

Research Article

Determinants of Psychological Distress Among Healthcare Workers in a Reference Medical Oncology Unit in Cameroon

**Berthe Sabine Esson Mapoko^{1,*} , Esther Dina Bell² ,
Marie Josiane Ntsama Essomba¹ , Veronique Batoum Mboua¹,
Etienne Atenguena¹ , Dominique Anaba³, Anne Sango³, Ruth Mapenya¹,
Anne Marthe Maison², Sidonie Ananga², Ambroise Ntama², Zacharie Sando¹,
Olga Bassong Mankollo⁴, Julienne Ngo Likeng⁴**

¹Faculty of Medicine and Biomedical Sciences, University of Yaounde I, Yaounde, Cameroon

²Faculty of Medicine and Pharmaceutical Sciences, University of Douala, Douala, Cameroon

³Faculty of Health Sciences, University of Buea, Buea, Cameroon

⁴School of Health Sciences, Catholic University of Central Africa, Yaounde, Cameroon

Abstract

Introduction: Healthcare professionals working in oncology are exposed to intense and constant stressors, given the severity of the diseases and frequent confrontation with patient death, which can lead to significant psychological distress and professional burnout. This study's objective was to identify the sociodemographic, social, and work-related determinants contributing to this distress among the nursing staff in the medical oncology department of the Yaoundé General Hospital. **Materials and Methods:** This was a qualitative study conducted from July to December 2017 in a reference medical oncology unit in Cameroon. The study population comprised the entire nursing and medical staff of the department. A non-probability, exhaustive sampling method was used, resulting in seventeen healthcare workers (13 women, 4 men; 10 nurses, 7 doctors) participating. Data were collected through audio-recorded individual semi-structured interviews and subsequently analyzed using manual content analysis. **Results:** The analysis revealed that psychological distress is a multifaceted issue driven by three main categories of determinants. Sociodemographic factors identified as sources of pressure included female gender, place of residence (linked to long commutes and traffic stress), family pressure, and personal/financial difficulties. Social factors highlighted varying coping strategies, from prayer and communication to emotional detachment (disconnection/splitting) in the face of patient suffering and death. Work-related environmental determinants were found to be the primary cause of distress, unanimously described by staff. These organizational factors included an unbearably heavy workload due to understaffing, stress from managing patient pain and death (often reduced to administrative tasks), difficult interprofessional communication between nurses and doctors, a severe lack of continuous professional training, and a complete absence of gratification or recognition from management. **Conclusion:** Psychological distress among oncology healthcare professionals is strongly associated with sociodemographic, social, and, critically, pervasive work-related environmental determinants. The heavy and poorly managed workload, coupled with a lack of institutional support, training, and recognition, are major sources of suffering that require urgent attention from hospital administrators to mitigate psychosocial risks.

*Corresponding author: mapokob@yahoo.fr (Berthe Sabine Esson Mapoko)

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Keywords

Determinants, Psychological Distress, Healthcare Workers, Oncology, Yaounde General Hospital

1. Introduction

The environment of cancer care is highly emotionally demanding due to the severity of the diseases treated [1-4]. Psychological distress among healthcare workers, linked to various determinants, is a common issue [4-6]. High levels of stress and a significant prevalence of professional burnout syndrome have been described by several authors [4, 6-9]. Oncologists, in particular, are exposed to stress from frequent confrontations with patient death and end-of-life decisions [1, 4]. Embriaco et al. identified a 46.5% burnout rate among physicians, with a higher prevalence in women [10]. According to these authors, organizational factors are most often associated with this exhaustion, suggesting that the work environment itself can be a source of psychological suffering for staff [11].

Other studies, such as that by Colombat et al. [12], identify causes related to the individual (character, personal history), the medical specialty, and the organization and workload. These findings prompted us to explore the factors explaining the shift from an initial idealistic commitment to stagnation, gradual disengagement, frustration, and eventually, a disillusioned apathy—all manifestations of healthcare workers' psychological distress. To inform policymakers and administrators about the reality experienced by staff in this department, our research aimed to explore the determinants of this distress within the medical oncology unit of the Yaoundé General Hospital. Specifically, we sought to determine the sociodemographic factors, as well as the social and environmental determinants related to the work.

To better understand the psychological experience of healthcare workers, it is crucial to consider established psychological models of reaction to stress. The theory of attitude developed by Dmitry Uznadze provides a relevant framework [13]. Uznadze defines attitude as an unconscious readiness of the individual to perceive and act in a certain direction, determined by both the immediate situation and specific needs. His work establishes a hierarchical principle of mental activity, differentiating two key levels:

- 1) The Level of Attitude: Behavior is determined by the immediate impact of the situation, and immediate, relevant needs are satisfied. This corresponds to the automatic, often emotionally-driven coping mechanisms observed in daily practice.
- 2) The Level of Objectification: Activity takes on a more generalized, conscious nature, independent of the situation. At this level, individuals consider social demands and the needs of others. This level is essential for the conscious, professional detachment and long-term ad-

aptation required in oncology.

Psychological distress often occurs when the intense demands of the work environment (attitude level) overwhelm the staff's capacity for objectification. Our study aims to specifically explore the organizational and environmental factors that challenge this higher-level objectification among oncology staff in a low-resource setting.

2. Methodology

2.1. Study Design and Setting

We conducted a qualitative study at the medical oncology department of the Yaoundé General Hospital from July to December 2017. The department is divided into two areas: the inpatient ward (on the 2nd floor, with 30-35 beds) and the day hospital (8 beds). At the time of the study, the department had 18 healthcare professionals (1 oncologist, 1 general practitioner, 5 oncology residents, and 10 nurses or nursing assistants). Semi-structured qualitative interviews were conducted to explore the subjective experience of psychological distress.

2.2. Study Population

The study included all healthcare professionals (doctors, nurses, nursing assistants) from the Medical Oncology Department of the Yaoundé General Hospital who agreed to participate. A non-probability and exhaustive sampling method was used. In total, 17 healthcare workers participated: 13 women and 4 men, comprising 10 nurses and 7 doctors.

2.3. Data Collection

Data were collected by a single interviewer through audio-recorded individual interviews conducted in a department consultation room. The interview guide covered:

- 1) Sociodemographic profile (gender, age, marital status, residence, number of children, and experience).
- 2) Sociodemographic determinants of psychological distress (influence of personal and private life factors on work).
- 3) Social determinants (physical exercise, substance use, and stress and emotional management when dealing with patients).
- 4) Work-related environmental determinants (workload,

organization, management of difficult situations, communication, training, and gratification).

2.4. Procedure

After obtaining research authorizations and a period of immersion to build trust, the interviewer proposed interviews to the healthcare workers. Informed consent was obtained from each participant. The interviews, lasting about 30 minutes, were recorded and transcribed verbatim.

2.5. Ethical Considerations

The study received research authorizations and ethical clearance from the Institutional Ethics Committee for Human Health Research (CEIRSH) N° 2017/0622/CEIRSH/ESS/MSP. Informed consent and confidentiality of all information were ensured.

2.6. Data Analysis

A manual content analysis was performed [14].

3. Results

3.1. Characteristics of the Study Population

Seventeen healthcare workers were exhaustively sampled, comprising 13 women and 4 men (a female-to-male ratio of 3.25:1). The participant pool was segmented into 10 nurses (predominantly female at an 8:2 ratio) and 7 doctors (5 women, 2 men). The nursing staff (Table 1) displayed greater professional tenure (range: 5-27 years; ages: 40-53 years), while the doctors (Table 2) were younger (ages: 26-42 years; professional experience: 4-15 years). This demographic distinction suggests two cohorts with potentially different maturity levels in dealing with professional stressors.

Table 1. Sociodemographic Profile of Nurses.

	Gender	Age (years)	Marital Status	Children in care	Professional Experience (years)	Oncology Experience
Informant 1	F	50	Divorced	7	20	2 years
Informant 2	F	40	Married	3	16	3 years
Informant 3	F	47	Married	1	17	3 years
Informant 4	M	47	Married	4	17	6 years
Informant 5	F	47	Married	5	15	3 years
Informant 6	F	53	Separated	7	23	2 years
Informant 7	F	53	Married	3	19	1 year
Informant 8	M	53	Married	5	27	5 months
Informant 9	F	44	Married	2	5	2 years
Informant 10	F	50	Married	4	17	years

Table 2. Sociodemographic Profile of Physicians.

	Gender	Age	Marital Status	Children in care	Professional Experience	Oncology Experience	Work Schedule
Info 11	M	42	Divorced	4	15 years	10 years	Every day, all hours, except when sleeping
Info 12	M	29	Single	0	4 years	3 years	7:30 a.m. - 5:00 p.m.
Info 13	F	30	Married	3	5 years	1 year	7:30 a.m. - 3:30 p.m./5:00 p.m. and on call
Info 14	F	26	Single	1	3 years	1 year	7:30 a.m. - 4:00 p.m./6:00 p.m. and on call
Info 15	F	34	Married	1	7 years	2 years	8 a.m. to 6 p.m. and on call
Info 16	F	36	Married	2	9 years	3 years	7:30 a.m. until 6:00 p.m./8:00 p.m. and on call

	Gender	Age	Marital Status	Children in care	Professional Experience	Oncology Experience	Work Schedule
Info 17	F	30	Single	0	7 years	2 years	No fixed schedule

3.2. Sociodemographic Determinants of Psychological Distress

The findings reveal that psychological distress is intricately linked to demographic and personal status, like age, gender, marital status, place of residence, and the number of children.

Age and Experience: Staff perception of age was contradictory. Older workers perceived advanced age as a source of wisdom and maturity, enabling them to better manage their daily practice: "I think age improves practice... you manage a lot of things that in every way have an impact on the profession, and you can only manage those things if you have age" (Info 11). Conversely, others felt youth was an asset due to the vitality and energy required: "...the staff in the oncology department should be younger to better care for the sick, to be quick to come to the aid of the sick..." (Info 4). Some young workers felt vulnerable to suffering: "At my age, I tell myself, I am still very young (40 years old), there are things I shouldn't have to see, for example in the oncology department..." (Info 2). Finally, some saw no influence of age at all.

Gender and Role: For some women, their gender was a disadvantage due to the risks associated with chemotherapy during pregnancy or physiological disturbances: "There is also the problem of gender, because it may be that when you are pregnant, you should not work in the department because of the effects of chemotherapy..." (Info 2). However, the majority viewed femininity as an asset, linked to compassion: "...an asset because I am a mother and when I go to a patient, for me I am going to a son, a daughter, a child regardless of their age..." (Info 7). Men also felt they brought "more moderation" (Info 11) and that patients were more willing to interact with them.

Marital Status: Marriage was dual-edged. Being married was an asset for some who found family support and balance in managing stress: "The fact that I am in a family helps me manage my work-related psychological distress a little..." (Info 15). For others, marriage was a source of additional pressure: "...only the fatigue, the fatigue because in oncology there is a lot of work... at any time, the husband is saying you haven't done this yet, you haven't done that yet" (Info 9). Single workers, meanwhile, highlighted their greater availability.

Place of Residence: Distance and traffic jams were a major source of fatigue and stress: "...I have to get up very early to get there on time and sometimes when I come home late, I have to drive for two hours to get home with work fatigue, the stress of traffic jams, it has a negative effect on me" (Info 12).

Personal Problems: Despite personal difficulties, most workers tried not to let them affect their work: "We are human but I force myself to separate things so that my problems in the neighborhood or at home or personal issues do not influence my work because where I have my difficulties the patient is not there" (Info 10).

3.3. Social Determinants of Psychological Distress

Staff exhibited diverse, often insufficient, strategies for managing the emotional burden of the oncology environment.

Physical Exercise: It was unanimously recognized as beneficial for well-being and stress management: "...it's a medicine for me..." (Info 9). However, many staff members did not exercise regularly due to a lack of time.

Substance Use: Alcohol was sometimes seen as a relaxant, but most workers considered substances like alcohol, sleeping pills, and drugs to be harmful and ineffective long-term: "...they are just like mirrors, it means you have the impression that when you consume them the problems will be sorted out, just that for the duration of the consumption alcohol and tobacco have their effect, but after the effect wears off we return to our suffering..." (Info 14).

Stress Management in the Face of Pain and Death: Staff used various coping mechanisms: denial, acceptance, identification, prayer, communication, or relativization. "It's the daily routine. The more patients we lose, the more we stress. We ask ourselves, is what we're doing not effective. We ask ourselves questions..." (Info 8).

Emotional Management: Patient suffering evoked empathy, sadness, and compassion. Some chose to "disconnect" or "split themselves" to protect themselves, remaining professional: "...I make an effort not to have emotions... it's to stay in the realm of empathy..." (Info 11).

Sick Leave: The reported low rate of sick leave was structurally misleading, attributed not to staff wellness, but to the administrative difficulty of obtaining permission in an already severely understaffed environment.

3.4. Work-Related Environmental Determinants

These factors were identified as the most consistent and powerful sources of distress, pointing to systemic organizational failures.

Workload: This was unanimously described as enormous and unbearable: "...the workload is heavy compared to the

staff working" (Info 3). This was exacerbated by understaffing and poor task allocation.

Work Organization: Collaboration among nurses and among doctors was considered good. However, communication between the two professions was more difficult: "...but it's with the nurses that it's a little difficult because sometimes we are forced to run after the nurses..." (Info 14).

Management of Difficult Situations: This was handled through different means: referral to management, silence, dialogue, and sometimes uncontrolled reactions.

Care Strategies: While physical pain management was well-mastered, psychological support was deemed insufficient due to a lack of time and specialized personnel. Deaths were particularly difficult for staff, often reduced to administrative formalities. "So that's the thing I manage least well I think because I don't always have the time necessary to accompany the death..." (Info 11).

Training and Gratification: Continuous training was almost non-existent for nurses, who learned through exchanging experiences. Doctor's training was more structured but hindered by the workload. The complete absence of gratification was perceived as a major factor in suffering and demotivation. "What we know is reproaches, insults... There is no thank you or encouragement" (Info 7).

4. Discussion

Our qualitative investigation offers a granular view of the psychological distress experienced by oncology healthcare workers in a low-resource setting, revealing a complex interplay of sociodemographic burdens, personal coping deficiencies, and critical organizational failures.

4.1. Sociodemographic Burdens and the Role of Gender

The finding that female gender is a cited determinant, both as an asset (compassion) and a risk (pregnancy/chemotherapy), aligns with prior studies reporting a higher prevalence of burnout among female oncologists [10]. This suggests that in addition to professional demands, women face the added complexity of navigating gendered risks and societal expectations (the "second shift" of domestic pressure mentioned by married staff) which compounds their professional stress. The burden of long, difficult commutes ("Place of Residence") further externalizes the workplace stress into their personal lives, consuming the crucial recovery time needed for psychological resilience. This is a profound finding in a developing country context, where infrastructure deficiencies become direct occupational health hazards.

4.2. Uznadze's Theory: The Failure of Objectification

Our findings are powerfully interpreted through the lens of

Uznadze's Theory of Attitude. The "disconnection" or "splitting" strategy used by staff to manage acute patient suffering reflects behavior at the Level of Attitude—an immediate, defensive, and *unconscious* coping mechanism [13]. While this protects the individual from immediate emotional collapse (survival), it represents a failure to achieve the Level of Objectification—the conscious, generalized mental activity required for long-term, sustainable professional practice.

The organizational environment actively prevents Objectification. The staff's *expressed needs* for structured communication, adequate staffing (to allow time for psychological support), and professional development (training) are the very elements that facilitate conscious, adaptive behavior. The fact that the hospital system systematically denies these needs forces staff to remain trapped in the emotionally draining, reactive Level of Attitude, sustaining their distress. The overwhelming workload and lack of time for accompanying patient death exemplifies this perfectly: staff are reduced to transactional tasks, unable to perform the conscious, compassionate care (Objectification) they know is necessary.

4.3. Organizational Failure as the Primary Psychosocial Hazard

The environmental determinants were not merely contributing factors; they were the root cause of chronic distress. The "unbearable workload" due to understaffing is the central pathology, amplifying all other stressors. This aligns with prior research identifying organizational factors as the strongest predictors of burnout [12]. The issues observed—workload, poor communication, and lack of reward—are recognized globally as critical psychosocial risks (PSRs), as defined by standards like ISO 45003:2021 (Psychological health and safety at work).

The finding that patient suffering evoked deep empathy, sadness, and compassion suggests that the suppression or management of these emotions requires continuous effort. The failure to fully express or process emotions in the care relationship, as highlighted by Bourdeaut, leads to cumulative repression that fuels professional distress [15].

1) Gratification and Motivation

The complete absence of gratification ("no thank you or encouragement" [7]) represents a failure to meet the fundamental security and recognition needs highlighted by motivation theory. This chronic deficiency corrodes the intrinsic value of the work, leading to demotivation and apathy—the classic pathway toward disillusioned professional disengagement.

2) Interprofessional Communication

The friction between nurses and doctors is a critical systemic fault. Effective, open communication is essential for teamwork, safety, and mutual support in a high-stakes environment. Its breakdown creates frustration and silos, preventing a unified response to the daily trauma of oncology care. Poor communication not only hinders the smooth flow

of medical operations [16] but also directly impairs the staff's ability to coordinate care, especially in emotionally sensitive areas like palliative care, where communication is essential for the coping of both patients and staff [17].

4.4. Implications and Future Research in Low-Resource Settings

The findings underscore a severe disparity between the high emotional demands of oncology and the minimal institutional support provided in this low-resource context. The low reported sick leave, while seemingly positive, is a false indicator of health, acting instead as a measure of the severity of the staffing crisis—a classic finding in overburdened public health systems.

Our qualitative results provide rich descriptive data, which must now inform subsequent quantitative research. To objectively substantiate the severity of these psychosocial hazards, we also evaluated the prevalence of the distress, the perception of the suffering and the management of the distress.

The organization's failure to address workload, training, and gratification is not just a human resource issue; it is a direct threat to the quality and sustainability of cancer care in Cameroon.

5. Conclusion

Psychological distress within the medical oncology department is a pervasive problem primarily driven by critical, unaddressed work-related environmental determinants. The confluence of an unsustainable workload due to understaffing, fractured interprofessional communication, and a crippling absence of both continuous training and professional gratification are the major sources of staff suffering. These organizational deficiencies necessitate an urgent, systemic response from hospital management focused on implementing structural reforms to mitigate psychosocial risks and preserve the well-being of the healthcare workforce.

Abbreviations

MD	Medicinae Doctor (Doctor of Medicine)
MPH	Master of Public Health
ORCID	Open Researcher and Contributor ID
CEIRSH	Ethics Committee for Human Health Research
PSRs	Psychosocial Risks
ISO	International Organization for Standardization

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Author Contributions

Berthe Sabine Esson Mapoko: Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Project administration, Resources, Software, Supervision, Validation, Visualization, Writing - original draft, Writing - review & editing

Esther Dina Bell: Conceptualization, Methodology, Supervision, Validation, Visualization, Writing - review & editing

Marie Josiane Ntsama Essomba: Validation, Visualization, Writing - review & editing

Veronique Batoum Mboua: Validation, Visualization, Writing - review & editing

Etienne Atenguena: Validation, Visualization, Writing - review & editing

Dominique Anaba: Validation, Visualization, Writing - review & editing

Anne Sango: Validation, Visualization, Writing - review & editing

Ruth Mapenya: Validation, Visualization, Writing - review & editing

Anne Marthe Maison: Validation, Visualization, Writing - review & editing

Sidonie Ananga: Validation, Visualization, Writing - review & editing

Ambroise Ntama: Validation, Visualization, Writing - review & editing

Zacharie Sando: Validation, Visualization, Writing - review & editing

Olga Bassong Mankollo: Validation, Visualization, Writing - review & editing

Julienne Ngo Likeng: Conceptualization, Data curation, Formal Analysis, Methodology, Project administration, Software, Supervision, Validation, Visualization, Writing - review & editing

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Data Availability Statement

The data is available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare no conflicts of interest.

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