of life of the patient, family and caregivers and palliative care should also be incorporated into cancer care [1].

© 2026 The Authors. This is an open access article distributed under the terms of the Creative Commons Attribution License 4.0 (https://creativecommons.org/licenses/by/4.0/).

DOI: 10.54254/2753-8818/2026.36829

However, palliative care does not only ensure a positive patient experience of care. It also causes much psychological distress to practitioners. Palliative care doctors, nurses and caregivers have to confront patients' suffering, family members' grief and death on a regular basis and they can be very emotional in their work. A systematic review and meta-analysis by Chen et al. suggest that palliative care nurses experience moderate levels of compassion fatigue (CF), burnout and secondary traumatic stress [2]. Without addressing these issues, they can impact physical and mental health, work satisfaction and may even impact the quality of care.

Therefore, psychological resilience has been seen as an important psychological tool for coping with work stress, maintaining mental health and providing excellent care for palliative care workers. Although there have been some studies which suggest that the palliative care practitioner should focus on his/her psychological resilience and mental stress management, there have been no systematic studies which elaborate on this. Resilience in psychology is not only about the acceptance of a stressful situation, but also about helping the practitioner keep his or her psychological state constant over long periods of time. This paper will explore the key methods of psychological resilience training for palliative care practitioners: mindfulness practice, self-care, cognitive behavioral therapy (CBT) and peer support (see Table 1).

2. Mindfulness practice

Practicing mindfulness is one of the key strategies palliative care practitioners can use to develop psychological resilience. Psychological resilience in palliative care is primarily manifested in the capacity of the caregiver to control their emotional reactions, cope with stress and continue functioning with patients, families and death. By practicing mindfulness, practitioners can gain an awareness and acceptance of their own emotions. It is not meant to alter the stressful events in the workplace, but to enable practitioners to be more aware and accept them. Hence, it could be a valuable strategy for enhancing psychological resilience. With mindfulness comes an emphasis on being present in the here and now, and on maintaining an attitude of calm and acceptance with regard to emotions and physical sensations. It incorporates body scan, breathing exercises, mindful pauses, loving-kindness meditation and compassion-oriented meditation. These practices can be used to manipulate the mind in order to minimize emotional fatigue in high stress occupations.

Orellana-Rios et al. piloted an observational, mixed method evaluation on mindfulness and compassion-oriented practices in palliative care teams [3]. Twenty-eight interdisciplinary palliative care team members were included in the study, with a 10-week "on-the-job" training in the workplace. The practicing of mindfulness, the loving-kindness meditation, the Tong-len meditation and the encouragement of practicing mindful pauses in the daily working routine were included. Self-report questionnaires, semi-structured interviews and measurement of cortisol were used to measure the intervention. Results indicated that there were significant gains in emotion exhaustion, personal accomplishment, anxiety, perceived stress, emotion regulation competences and joy at work [3]. This study did not only focus on psychological resilience as outcome, but emotional exhaustion and improved emotion regulation and increased joy at work are closely related to stress recovery and continued work ability. Thus, the study gives support to the use of mindfulness practice to help develop psychological resilience for palliative care practitioners.

Lautwein et al. also explored mindfulness and compassion trainings with palliative care teams [4]. The study provided an 8-week mindfulness and compassion program in a specialized palliative care unit in a university setting. The course provided mindfulness practice, breathing meditation, loving kindness meditation, tong len meditation and an attempt was made to practice these in everyday work with the patient and within the multiprofessional palliative care team. The results

DOI: 10.54254/2753-8818/2026.36829

indicated that the majority of the participants were pleased with the course. In particular, 91% said that they were moderately-very satisfied with it and would recommend that it be used in palliative care. The study also revealed that there were definitely learning gains of the participants in knowledge and techniques, and an opportunity of self-care in professional context was mentioned [4]. Thus, mindfulness practice can not only be a personal stress reduction technique, but it is also a viable strategy for promoting psychological resilience of palliative care staff.

Table 1. Comparison of intervention strategies for psychological resilience among palliative care practitioners

Intervention Strategy	Specific Methods	Primary Effects	Limitations or Considerations	Ref.
Mindfulness Practice	Body scan, breathing exercises, mindful pauses, loving-kindness meditation, Tong-len meditation; on-the-job training (10 or 8 weeks)	Reduces emotional exhaustion; enhances emotion regulation; increases work enjoyment; improves personal accomplishment	Mostly short-term training; effects rely on self-report; long-term maintenance needs verification	[3, 4]
Self-care	Daily meditation app practice; expressive writing (on traumatic or stressful events); stressor assessment and reflection	Replenishes psychological resources; reduces intrusiveness and hyperarousal; mitigates depersonalization	Direct effect on resilience indicators not significant; insufficient long-term evidence	[5, 6]
Cognitive Behavioral Therapy (including ACT)	Acceptance and Commitment Therapy (cognitive defusion, value-guided action); online workshops and self-study modules (8 weeks)	Enhances psychological flexibility; reduces self-blame and rumination; maintains professional judgment under stress	Small sample sizes; effects on perceived stress and burnout only marginal	[7, 8]
Organizational and Peer Support	Team emotional debriefing (e.g., 10 min after case discussions); buddy systems; resilience education courses; protected time and structured programs (workshops + follow-up)	Strengthens team connectedness; reduces personal distress and compassion fatigue; improves professional quality of life	Requires managerial support and time allocation; may add extra stress if poorly designed	[9-11]

To sum up, the contribution of the mindfulness practice in promoting psychological resilience among palliative care practitioners is primarily in two ways. First, it makes practitioners more aware of regulating their stress response. Second, it helps them maintain a certain level of work engagement when they face patients' suffering and death over a long period of time. But, most of the current studies are short term training, self-assessment and long-term effects are still needed to be

DOI: 10.54254/2753-8818/2026.36829

followed. From a practical point of view, mindfulness training should also be integrated with clinical working hours, teamwork and organizational structure to enhance engagement and maintenance.

3. Self-care

Self-care is important and is a key element of psychological resilience. It is fundamentally about practitioners being able to identify and embrace their own emotions and stress response, and to be able to actively regulate themselves and maintain mental health. People working in palliative care are constantly faced with suffering, death and grief of families. When they keep missing their own signs of emotional exhaustion, they could be at risk for developing emotional exhaustion and compassion fatigue. Thus, in this section the self-care is not just about resting or relaxing. Instead, it is a process of recognizing, evaluating and controlling the practitioner's own level of stress. It can involve stress coping skills training, meditation practice, stressor assessment and reflection and support following traumatic work events. These techniques can help practitioners understand where they are stressing and keep them relatively calm in the long-term work environment.

Pandya's study is a good example of the continuous self-practice in the process of self-care. The target group for this study included chaplains in Asian and African cities, serving hospices of older people, and a comparison was made between the impact of a smartphone meditation application and a leisure application on burnout and resilience [5]. These chaplains do not give a patient medical care, but they are also involved with people at the end of life and are under stresses due to death, suffering and emotional support. For this reason, some of the issues they encounter regarding resilience, are similar to those of palliative care practitioners. With respect to the results, it was found that the chaplains who used meditation app had less emotional exhaustion and depersonalization and more personal achievement and resilience than the chaplains who used leisure app [5]. This result offers potential for the ongoing use and self-practice to recover psychological resources and mitigate symptoms of burnout and to readjust and maintain functioning during chronically stressful situations.

Self-care also receives support from the study conducted by Cosentino et al., from the expressive writing standpoint [6]. A sample of 50 palliative care professionals from northern and central Italy was recruited to do this study and an expressive writing group was compared to a neutral writing group. The expressive writing group was asked to continuously write about traumatic, stressful and emotionally significant events in their professional lives. The findings indicated that following the expressive writing intervention, there was a change in participants in the following organizational and emotional variables: anger, sleep, request for help, intrusiveness and hyperarousal [6]. The results of this study, although this study did not get the result of a significant difference in the value of the resilience indicator so that it cannot be directly interpreted that expressive writing has an effect on psychological resilience, but this result has an indirect relationship with the recovery process of psychological resilience. Intrusiveness and hyperarousal are frequently the experiences of palliative care practitioners, so that traumatic experiences in the workplace have a psychological impact. Expressive writing can be used to help process events, express emotions and organise thoughts, decreasing the impact of traumatic experiences. So, expressive writing can be seen as an adjunct form of self-care to support practitioners in decreasing psychological burden and to build conditions of resilience recovery.

In summary, the role of self-care in building psychological resilience among palliative care practitioners is mainly reflected in two aspects. Mornings spent meditating and continuously practicing can be helpful to get back to a state of psychological resources and alleviate emotional exhaustion due to the daily work environment. Second, they can express their writing and reflect on

DOI: 10.54254/2753-8818/2026.36829

their negative experiences of work in order to minimise the ongoing impact of work experiences. Self-care emphasizes more on the practitioners' active management and sustained monitoring and maintenance of their stress status than is done in mindfulness practice. Although some evidence indicates that self-care interventions might have an impact on certain emotional and work-related outcomes, further research is needed to determine long-term outcomes.

4. Cognitive behavioral therapy

Another crucial means for palliative care professionals to develop psychological resilience is cognitive behavioral therapy (CBT). CBT also focuses more on the practitioners' understanding of the context of the stressful event, and the practitioners' adjustment of emotional and behavioral reactions to it, than do mindfulness practice and self-care. Palliative care practitioners are often left to cope with the following: patient mortality, limited outcomes of treatment, family grief, which can result in self-blame, helplessness, rumination and emotional exhaustion. These negative cognitions, if present for an extended period, can also contribute to more burnout and compassion fatigue. Thus, CBT can be used as a general treatment model to enable practitioners to identify negative thoughts, change the way the individual thinks about stressful events, and decrease the unnecessary psychological burden. In particular, Acceptance and Commitment Therapy (ACT) is a representative therapy within this field. It does not require practitioners to completely remove painful emotions. Rather, it aids the individual in accepting these feelings and to still exercise professional soundness of judgment and care work under stress. An important technique is cognitive defusion, which helps the ACT practitioner maintain a distance from negative thoughts and not take thoughts generated in stressful situations as facts.

Finucane et al. demonstrate how ACT can be used to psychologically support palliative care practitioners [7]. ACT is a type of CBT that focuses on enhancing mental health and wellbeing through the application of behavioral psychology, values and acceptance/mindfulness. It's not about getting rid of all the negative feelings, but about enabling the practitioner to be open to difficult internal experiences, and to keep doing meaningful care work in the midst of stress and distress. A study was done with staff at Marie Curie hospice and nursing services in Scotland, and involved an 8-week online ACT intervention. The intervention comprised three online facilitated group workshops and five online self-directed learning modules focusing on values, present moment awareness, openness, defusion and compassion. Results indicated that 25 staff members started the intervention and 23 finished (93% completion). The intervention was found to be fun, informative and helpful by the participants. The study also showed some initial positive results with regard to psychological flexibility and mental wellbeing, while perceived stress, burnout and compassion satisfaction were only marginally affected [7]. Kaur et al. also reported that mindfulness integrated cognitive behavioural intervention could reduce burnout and secondary traumatic stress, while improving compassion satisfaction, psychological well-being, and mindfulness skills among palliative cancer care professionals [8].

This study is closely related to the building of psychological resilience. Psychological resilience does not imply that practitioners will no longer have stress or sadness. Instead, it means they are able to adapt themselves following stress, and stay in their job. In ACT, cognitive defusion can be taught to allow practitioners to maintain a certain distance from negative thoughts. In other words, with thoughts like 'I did not help the patient' or 'I did not do well enough', the practitioner is not forced to hard-negate the thoughts with cognitive defusion. Rather, it allows them to identify that these are thoughts that are coming up in response to the pressure and not necessarily facts. In this

DOI: 10.54254/2753-8818/2026.36829

way, ACT can help to decrease the tendency to feel bad about oneself, rumination, and over-identification with suffering patients, in order to recover psychological resilience.

To summarize, CBT interventions in psychological resilience building of palliative care practitioners are largely manifested in three ways. First, it enables the practitioner to recognize and modify negative thoughts. Second, it enables them to keep on working professionally in spite of feelings of stress and painful emotions. Third, it helps to lessen the psychological burden from repeated self-blame and over-identification with patients and families. CBT is more focused on adjusting thoughts and changing behaviours than mindfulness practice and self-care. However, there is still a lack of feasibility studies and small-scale studies in this area and more long-term research is needed to confirm its long-term effects on psychological resilience, burnout and compassion fatigue.

5. Organizational and peer support

If adherence to the above (mindfulness, self-care, CBT) is based on practitioners' personal commitment, it could be difficult in the long run. Palliative care work is often fast-paced and emotionally demanding; therefore, building psychological resilience needs to be connected with the real work environment. Training courses, lectures and group workshops can assist institutions in developing practitioners' understanding of the interconnection between burnout, compassion fatigue, and psychological resilience. Such activities can also help practitioners learn specific ways to regulate their emotions and/or coping with stress.

Peer support is also a key strategy, in addition to education and training. Palliative care practitioners are exposed to chronic and recurrent work stress. If they are not allowed to release their emotions, then they can slowly build up. So, practitioners can have some space for expression in group discussions, one to one buddy support, mentorship, and team de-brief. For instance, following discussions of challenging cases, the team can be set up for a brief emotional feedback session, for example, 10 minutes. This can be led by a more experienced member of staff and can be an opportunity for staff to discuss their own experiences of stress and emotions related to care. McCool et al. also demonstrated that a buddy system can be a beneficial and easily implemented workplace intervention strategy, as it can enhance team members' sense of support and connection and potentially help to decrease personal distress and compassion fatigue [9]. Klein et al. also suggested that resiliency education may help clinicians improve professional quality of life, increase compassion satisfaction, and reduce burnout-related outcomes [10].

Simultaneously, organizational support is also needed. With the addition of psychological support programs to practitioners' already demanding workload, these programs can be another source of stress. Thus, institutions can allow protected time for participation, minimise the time pressure for attending training activities and/or group activities, and have management support. In addition, Tamura et al. have developed a program called MaHALO, which indicates that training that is based on resilience may be more feasible when it is designed as a structured program, for example, a workshop, follow-up sessions, self-practice, and online support, than just a one-time lecture [11]. In general, building psychological resilience should involve individual daily practices, team member support and organization resources. In this way, psychological support can be provided more regularly and continuously in palliative care teams.

6. Conclusion

To sum up, palliative care practitioners deal with patient suffering, patient death and family grief, and have an inherent risk of developing burnout, compassion fatigue and emotional exhaustion and

DOI: 10.54254/2753-8818/2026.36829

secondary traumatic stress. Thus, it is crucial to develop psychological resilience to support practitioners' mental wellbeing and the provision of good care. Previous research indicates that mindfulness training may be useful for detecting and controlling stress reactions, self-care may be valuable for replenishing psychological resources and working through adverse work experiences, and cognitive behavioral therapy may be beneficial for recognizing and changing negative thoughts. In the meantime, peer support, education and training and supporting organizations can set the stage for the effective implementation of these approaches in the long term. In general, building psychological resilience should not be solely the responsibility of individual practitioners, but should be achieved through the combined efforts of individuals, teams and institutions.

However, there are some drawbacks to the current research, including small sample size and short follow-up periods, and a lack of studies examining the long-term effects. Sustained effects of these interventions in the real world of work could be examined by extending the follow-up period in the future. Meanwhile, the synergy between individual practice, team support and organizational management should be given more consideration. Further investigations on how they can be integrated in various palliative care settings might lead to more stable and sustainable psychological support of practitioners.

References

[1] Tererai, A. C., Borok, M., Chirenje, Z. M., Gwyther, L., Farrant, L., Ndlovu, N., & Rusakaniko, S. (2026). A scoping review on pathways/models/frameworks for palliative care provision for cancer patients while admitted at hospitals within sub-Saharan Africa. *Ecancermedicalscience, 20*, 2104.

[2] Chen, M., Wei, S., Sun, J., & Zhang, C. (2026). Compassion fatigue and associated factors among palliative care nurses: A systematic review and meta-analysis. *Applied Nursing Research, 89*, 152070.

[3] Orellana-Rios, C. L., Radbruch, L., Kern, M., Regel, Y. U., Anton, A., Sinclair, S., & Schmidt, S. (2017). Mindfulness and compassion-oriented practices at work reduce distress and enhance self-care of palliative care teams: A mixed-method evaluation of an "on the job" program. *BMC Palliative Care, 17*(1), 3.

[4] Lautwein, F., Schallenburger, M., Scherg, A., Schlieper, D., Karger, A., Regel, Y. U., Schwartz, J., & Neukirchen, M. (2023). Mindfulness and compassion training on daily work with patients and within the multiprofessional palliative care team: A retrospective self-assessment study. *BMC Palliative Care, 22*(1), 37.

[5] Pandya, S. P. (2021). Meditation app alleviates burnout and builds resilience for chaplains in hospices for older adults in Asian and African cities. *Journal of Health Care Chaplaincy, 27*, 129-145.

[6] Cosentino, C., D'apice, C., Del Gaudio, M., Bertoletti, C., Bini, M., Liotti, M. C., Melli, E., Tesa, F., Sarli, L., & Artioli, G. (2021). Effectiveness of expressive writing protocol in palliative care healthworkers: A quantitative study. *Acta Biomedica, 92*(S2), e2021010.

[7] Finucane, A. M., Hulbert-Williams, N. J., Swash, B., Spiller, J. A., Wright, B., Milton, L., & Gillanders, D. (2023). Feasibility of RESTORE: An online acceptance and commitment therapy intervention to improve palliative care staff wellbeing. *Palliative Medicine, 37*(2), 244–256.

[8] Kaur, A., Sharma, M. P., & Chaturvedi, S. K. (2023). Mindfulness integrated cognitive behavioural intervention: Effects on palliative cancer care professionals. *BMJ Supportive & Palliative Care, 13*, e1048–e1055.

[9] McCool, N., Reidy, J., Steadman, S., & Nagpal, V. (2022). The buddy system: An intervention to reduce distress and compassion fatigue and promote resilience on a palliative care team during the COVID-19 pandemic. *Journal of Social Work in End-of-Life & Palliative Care, 18*, 302–324.

[10] Klein, C. J., Riggenbach-Hays, J. J., Sollenberger, L. M., Harney, D. M., & McGarvey, J. S. (2018). Quality of life and compassion satisfaction in clinicians: A pilot intervention study for reducing compassion fatigue. *American Journal of Hospice and Palliative Care, 35*(6), 882–888.

[11] Tamura, N., Park, S., Sato, Y., Takita, Y., Morishita, J., Ninomiya, A., Kosugi, T., Sado, M., Mimura, M., & Fujisawa, D. (2020). Study protocol for evaluating the efficacy of mindfulness for health professionals building resilience and compassion program: A randomized, waiting-list controlled trial. *Journal of Psychosocial Oncology Research & Practice, 2*(2), e22.