SJIF Impact Factor (2026): 8.863| ISI I.F. Value: 1.241| Journal DOI: 10.36713/epra2016 ISSN: 2455-7838(Online)
EPRA International Journal of Research and Development (IJRD)
Volume: 11 | Issue: 10| October 2026 - Peer Reviewed Journal

COMPASSION FATIGUE AND BURNOUT AMONG ONCOLOGY NURSES: A CROSS-SECTIONAL STUDY

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ABSTRACT

This cross-sectional, descriptive-correlational study examined compassion fatigue and burnout among 58 oncology nurses at Prince Faisal Cancer Center in Buraydah, Qassim Region, Kingdom of Saudi Arabia. Data were collected using a demographic and work-related profile sheet and the Professional Quality of Life Scale, Version 5 (ProQOL-5). Descriptive statistics and inferential tests were used to summarize respondents' characteristics, describe the study variables, and examine associations. The reported mean scores were 2.72 (SD = 0.56) for Secondary Traumatic Stress, used as the study's indicator of compassion fatigue, and 3.32 (SD = 0.64) for burnout; the original analysis classified both as moderate. Age, sex, civil status, years of nursing experience, and work shift were not significantly associated with either outcome (all reported p values > .05). Secondary Traumatic Stress and burnout were positively correlated (r = .624, p < .001). The reported internal consistency coefficient was .903 for Secondary Traumatic Stress and .283 for burnout. The low burnout coefficient limits confidence in burnout-related findings and warrants careful interpretation. The findings support attention to both trauma-related distress and occupational strain and provide an initial basis for an Oncology Nurse Wellness and Resilience Program. Because of the single-center cross-sectional design, the results are associative and should not be interpreted causally.

KEYWORDS: *Burnout; Compassion Fatigue; Oncology Nurses; ProQOL-5; Secondary Traumatic Stress; Nurse Well-Being*

INTRODUCTION

The Problem and its Background

Oncology nurses provide care across the cancer trajectory, including diagnosis, active treatment, symptom management, recurrence, disease progression, and end-of-life care. Their responsibilities extend beyond clinical monitoring and treatment administration to include patient and family education, emotional support, communication about difficult outcomes, and coordination of multidisciplinary services. Repeated exposure to suffering, uncertainty, grief, and complex clinical demands may affect nurses' professional quality of life and make compassion fatigue and burnout important workforce concerns.

The Professional Quality of Life framework distinguishes compassion satisfaction from the negative dimensions of burnout and Secondary Traumatic Stress (STS). STS refers to trauma-related stress associated with indirect exposure to other people's traumatic experiences; burnout reflects work-related exhaustion and negative occupational experiences (Stamm, 2010). In this study, compassion fatigue was operationalized through the STS subscale of the Professional Quality of Life Scale, Version 5 (ProQOL-5), while burnout was examined as a separate subscale. The ProQOL-5 is a research and screening instrument and is not a diagnostic tool.

Research has documented compassion fatigue and burnout among oncology nurses across different healthcare settings. A systematic review and meta-analysis by Algamdi (2022) examined compassion satisfaction, burnout, and STS among oncology nurses and demonstrated the continuing relevance of these dimensions to professional quality of life. Xie *et al*. (2021) similarly reviewed the levels, prevalence, and associated factors of compassion fatigue in oncology nursing. More recent work has continued to examine burnout in oncology nurses and has highlighted variation across samples and measurement approaches (Helaß & Maatouk, 2024). A multicenter study in Oman also found that moderate STS and burnout were common among participating oncology nurses, underscoring the importance of examining experiences within regional healthcare contexts (Jacob *et al*., 2024).

The Job Demands–Resources Model provides a useful framework for interpreting occupational strain. It proposes that sustained job demands can contribute to exhaustion, while resources such as supportive leadership, teamwork, autonomy, and opportunities for recovery may help workers manage demands (Bakker & Demerouti, 2017; Demerouti *et al*., 2001). In oncology settings, emotional labor and repeated contact with patient suffering may interact with workload and organizational resources. However, demographic characteristics alone may not fully explain differences in professional quality of life.

Although international studies have examined compassion fatigue and burnout, institution-specific evidence remains useful because staffing practices, organizational support, cultural context, and clinical responsibilities differ between settings. Evidence from other countries cannot automatically be assumed to describe nurses working in a specialized cancer center in the Qassim Region of Saudi Arabia. Local assessment can help describe the reported levels of STS and burnout and inform practical support strategies.

This study examined compassion fatigue, operationalized through STS, and burnout among oncology nurses at Prince Faisal Cancer Center in Buraydah, Saudi Arabia. It also examined the relationships between these outcomes and selected demographic and work-related characteristics—age, sex, civil status, years of nursing experience, and work shift—and determined the relationship between STS and burnout. The findings were intended to inform the proposed Oncology Nurse Wellness and Resilience Program.

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Statement of the Problem

This study therefore determined the levels of compassion fatigue and burnout, examined their relationships with selected respondent characteristics, and used the findings as the basis for an Oncology Nurse Wellness and Resilience Program. Specifically, it aims to answer the following research questions:

1.What is the demographic and work-related profile of the respondents in terms of Age, Sex, Civil status, Educational attainment, Years of nursing experience, and Years of oncology nursing experience?
2. What is the level of compassion fatigue among oncology nurses, as operationalized through secondary traumatic stress scores on the ProQOL-5 in terms of Low level, Moderate level, and High level?
3. What is the level of burnout among oncology nurses as measured through the Burnout dimension of the ProQOL-5 in terms of Low level, Moderate level, and High level?
4. Is there a significant relationship between the respondents' demographic and work-related profile and their levels of compassion fatigue?
5. Is there a significant relationship between the respondents' demographic and work-related profile and their levels of burnout?
6. Is there a significant relationships between compassion fatigue and burnout among oncology nurses?
7. based on the findings, what Oncology Nurse Wellness and Resilience Program may be proposed?

Conceptual Framework

The conceptual framework treated age, sex, civil status, years of nursing experience, and work shift as contextual variables potentially associated with compassion fatigue and burnout. Compassion fatigue was operationalized through the Secondary Traumatic Stress (STS) subscale of the ProQOL-5, while burnout was assessed as a separate subscale. The study also examined the association between STS and burnout. Because the design was cross-sectional, the framework represents statistical relationships rather than causal effects. The findings were intended to inform a proposed Oncology Nurse Wellness and Resilience Program.

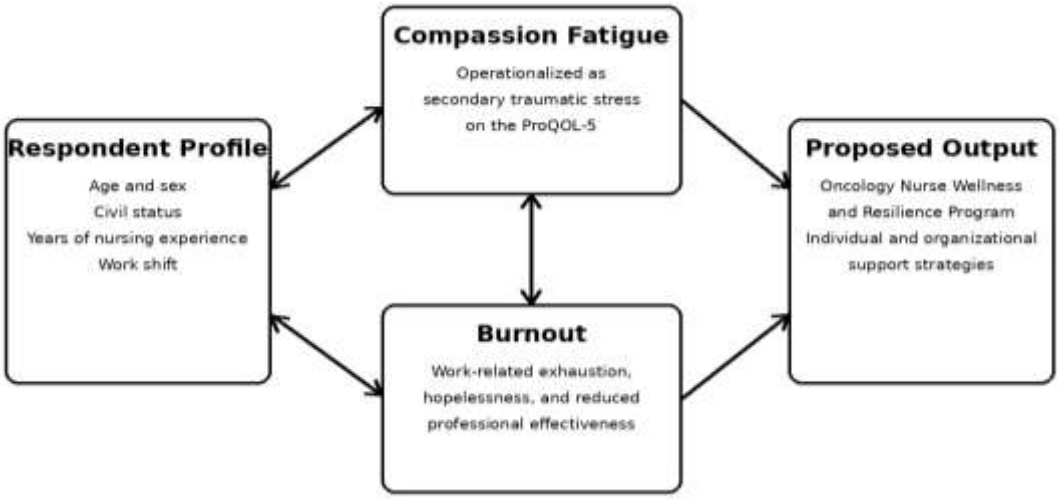


Figure 1. Conceptual Framework of the Study

Note. Developed by the researcher based on the Job Demands-Resources Model and the Professional Quality of Life framework (Bakker & Demerouti, 2017; Demerouti et al., 2001; Stamm, 2010).

METHODOLOGY

Research Design and Setting

A quantitative, descriptive-correlational, cross-sectional design was used. The study described respondents' demographic and work-related characteristics and their reported STS and burnout scores. It also examined associations between selected respondent characteristics and the study variables and the correlation between STS and burnout. Data were collected at one point in time; therefore, the design could identify associations but could not establish temporal or causal relationships. The study was conducted at Prince Faisal Cancer Center in Buraydah, Qassim Region, Kingdom of Saudi Arabia.

Participants and Sampling

The study included 58 nurses providing direct oncology care at the study site. Eligible participants were actively employed, directly involved in oncology patient care, and had at least six months of oncology nursing experience. Nurses assigned exclusively to administrative duties, those on extended leave during data collection, and those temporarily rotated to oncology for less than six months were excluded. A total-enumeration approach was attempted, whereby eligible nurses were invited to participate. Participation was voluntary.

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Measures

The questionnaire comprised a researcher-developed demographic and work-related profile sheet and the Professional Quality of Life Scale, Version 5 (ProQOL-5; Stamm, 2010). The profile sheet covered age, sex, civil status, years of nursing experience, and work shift. The ProQOL-5 contains 30 items across three 10-item subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. The present study focused on the Burnout and STS subscales. STS was used as the operational indicator of compassion fatigue, while burnout was analyzed separately. Burnout items 1, 4, 15, 17, and 29 require reverse scoring before the subscale is computed. The ProQOL-5 is not intended to diagnose a mental health condition.

The STS and burnout results are reported as mean scores on the five-point response metric and were classified as moderate under the study's scoring approach. These labels are descriptive rather than diagnostic. The ProQOL-5 should be interpreted at the subscale level, and continuous scores are generally preferred to arbitrary categories (Stamm, 2010).

Data Collection and Ethical Considerations

Ethical approval was obtained from a PHREB-accredited Research Ethics Committee before data collection, and institutional permission was obtained from the study site. Respondents received information about the study and participated voluntarily after providing informed consent. No names or employee numbers were collected, and findings were reported in aggregate form. Confidentiality safeguards were maintained throughout the study.

Statistical Analysis

Frequencies and percentages summarized categorical respondent characteristics. Means and standard deviations summarized the STS and burnout scores. Pearson correlation was used for age and years of nursing experience, independent-samples t-tests for sex, and analysis of variance (ANOVA) for civil status and work shift. Pearson correlation was used to examine the relationship between STS and burnout. Statistical significance was set at $p < .05$.

Respondent Profile

Table 1 presents respondents' distribution by sex. Female nurses represented 74.14% of the sample.

Table 1. Profile of Respondents According to Sex (N = 58)

Sex	f	%
Female	43	74.14
Male	11	18.97
Prefer not to say	4	6.90
Total	**58**	**100.00**

The sample was predominantly female. This table describes the composition of participants and should not be interpreted as evidence that sex was associated with either outcome.

Table 2 presents the age distribution. The largest group was aged 26–35 years (56.90%).

Table 2. Profile of Respondents According to Age Group (N = 58)

Age Group	f	%
18-25 years	0	0.00
26-35 years	33	56.90
36-45 years	18	31.03
46-55 years	7	12.07
56 years and above	0	0.00
Total	**58**	**100.00**

More than half of the respondents belonged to the 26–35 years category, followed by those aged 36–45 years. No respondents were reported in the 18–25 years or 56-years-and-above categories.

Table 3 presents respondents' civil status. Married respondents comprised the largest category (46.55%).

Table 3. Profile of Respondents According to Civil Status (N = 58)

Civil Status	f	%
Married	27	46.55
Single	23	39.66
Prefer not to say	7	12.07
Widowed	1	1.72
Total	**58**	**100.00**

Respondents represented several civil-status categories. The distribution is descriptive; the inferential analysis is presented separately in Table 8 and Table 9.

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Table 4 presents respondents' years of nursing experience. The largest category had 5–10 years of experience (43.10%).

Table 4. Profile of Respondents According to Years of Nursing Experience (N = 58)

Years of Nursing Experience	f	%
Less than 5 years	14	24.14
5–10 years	25	43.10
11–15 years	11	18.97
16–20 years	5	8.62
More than 20 years	3	5.17
Total	**58**	**100.00**

Most respondents reported between 5 and 10 years of nursing experience. The study did not establish a statistically significant relationship between years of experience and either outcome in the reported analyses.

Table 5 presents respondents' work shifts. Rotating-shift nurses represented the largest category (36.21%).

Table 5. Profile of Respondents According to Work Shift (N = 58)

Work Shift	f	%
Day Shift	20	34.48
Evening Shift	9	15.52
Night Shift	8	13.79
Rotating Shift	21	36.21
Total	**58**	**100.00**

Rotating-shift nurses formed the largest group, followed by day-shift nurses. Work shift was not significantly associated with either STS or burnout in the reported analyses.

Levels of Secondary Traumatic Stress and Burnout

Table 6 presents the reported mean and standard deviation for STS, used as the study's indicator of compassion fatigue.

Table 6. Level of Secondary Traumatic Stress as an Indicator of Compassion Fatigue

Variable	Mean	SD
Secondary Traumatic Stress (Compassion Fatigue)	2.72	0.56

The reported mean was 2.72 (SD = 0.56), classified as moderate in the thesis. This is reproduced as reported; the scoring metric and classification should be verified against the official ProQOL-5 scoring guidance before publication.

Table 7 presents the reported mean and standard deviation for burnout.

Table 7. Level of Burnout Among Oncology Nurses

Variable	Mean	SD
Burnout	3.32	0.64

The reported burnout mean was 3.32 (SD = 0.64), classified as moderate in the thesis. The reported internal consistency coefficient for the burnout subscale was low (α = .283), so this result and other burnout-related findings require cautious interpretation pending verification of scoring and item coding.

Associations Between Respondent Characteristics and Study Outcomes

Table 8 summarizes the reported tests of associations between respondent characteristics and compassion fatigue, operationalized through STS.

Table 8. Relationship Between Respondent Profile and Compassion Fatigue

Profile Variable	Test Used	p-value	Decision
Age	Pearson r	.166	Not Significant
Years of Experience	Pearson r	.296	Not Significant
Sex	t-test	.204	Not Significant
Civil Status	ANOVA	.390	Not Significant
Work Shift	ANOVA	.454	Not Significant

None of the reported p values was below .05. The null hypothesis of no significant relationship between respondent profile and compassion fatigue was therefore not rejected. The original table did not report full test statistics, degrees of freedom, confidence intervals, or effect sizes.

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Table 9 summarizes the reported tests of associations between respondent characteristics and burnout.

Table 9. Relationship Between Respondent Profile and Burnout

Profile Variable	Test Used	p-value	Decision
Age	Pearson r	.111	Not Significant
Years of Experience	Pearson r	.242	Not Significant
Sex	t-test	.353	Not Significant
Civil Status	ANOVA	.315	Not Significant
Work Shift	ANOVA	.228	Not Significant

None of the reported p values was below .05, so the null hypothesis was not rejected. Because the burnout subscale's reported Cronbach's alpha was .283, these nonsignificant results should be interpreted cautiously until the original item-level data and scoring have been checked.

Table 10 presents the reported correlation between compassion fatigue (STS) and burnout.

Table 10. Relationship Between Compassion Fatigue and Burnout

Variables	r	p-value	Interpretation
Compassion Fatigue and Burnout	0.624	<.001	Significant Positive Relationship

A statistically significant positive correlation was reported between STS and burnout ($r = .624$, $p < .001$). Respondents with higher STS scores tended to report higher burnout scores. The result does not establish causality because the study was cross-sectional. The low burnout reliability estimate also means the correlation should be rechecked after confirming reverse-scoring and subscale calculations.

DISCUSSION

The descriptive results indicate that the sample was predominantly female, with the largest age group being 26–35 years and the largest experience category being 5–10 years. Rotating shifts were the most frequently reported work arrangement. These characteristics describe the participating group but should not be treated as risk factors because the reported tests did not identify significant associations with STS or burnout.

The original analysis classified both STS and burnout as moderate. These findings are consistent with the broader literature that identifies STS and burnout as relevant occupational concerns in oncology nursing, although estimates differ by setting, sample, and measurement approach (Algamdi, 2022; Helaß & Maatouk, 2024; Xie *et al*., 2021). A multicenter study in Oman also examined compassion fatigue dimensions among oncology nurses, supporting the relevance of context-specific assessment in the region (Jacob *et al*., 2024).

The reported absence of significant associations between the selected profile variables and STS or burnout does not prove that demographic and work-related characteristics are irrelevant. The sample size, limited set of predictors, and unmeasured workplace factors may have constrained the analysis. The Job Demands–Resources Model offers a possible interpretive framework for future research because it emphasizes the interaction of job demands and available resources (Bakker & Demerouti, 2017; Demerouti *et al*., 2001). However, the current study did not directly measure staffing adequacy, workload, leadership support, psychological safety, or recovery opportunities.

The positive correlation between STS and burnout suggests that these negative dimensions of professional quality of life co-occurred in the sample. The result aligns conceptually with the ProQOL framework, which treats STS and burnout as distinct but potentially overlapping occupational experiences (Stamm, 2010). Nonetheless, the reported burnout reliability coefficient ($\alpha = .283$) is a substantial limitation. It may reflect sample-specific measurement behavior or a scoring/data-processing issue; the available materials do not establish which explanation is correct. The burnout item coding, reverse scoring, subscale calculations, and correlation therefore need to be checked against the original respondent-level dataset before strong conclusions are drawn.

Limitations

The findings should be interpreted in light of several limitations. The cross-sectional design does not support causal inference. The sample of 58 nurses came from one specialized cancer center, which limits generalizability. The study relied on self-reported responses and did not measure several potentially relevant organizational factors. The number of eligible nurses invited and the response rate were not stated in the thesis results available for this manuscript. In addition, the reported burnout reliability coefficient ($\alpha = .283$) is low and requires verification. Finally, the mean scores and their categorical labels should be checked against the official ProQOL-5 scoring guidance and the original respondent-level data before publication.

CONCLUSIONS

Among the 58 oncology nurses included in the study, the reported mean scores for STS, used as the indicator of compassion fatigue, and burnout were both classified as moderate in the original analysis. Age, sex, civil status, years of nursing experience, and work shift were not significantly associated with either outcome in the reported analyses. STS and burnout showed a significant positive correlation ($r = .624$, $p < .001$), indicating that higher scores on one measure tended to occur alongside higher scores on the other. The results suggest that trauma-related distress and occupational strain should be considered together when planning support

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for oncology nurses. However, the low reported internal consistency of the burnout subscale limits confidence in burnout-related findings and must be considered when interpreting the correlation.

RECOMMENDATIONS

The proposed Oncology Nurse Wellness and Resilience Program may be organized around four components: (1) assessment and early identification; (2) emotional support and resilience development; (3) organizational support and workplace enhancement; and (4) monitoring and continuous improvement. Under the second component, the "Stronger Together" team-building activity may support communication, collaborative problem-solving, peer support, and mutual recognition. The thesis proposed a direct program budget of ₱50,000; the amount and currency should be reviewed against local institutional costs before implementation at the Saudi study site.

At the organizational level, nursing leaders may consider confidential, nonpunitive pathways to wellness support, peer-support opportunities, facilitated debriefing after emotionally difficult clinical events, supportive supervision, and review of workload and recovery arrangements. Individual self-care activities should complement, not replace, organizational responsibility for a safe and supportive working environment. Prior work on oncology nurse interventions has described the potential value of education, self-care, and structured support, while also emphasizing the need to evaluate interventions in their intended settings (Collier *et al*., 2024; Wentzel *et al*., 2023).

Future research should use larger multisite samples, report the number of eligible nurses invited and the response rate, include organizational predictors, and provide effect sizes and confidence intervals. Before further analysis or program evaluation, researchers should verify the ProQOL-5 item coding, reverse scoring, subscale calculations, and internal consistency using the original respondent-level dataset. Any evaluation of the proposed program should use an appropriate follow-up design and pre-specified outcomes.

ACKNOWLEDGMENT

The author gratefully acknowledges the oncology nurses who participated in the study and the academic and institutional personnel whose guidance and support contributed to the completion of the research.

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