VOLUME 1
ISSUE 4
OCTOBER-DECEMBER
2026

Print ISSN: 3116-3866
Electronic ISSN: 3116-3874

INCLINPHS

International Journal of Clinical, Nursing, and Population Health Sciences

A Quarterly Peer-Reviewed International Research Journal

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International Journal of Clinical, Nursing, and Population Health Sciences (INCLINPHS)
Published by ETCOR, Publisher of the Best Homiletics Book "Preaching with My Scars", 20th Cardinal Sin Catholic Book Awards

International Journal of Clinical, Nursing, and Population Health Sciences (INCLINPHS)
Print ISSN: 3116-3866; Electronic ISSN: 3116-3874

National Book Development Board Registration as Book Publisher (Print & Digital): 6312
PRC-CPD Accredited Provider: PTR-2025-749

Coping mechanisms and professional quality of life among hospital nurses in Bulacan, Philippines: The mediating role of resilience

Philip Joseph M. Moratillo[1]*, Joanne D.G Maqueda[2], April C. Estanislao[3], Gabriel Luis B. Jose[4], Mark Anthony J. Morato[5], Elaine Joy D. Tan[6], Joseph Erol T. Cuevas[7], and Allan M. Manaloto[8]
[1, 2, 3, 4, 5, 6, 7] La Consolacion University Philippines
[8] Bulacan State University
Malolos, Bulacan, Philippines 3000
*Corresponding author email: philipjoseph.moratillo@email.lcup.edu.ph

Received: 15 October 2026 **Revised**: 16 October 2026; 13 November 2026

Accepted: 20 November 2026 **Available Online**: 21 November 2026

Volume 1 (2026), Issue 4, P-ISSN – 3116-3866; E-ISSN - 3116-3874

https://doi.org/10.63498/inclinphs19

Abstract
Aim: This study examined whether resilience mediated the relationship between coping mechanisms and professional quality of life among registered nurses in two private Level 2 hospitals in Bulacan, Philippines. Specifically, it sought to determine how different coping mechanisms were associated with burnout and compassion satisfaction and whether resilience accounted for these relationships, providing evidence relevant to nursing practice and professional well-being.
Methodology: A cross-sectional descriptive-correlational design with mediation analysis was employed, involving 93 registered nurses selected through total enumeration from two private Level 2 hospitals. Data were collected using the Brief COPE, Brief Resilience Scale, and Professional Quality of Life Scale Version 5 (ProQOL-5). Statistical analyses included descriptive statistics, Spearman rank-order correlation, and PROCESS Model 4 with 5,000 bootstrap resamples at a 0.05 significance level.
Results: Problem-focused (M = 3.19) and emotion-focused coping (M = 3.02) were moderately used, while avoidant coping was slightly used (M = 2.02). Resilience was within the normal range (M = 3.45), while burnout (sum M = 24.19) and compassion satisfaction (sum M = 37.86) were both moderate. Resilience was significantly and inversely associated with burnout ($\rho = -.497$, $p < .001$) and positively associated with compassion satisfaction ($\rho = .454$, $p < .001$). Significant indirect effects through resilience were observed for problem-focused coping and emotion-focused coping in relation to burnout ($B = -0.214$, 95% CI [−0.410, −0.095]; $B = -0.246$, 95% CI [−0.447, −0.117], respectively) and for both adaptive coping dimensions in relation to compassion satisfaction, where direct effects also persisted. Avoidant coping was not significantly associated with resilience ($\rho = -.070$, $p = .503$) and showed no significant indirect effect, but was significantly associated with higher burnout ($\rho = .440$, $p < .001$).
Conclusion: Within the limitations of the cross-sectional design, resilience was identified as a pathway through which adaptive coping mechanisms were associated with professional quality of life, whereas avoidant coping was associated with burnout independently of resilience. The findings suggest that nursing administrators and staff development units may consider resilience-building initiatives to support nurses' professional well-being while developing complementary interventions to address avoidant coping behaviors. These findings may inform nursing practice and personnel development in comparable hospital settings.
Keywords: coping mechanisms, resilience, professional quality of life, burnout, compassion satisfaction, mediation analysis, nurses, Philippines

INTRODUCTION

Nurses are the largest occupational group in the health workforce, and the conditions under which they work bear directly on whether they stay in it. The World Health Organization (2025) reported a global nursing stock of 29.8 million in 2023 against a shortage of 5.8 million, down from 6.2 million in 2020, with the deficit projected to narrow to 4.1 million by 2030 if current gains hold. Nurses' occupational strain also has consequences beyond the individual. In a meta-analysis of 85 studies involving 288,581 nurses in 32 countries, most of them cross-sectional,

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International Journal of Clinical, Nursing, and Population Health Sciences (INCLINPHS)
Print ISSN: 3116-3866; Electronic ISSN: 3116-3874
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burnout was associated with a weaker patient safety climate, more nosocomial infections, patient falls, and medication errors, lower patient satisfaction, and lower nurse-assessed quality of care (Li et al., 2024), consistent with an earlier systematic review of 20 hospital studies that found burnout inversely associated with patient safety, quality of care, organizational commitment, productivity, and patient satisfaction (Jun et al., 2021). These associations explain why nurses' professional quality of life matters to service delivery; the present study did not measure patient or care outcomes. Workforce strain also bears on retention: a review of 43 studies conducted in the Middle East, the Americas, the Asia-Pacific region, and Europe identified psychological responses to stress and adverse working conditions among the factors associated with health workers' turnover intention during the pandemic (Poon et al., 2022). Burnout prevention and nurse retention are therefore concerns shared by health systems across countries, and evidence from the Philippines, among the world's leading source countries for health workers (Pepito et al., 2025), adds to that comparative discussion. Working in understaffed hospitals exposes nurses to sustained occupational strain, which Stamm (2010) framed as professional quality of life: compassion satisfaction on the positive side, and compassion fatigue, within which burnout sits alongside secondary traumatic stress, on the negative. What nurses do with that strain is a matter of coping, the cognitive and behavioral response to a demand appraised as exceeding available resources (Lazarus & Folkman, 1984), and of resilience, the capacity to recover once the demand has passed (Smith et al., 2008).

Philippine hospitals operate under conditions that intensify this strain. Drawing on 2022 labor force and health workforce data, the Second Congressional Commission on Education (2026) reported a national density of 21.2 health workers per 10,000 population, less than half the World Health Organization benchmark of 44.5, estimated that meeting that threshold would require 196,000 additional nurses, and noted 3,300 Department of Health plantilla positions left unfilled. Alibudbud (2023) identified low salaries, delayed benefits, understaffing, overwork, and job insecurity as structural features of Philippine nursing work that workplace mental health programs alone do not resolve. Shortages also differ by sector. Using a separate estimate, Pepito et al. (2025) reported a national shortage of 127,000 nurses with more acute shortages in the private sector, and private-sector informants in their qualitative study attributed a perennial nurse shortage to salaries that could not match those of government nurses. Published nursing workforce data specific to Bulacan or to its private hospitals were not available to the researchers, so the present study provides hospital-level evidence from a setting for which local data remain limited. Among Filipino nurses surveyed during the pandemic, Castillejos et al. (2025) reported compassion satisfaction that they classified as high (M = 41.95, SD = 5.97) together with moderate burnout (M = 23.56, SD = 6.07), with both dimensions elevated in the same sample.

Three gaps follow from this evidence. Empirically, nursing research has documented which coping strategies nurses use more thoroughly than how specific coping dimensions relate to distinct professional quality of life outcomes. In a single-center Italian study of 143 nurses and physicians, avoidance coping predicted higher burnout and lower compassion satisfaction, problem orientation predicted higher burnout, and a positive attitude predicted better outcomes on both (Calegari et al., 2022), a pattern that diverges from other evidence in ways plausibly traceable to differences between coping instruments. The mediation evidence closest to the present question came from a single Philippine research program, where resilience mediated relationships involving compassion fatigue and nurse work outcomes (Labrague & de los Santos, 2021) rather than coping dimensions and the two professional quality of life dimensions modeled separately. Contextually, the Filipino coping literature that would account for culturally favored strategies such as prayer was generated outside nursing (Ahmadi et al., 2024; Fudolig et al., 2026), and most nurse-focused data was collected under pandemic conditions that no longer describe routine hospital work. Methodologically, professional quality of life is frequently reported as one continuum, which obscures whether a coping dimension relates to burnout, to compassion satisfaction, or to both.

This study examined the mediating role of resilience in the relationship between coping mechanisms and professional quality of life among registered nurses in selected hospitals in Bulacan. Specifically, it described the demographic profile of the respondents; determined their levels of problem-focused, emotion-focused, and avoidant coping, of resilience, and of professional quality of life in terms of burnout and compassion satisfaction; tested the relationships among coping mechanisms, resilience, and the two professional quality of life dimensions; and determined whether resilience significantly mediated the relationships between each coping dimension and burnout, and between each coping dimension and compassion satisfaction. The study's contribution lies in a specific combination: the three dimensions of the Brief COPE (Carver, 1997), problem-focused, emotion-focused, and avoidant coping, examined separately; resilience tested as a statistical mediator; burnout and compassion satisfaction modeled as two separate outcomes rather than opposite poles of one scale; and registered nurses in Philippine private hospitals studied outside the pandemic period. Theoretically, the study examined whether recovery

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capacity statistically accounted for the relationships between specific coping dimensions and occupational outcomes. As a measurement-reporting contribution, it reports sample-level internal consistency for a researcher-selected three-dimension grouping of the Brief COPE, which Carver (1997) did not recommend as a composite, while recognizing that alpha does not establish dimensional structure. Practically, the findings identify which coping dimensions were associated with which outcome, directly and through resilience, and may inform staff development and well-being initiatives in hospitals facing the workforce shortages documented above (World Health Organization, 2025; Second Congressional Commission on Education, 2026); whether resilience-building programs reduce burnout or improve compassion satisfaction remains a question for intervention studies. The contribution lies mainly in nursing science and health workforce research; patient, clinical, and population-level outcomes were not measured, so any implications for those areas are indirect.

Review of Related Literature and Studies

Coping Mechanisms Among Hospital Nurses

Coping is what a person does once a workplace demand has been appraised as threatening and the resources for meeting it judged insufficient (Lazarus & Folkman, 1984). The Brief COPE, the 28-item abbreviated form of the COPE inventory, operationalizes this through 14 two-item subscales (Carver, 1997), which nursing studies then aggregate into problem-focused, emotion-focused, and avoidant dimensions using item allocations that differ from one study to the next: Eysa et al. (2025) grouped the 28 items as 8, 12, and 8 across the three dimensions, whereas the present study follows a 6, 10, and 12 split (Cooper et al., 2008). Avoidant coping therefore does not denote the same set of behaviors throughout this literature, and comparison of dimension scores across studies calls for caution. What the evidence does support is the prominence of active strategies. Among 220 Polish hospital nurses, the most frequently used strategies were seeking emotional support (M = 2.23), active coping and seeking instrumental support (both M = 2.22), and planning (M = 2.20), and the most experienced respondents reported turning to religion (Antczak-Komoterska et al., 2023). A systematic review of quantitative pandemic-era studies likewise found health care workers drawing on both problem-focused and emotion-focused coping, with coping behaviors associated with more favorable mental health outcomes (Labrague, 2021b). In Philippine settings, faith shapes the emotion-focused repertoire. Prayer appeared among the stress-relief practices identified in a Northern Luzon sample of 1,196 Filipinos (Fudolig et al., 2026), and religious meaning-making alongside close family ties featured in how 20 Filipino adults with cancer made sense of their illness (Ahmadi et al., 2024). Neither sample consisted of nurses, so the reach of this patterning into hospital practice remains untested, and whether culturally favored strategies translate into recovery from strain is where the literature turns next.

Resilience as a Protective Resource

Resilience, as this study measures it, is recovery capacity: the ability to bounce back after stress, deliberately separated from the personal and social resources that may promote such recovery (Smith et al., 2008). The distinction matters for reading the evidence, because reported resilience levels are not comparable across instruments of differing length and scaling, as the 14-item Resilience Scale (RS-14) applied by Suazo Galdames et al. (2024) and the six-item Brief Resilience Scale used here illustrate. Direction of association, however, holds. Resilience correlated positively with problem-focused (r = .33) and emotion-focused coping (r = .25) among 320 Iranian nurses assigned to COVID-19 wards (Ruhabadi et al., 2022), and among 1,165 Spanish nurses recruited through stratified random sampling, a stronger design than the convenience samples found elsewhere in this evidence base, it was inversely related to burnout and to mental health problems in a structural model (Suazo Galdames et al., 2024). Resilience has also been examined as a mediating variable and not as a correlate alone. Among 255 Filipino frontline clinical nurses assessed with the same six-item scale used here, it partially mediated the relationships between pandemic fatigue and mental health, sleep quality, and job contentment (Labrague, 2021a). Where it belongs within a model is still contested, since Al Yahyaei et al. (2025) found that resilience correlated with turnover intention (r = −.317) among 456 Omani oncology nurses yet did not moderate the relationship between professional quality of life and turnover intention, a null result that favors treating resilience as a variable through which associations travel rather than one that conditions them.

Professional Quality of Life and the Coping-Resilience Pathway

Professional quality of life is not one continuum but a pairing of a positive dimension, compassion satisfaction, with the negative dimension of compassion fatigue, within which burnout sits alongside secondary

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traumatic stress (Stamm, 2010). Reported levels vary by setting. Castillejos et al. (2025) surveyed Filipino nurses through their national association during the pandemic and reported compassion satisfaction that they classified as high (M = 41.95, SD = 5.97) and moderate burnout (M = 23.56, SD = 6.07), whereas trauma nurses in Qatar reported lower satisfaction (M = 37.8, SD = 6.3) at a similar burnout level (M = 24.1, SD = 5.4) (Eysa et al., 2025). Philippine figures of this kind rest on structural conditions that workplace mental health programs alone do not resolve, among them low salaries, delayed benefits, understaffing, overwork, and job insecurity (Alibudbud, 2023). Staffing links these conditions to burnout at the system level. Across 254 hospitals in New York and Illinois surveyed immediately before the pandemic, medical-surgical staffing ranged from 3.3 to 9.7 patients per nurse, over half of nurses reported high burnout, and each additional patient per nurse increased the odds of unfavorable quality and safety reports from nurses and patients (Lasater et al., 2021). Where shortages are more acute, as reported for Philippine private facilities (Pepito et al., 2025), individual coping and recovery capacity operate within staffing conditions that they cannot resolve, a context the present design acknowledges but did not measure. How coping relates to these outcomes is less settled than the adaptive versus maladaptive framing implies. Among 143 Italian nurses and physicians, avoidance coping was associated with higher burnout and lower compassion satisfaction, problem orientation with higher burnout but not with compassion satisfaction, and social support with secondary traumatic stress alone, while a positive attitude was the strongest predictor of both scored dimensions (Calegari et al., 2022), a divergence plausibly traceable to instrument differences rather than to the populations themselves. The two outcome dimensions also bear on retention: in the Omani oncology sample described above, compassion satisfaction correlated with lower turnover intention (r = −.311) alongside resilience (Al Yahyaei et al., 2025), and burnout has been associated across hospital studies with lower patient safety, patient satisfaction, and nurse-assessed quality of care (Jun et al., 2021; Li et al., 2024). Neither link was measured in the present study; both explain why the two dimensions are worth modeling separately. Resilience is the variable most often proposed as a mediator of the link: among Filipino frontline nurses it fully mediated the relationship between compassion fatigue and nurse-reported quality of care and partially mediated its relationships with job satisfaction and turnover intention (Labrague & de los Santos, 2021). The step before that remains unexamined, namely whether the three coping dimensions relate to burnout and to compassion satisfaction as separate outcomes, and whether resilience statistically accounts for those relationships, among Philippine hospital nurses outside a pandemic context.

Synthesis

Taken together, the reviewed evidence indicates that hospital nurses rely mainly on active and emotion-regulating coping, that resilience is positively associated with those strategies and inversely associated with burnout, and that it has been found to mediate the relationship between occupational strain and nurses' work outcomes. That picture rests on an uneven base. Nearly all of the evidence is cross-sectional, several samples were drawn by convenience at one or two sites, coping and resilience scores are not comparable across the instruments used, and much of the data was collected under pandemic conditions that no longer describe routine hospital work. The mediation evidence closest to the present design comes from a single Philippine research program and was modeled on compassion fatigue and work outcomes rather than on coping dimensions and the two dimensions of professional quality of life, while the Filipino coping literature that would explain why religious strategies feature so prominently was generated outside nursing altogether. Against that backdrop, this study tested resilience as the mediator between each coping dimension and both burnout and compassion satisfaction among registered nurses in Bulacan, treating the two outcome dimensions as separate rather than as opposite ends of a single scale, and addressing what the literature leaves open: which coping strategies relate to which outcome, and through what pathway.

Theoretical Framework

This study was anchored on the Neuman Systems Model, developed by Betty Neuman (Neuman & Young, 1972; see also Neuman & Fawcett, 2011). The model conceptualizes the client as an open system whose core of energy resources is protected by a flexible line of defense that buffers incoming stressors, a normal line of defense representing usual wellness, and lines of resistance activated once a stressor penetrates, working to stabilize the system and return it toward wellness. Outcomes are expressed as degree of system stability rather than presence or absence of disease. Three assumptions of the model informed the researchers' application of it to this study. The mapping that follows is the researchers' conceptual application; Neuman did not define the lines of defense and resistance in terms of the constructs measured here. First, stressors are buffered rather than absorbed passively. Because coping refers to the effort a person directs at a demand once it has been appraised (Lazarus & Folkman, 1984), the researchers treated coping mechanisms as the behaviors that make up the flexible line of defense against

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International Journal of Clinical, Nursing, and Population Health Sciences (INCLINPHS)
Print ISSN: 3116-3866; Electronic ISSN: 3116-3874
National Book Development Board Registration as Book Publisher (Print & Digital): 6312
PRC-CPD Accredited Provider: PTR-2025-749

the intrapersonal, interpersonal, and extrapersonal demands of hospital work. Second, protection operates in sequence, with deeper resistance capacity mobilized when the outer buffer proves insufficient. The researchers positioned resilience at that inner layer because the Brief Resilience Scale measures recovery after stress rather than the resources that promote it (Smith et al., 2008), which corresponds more closely to the stabilizing function the model assigns to the lines of resistance than to a first-line buffer. Third, the outcome is a graded state. The researchers treated compassion satisfaction and burnout as conceptual analogues of retained stability and of energy depletion, respectively; professional quality of life is not a clinical measure of system stability, and the model does not define it as one. One qualification belongs here: Neuman developed the model with the recipient of care as the client system, and treating the nurse as the client system is a permitted but extended application, one proposed specifically for nurse resilience by Turner and Kaylor (2015).

The model specifies that a buffer exists without differentiating the behaviors that constitute it, so the transactional model of stress and coping (Lazarus & Folkman, 1984) supplemented it at the level of the independent variable. That model holds that stress arises when a demand is appraised as exceeding available resources, and that coping effort is directed either at altering the demand or at regulating the emotional response to it. This distinction underlies the three dimensions measured here: problem-focused coping, emotion-focused coping, and avoidant strategies that withdraw effort from both targets. On the outcome side, Stamm (2010) conceptualized professional quality of life as compassion satisfaction paired with compassion fatigue, within which burnout is distinguished from secondary traumatic stress. That conceptualization is why burnout and compassion satisfaction were modeled as two separate outcomes rather than opposite ends of one scale, consistent with Neuman's framing of stability as a degree.

The frameworks anchored different parts of one pathway. Neuman supplied the structure, stressors met by an outer buffer, deeper resistance capacity mobilized when that buffer is breached, and an outcome expressed as degree of stability. The transactional model supplied the content of the buffer, differentiating the coping dimensions Neuman leaves unspecified. Together they imply that coping relates to professional quality of life through recovery capacity and not only directly, which this study examined as a statistical indirect effect. Neither framework licenses a causal reading of the results, since the design observed all three constructs at a single point in time.

Figure 1 below depicts a simple mediation model in which coping mechanisms serve as the independent variable, resilience as the mediating variable, and professional quality of life as the dependent variable, operationalizing the sequence specified in the theoretical framework. Coping mechanisms are represented by the three dimensions measured in this study, problem-focused, emotion-focused, and avoidant coping, and professional quality of life by its two scored dimensions, burnout and compassion satisfaction, each treated as a separate outcome rather than as opposite poles of one scale. Path a represents the relationship between a coping dimension and resilience, path b the relationship between resilience and an outcome, and path c′ the direct relationship between a coping dimension and an outcome once resilience is accounted for. The product of paths a and b is the indirect effect attributed to resilience, which this study estimated using bias-corrected bootstrap confidence intervals. Because each coping dimension was paired with each outcome, the model was tested as six separate configurations rather than as one simultaneous model. The path labels correspond to the coefficients reported in the mediation analyses, and the arrows denote tested statistical associations rather than causal effects, since all three constructs were measured at a single point in time.

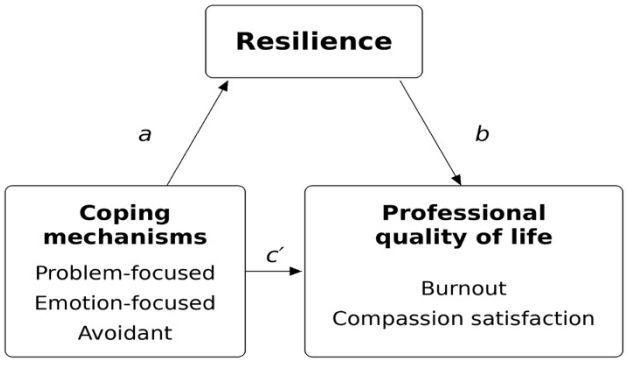


Figure 1
Conceptual Framework of the Study

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Print ISSN: 3116-3866; Electronic ISSN: 3116-3874
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Note. a = path from each coping dimension to resilience; *b* = path from resilience to each outcome; *c′* = direct path from each coping dimension to each outcome. Each coping dimension was paired with each outcome in six separate models. Arrows denote tested statistical associations, not causal effects.

Statement of the Problem

Nursing professionals experience occupational challenges that may affect their professional quality of life, including burnout and compassion satisfaction. In the Philippines, these challenges are compounded by structural conditions such as low salaries, delayed benefits, understaffing, overwork, and job insecurity (Alibudbud, 2023), alongside a health workforce density that remains below the World Health Organization benchmark (Second Congressional Commission on Education, 2026). These conditions highlight the importance of understanding how hospital nurses manage occupational demands and maintain their professional well-being.

Although previous studies have examined coping mechanisms, resilience, and professional quality of life among healthcare professionals, important questions remain insufficiently addressed. In particular, there is a need to determine whether specific coping dimensions (problem-focused, emotion-focused, and avoidant coping) are differently associated with burnout and compassion satisfaction. Moreover, the extent to which resilience statistically mediates the relationships between these coping dimensions and the two professional quality of life outcomes remains insufficiently examined among Philippine hospital nurses working outside the pandemic context.

Understanding these relationships is important to nursing science and hospital workforce management because the findings may provide evidence to guide the development of more focused staff development and occupational well-being initiatives. Accordingly, this study examined the mediating role of resilience in the relationship between coping mechanisms and professional quality of life, specifically burnout and compassion satisfaction, among registered nurses in selected hospitals in Bulacan.

Research Objectives

General Objective

To examine the mediating role of resilience in the relationship between coping mechanisms and professional quality of life, in terms of burnout and compassion satisfaction, among registered nurses in selected hospitals in Bulacan.

Specific Objectives

Specifically, this study sought:

1. To describe the demographic profile of the respondents in terms of age, sex, highest educational attainment, years of clinical experience, and area of assignment;
2. To determine the level of coping mechanisms among the respondents in terms of problem-focused, emotion-focused, and avoidant coping;
3. To determine the level of resilience among the respondents;
4. To determine the level of professional quality of life among the respondents in terms of burnout and compassion satisfaction;
5. To determine the relationships between the three coping dimensions and resilience;
6. To determine the relationships between the three coping dimensions and professional quality of life in terms of burnout and compassion satisfaction;
7. To determine the relationships between resilience and professional quality of life in terms of burnout and compassion satisfaction;
8. To determine whether resilience significantly mediates the relationships between each coping dimension and burnout; and
9. To determine whether resilience significantly mediates the relationships between each coping dimension and compassion satisfaction.

Research Questions

This study sought to answer the following questions:

1. What is the demographic profile of the respondents in terms of:
   1.1. Age;
   1.2. Sex;

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1.3. Highest educational attainment;
1.4. Years of clinical experience; and
1.5. Area of assignment?

2. What are the levels of coping mechanisms among the respondents in terms of:
2.1. Problem-focused coping;
2.2. Emotion-focused coping; and
2.3. Avoidant coping?
3. What is the level of resilience among the respondents?
4. What is the level of professional quality of life among the respondents in terms of:
4.1. Burnout; and
4.2. Compassion satisfaction?
5. Are problem-focused, emotion-focused, and avoidant coping significantly related to resilience?
6. Are problem-focused, emotion-focused, and avoidant coping significantly related to professional quality of life in terms of:
6.1. Burnout; and
6.2. Compassion satisfaction?
7. Is resilience significantly related to professional quality of life in terms of:
7.1. Burnout; and
7.2. Compassion satisfaction?
8. Does resilience significantly mediate the relationships between each coping dimension and burnout?
9. Does resilience significantly mediate the relationships between each coping dimension and compassion satisfaction?

Null Hypotheses

All hypotheses were tested at the 0.05 level of significance. Each null hypothesis was evaluated separately for the applicable variable pairings.

H_{01}: There is no significant relationship between each of the three coping dimensions (problem-focused, emotion-focused, and avoidant coping) and resilience.

H_{02}: There is no significant relationship between each of the three coping dimensions and professional quality of life in terms of burnout and compassion satisfaction.

H_{03}: There is no significant relationship between resilience and professional quality of life in terms of burnout and compassion satisfaction.

H_{04}: The indirect effects of each of the three coping dimensions on burnout through resilience are not statistically significant.

H_{05}: The indirect effects of each of the three coping dimensions on compassion satisfaction through resilience are not statistically significant.

METHODOLOGY

Research Design

This study employed a cross-sectional descriptive-correlational design with mediation analysis. Descriptive-correlational designs characterize variables as they naturally occur and examine relationships among them without manipulation or random assignment (Polit & Beck, 2021), while mediation analysis decomposes an observed relationship into direct and indirect components to determine whether a third variable accounts for it (Hayes, 2022). The design matched the objectives, which required describing the levels of coping mechanisms, resilience, and professional quality of life, testing the relationships among them, and determining whether resilience accounted for the relationships between coping dimensions and each professional quality of life outcome. Because all variables were measured on a single occasion, the findings support conclusions about how the variables are related, not about which came first or what caused what. Accordingly, the mediation results are reported as statistical indirect effects, that is, as decompositions of observed associations, not as evidence of causal mechanisms.

Population and Sampling

The study was conducted in two private Level 2 hospitals in Malolos, Bulacan, Philippines. Under Department of Health Administrative Order No. 2012-0012, a Level 2 hospital maintains departmentalized clinical

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services in medicine, pediatrics, obstetrics and gynecology, and surgery, together with a general intensive care unit and tertiary laboratory and imaging capability (Department of Health, 2012). The two hospitals were selected purposively for their comparable service capability, so that respondents across both sites worked under similar case mix and staffing conditions. Within the selected sites, no further selection was applied: all eligible nurses were enumerated. Sampling therefore involved two distinct decisions: purposive selection of the hospitals, and total enumeration of eligible nurses within them.

Three inclusion criteria applied: a valid registered nurse license issued by the Professional Regulation Commission, employment in one of the participating hospitals for at least six months regardless of employment status, and direct involvement in patient care activities. The six-month requirement provided a minimum period of exposure to the work environment before coping behaviors and professional quality of life were reported. Nurses assigned solely to administrative functions were excluded, as were student nurses, nursing interns, and volunteers, none of whom carries independent professional responsibility for patient care and whose exposure to the occupational demands under study therefore differs from that of employed staff nurses.

Respondents were obtained through total enumeration of the eligible population. Of the 104 registered nurses employed by the two hospitals, 93 met the eligibility criteria, representing 89.4% of the total nursing workforce. All 93 were invited and all took part, giving a response rate of 100%. The 93 respondents therefore constituted the complete eligible nursing population of the participating hospitals rather than a sample drawn from it. Because all eligible nurses in the participating hospitals were invited and all completed the questionnaire, non-response among the eligible population was not observed. Nevertheless, the purposive selection of the hospitals and the defined eligibility criteria limit the generalizability of the findings beyond the participating institutions.

Because all eligible nurses were enumerated, the number of respondents was fixed by the population rather than determined by computation. Adequacy was evaluated against a power analysis conducted in G*Power (Faul et al., 2007) for a two-tailed test of a bivariate correlation, with an expected effect size of $\rho = .30$, $\alpha = .05$, and power = .80, which indicated a minimum of 84 respondents. The enumerated population of 93 exceeded this minimum. At this size the achieved power for a correlation of $\rho = .30$ was .84, and the smallest correlation detectable at .80 power was $r = .29$. The mediation models were not separately powered. Detecting an indirect effect at .80 power using the bias-corrected bootstrap requires approximately 71 cases when both the *a* and *b* paths are of medium magnitude but several hundred when either path is small (Fritz & MacKinnon, 2007), so the enumerated population was adequate for medium-sized indirect effects and underpowered for small ones.

Instruments

The study used a self-administered questionnaire of four parts totaling 69 items, requiring approximately 15 to 20 minutes to complete. Three standardized instruments were adopted without modification to item content: the Brief COPE (Carver, 1997), the Brief Resilience Scale (Smith et al., 2008), and the Professional Quality of Life Scale Version 5 (ProQOL-5; Stamm, 2009); the only wording change was the permitted ProQOL-5 term substitution described in Part IV. All three are freely available for research use. The instruments were administered in English, the language in which they were published, without translation. Because no item content was altered, no content validity indexing or pilot test was conducted; reliability was instead examined in the study sample, as reported below.

Part I. Demographic Profile. Five items gathered age, sex, highest educational attainment, years of clinical experience, and area of assignment, corresponding to Objective 1.

Part II. Coping Mechanisms. The Brief COPE (Carver, 1997) comprises 28 items in 14 two-item subscales rated from 1 (*I haven't been doing this at all*) to 4 (*I've been doing this a lot*), with no reverse-scored items. Following Lazarus and Folkman's (1984) typology, the 14 subscales were grouped, as an operational arrangement for this study, into three dimensions using the composite allocation reported by Cooper et al. (2008), who termed the third composite dysfunctional coping: problem-focused coping (active coping, Items 2 and 7; planning, Items 14 and 25; instrumental support, Items 10 and 23; 6 items), emotion-focused coping (emotional support, Items 5 and 15; positive reframing, Items 12 and 17; acceptance, Items 20 and 24; religion, Items 22 and 27; humor, Items 18 and 28; 10 items), and avoidant coping (self-distraction, Items 1 and 19; denial, Items 3 and 8; venting, Items 9 and 21; substance use, Items 4 and 11; behavioral disengagement, Items 6 and 16; self-blame, Items 13 and 26; 12 items), with item numbers following Carver's (1997) scoring key. This allocation was used because it preserves the transactional model's distinction between efforts directed at the demand and efforts directed at the emotional response, while separating disengagement strategies into their own dimension. The grouping was not factor-analyzed in the present sample (see Limitations). Dimension scores were computed as item means and interpreted against equal-interval bands constructed by the researchers, since Carver (1997) published none: 1.00 to 1.75 (Not

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at all used), 1.76 to 2.50 (Slightly used), 2.51 to 3.25 (Moderately used), and 3.26 to 4.00 (Highly used). In Carver's (1997) original sample, subscale alpha ranged from .50 to .90. Because Carver (1997) did not recommend combining subscales into composites, and because Rodrigues et al. (2022) found second-order and bifactor specifications of the Brief COPE to show poor fit or fail to converge, internal consistency of this three-dimension clustering was examined in the study sample and its dimensional structure is treated as an acknowledged limitation.

Part III. Resilience. The Brief Resilience Scale (Smith et al., 2008) comprises six items rated from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), of which Items 2, 4, and 6 are negatively worded and were reverse-scored prior to computing the scale mean, interpreted as 1.00 to 2.99 (Low), 3.00 to 4.30 (Normal), and 4.31 to 5.00 (High) (Smith et al., 2013). In the developers' four validation samples, alpha ranged from .80 to .91 (Smith et al., 2008).

Part IV. Professional Quality of Life. The ProQOL-5 (Stamm, 2009) comprises 30 items rated from 1 (*Never*) to 5 (*Very Often*) for experiences within the past 30 days. Two of the three subscales were scored: Compassion Satisfaction (Items 3, 6, 12, 16, 18, 20, 22, 24, 27, 30) and Burnout (Items 1, 4, 8, 10, 15, 17, 19, 21, 26, 29, with Items 1, 4, 15, 17, and 29 reverse-scored prior to computing the subscale sum and mean); in the developer's normative data, alpha was .88 for Compassion Satisfaction and .75 for Burnout (Stamm, 2010). Secondary Traumatic Stress fell outside the mediation model and was not scored, although all 30 items were administered to preserve the psychometric integrity of the scored subscales (Stamm, 2010). Subscale sum scores were interpreted as 22 or below (Low), 23 to 41 (Moderate), and 42 or above (High) (Stamm, 2009). The standardized ProQOL-5 instrument was adopted, with the context-specific substitution of '[helper]' with 'nurse' and of '[help]' and its verb forms with 'care for' wherever these terms appeared in the instructions and items, in accordance with the instrument's permitted usage guidance (Stamm, 2009). No other item wording was modified.

Internal consistency was computed for the study sample (N = 93). All six analysis scales (the three Brief COPE dimensions, the Brief Resilience Scale, and the two scored ProQOL-5 subscales) met the .70 threshold, with Cronbach's alpha ranging from .761 for Burnout to .912 for Compassion Satisfaction. The three Brief COPE dimensions returned α = .806 for problem-focused, .825 for emotion-focused, and .855 for avoidant coping, and the Brief Resilience Scale returned α = .860. These values indicate adequate internal consistency for the dimension scores used in the analyses; because alpha addresses item homogeneity rather than dimensional structure, they do not by themselves establish that the three-dimension Brief COPE grouping is unidimensional. These sample values are distinct from the original reliabilities reported above. The Burnout point estimate (α = .761) met the .70 threshold; its 95% confidence interval (.681 to .827) was the widest of the six analysis scales, with a lower bound slightly below .70, indicating that this subscale's reliability was the least precisely estimated rather than unacceptable.

Data Collection

Data were collected from April 13 to April 28, 2026. The researchers personally distributed the printed self-administered questionnaire to eligible nurses and retrieved the completed forms; unit supervisors and hospital administrators did not distribute, collect, or handle the questionnaires. Nurses completed the questionnaire, which required approximately 15 to 20 minutes, during their break or after duty, and deposited the completed form in a drop box. All 93 questionnaires were returned complete and retained for analysis.

Treatment of Data

Data were encoded and analyzed using IBM SPSS Statistics version 29. Objective 1 was addressed through frequency and percentage distributions, with mean, standard deviation, median, and range reported for age. Objectives 2 to 4 were addressed through means and standard deviations, with dimension scores computed as item means and interpreted against the verbal interpretation bands described under Instruments (researcher-constructed for the Brief COPE; published for the Brief Resilience Scale and ProQOL-5), and with ProQOL-5 subscale sum scores additionally classified using Stamm's (2009) cutoffs. For the mediation analyses, item means were used for all variables to standardize the metric across instruments; the published sum-score cutoffs were applied only for descriptive interpretation under Objective 4. The same item-level scoring was applied to the item means used in the analyses and to the sum scores used for the ProQOL-5 classifications. All 93 questionnaires were complete, so no missing-data procedure was required.

During data screening, five cases were flagged as composite-score outliers and were retained, since none reflected a data entry error and all values fell within the instruments' valid response ranges. Distributional assumptions were examined before the inferential analyses using the Shapiro-Wilk test at α = .05. Five of the six continuous variables departed significantly from normality: problem-focused coping (W = 0.929, p < .001), emotion-

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Print ISSN: 3116-3866; Electronic ISSN: 3116-3874
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focused coping (W = 0.965, p = .013), avoidant coping (W = 0.936, p < .001), resilience (W = 0.956, p = .003), and burnout (W = 0.950, p = .001). Only compassion satisfaction did not depart significantly from normality (W = 0.976, p = .079). Skewness ranged from −0.981 to 1.120 and kurtosis from −0.139 to 2.441, well within the absolute values of 2 and 7 commonly referenced as indicating moderate nonnormality (Curran et al., 1996).

These two results guided different choices. Because the Shapiro-Wilk test was significant for five of six variables, Spearman rank-order correlation was used for all bivariate analyses under Objectives 5 to 7, applied uniformly rather than mixed with Pearson correlation so that coefficients would remain comparable across variable pairs. Confidence intervals for the rank correlations were obtained by Fisher z transformation using the rank-correlation standard error $\sqrt{[1.06/(n - 3)]}$ (Fieller et al., 1957). As a sensitivity check, Bonferroni-corrected thresholds were applied within each research question (α = .017 for Objective 5, .008 for Objective 6, and .025 for Objective 7). Correlation magnitudes were classified following Cohen (1988) as negligible (below .10), weak (.10 to .29), moderate (.30 to .49), or strong (.50 or above).

Objectives 8 and 9 were addressed using the PROCESS macro for SPSS, a regression-based macro that estimates direct and indirect effects (Hayes, 2022), applying Model 4 with resilience as mediator and burnout and compassion satisfaction modeled as separate outcomes across three coping dimensions, producing six models. Spearman correlation thus addressed the bivariate associations under Objectives 5 to 7, whereas the mediation paths under Objectives 8 and 9 were estimated by ordinary least squares regression on item-mean scores; the two sets of coefficients answer different questions and are not interchangeable. PROCESS estimates the a, b, and c' paths by ordinary least squares regression, and indirect effects were tested using 5,000 bootstrap resamples with bias-corrected 95% confidence intervals. Bootstrapping addresses the non-normal sampling distribution of the indirect effect but does not replace the assumptions of the ordinary least squares models used to estimate the a, b, and c' paths. Multicollinearity between each coping dimension and resilience in the outcome models was low (variance inflation factor [VIF] ≤ 1.25). An indirect effect was considered significant when its confidence interval excluded zero. Indirect, direct, and total effects were reported for each model without applying full or partial mediation labels, following the recommendation against classifying mediation by the significance of the direct or total effect (Hayes, 2022). Inferential decisions were made at the .05 level of significance, with the Bonferroni thresholds applied as a sensitivity check for the correlations.

Ethical Considerations

The study was conducted in accordance with the applicable ethical principles and institutional requirements governing research involving human participants. Written permission to conduct the study was secured from the administrators of the two participating hospitals before data collection commenced.

Written informed consent was obtained from all respondents before questionnaire administration. Participants were informed about the purpose of the study, the procedures involved, the voluntary nature of participation, the potential risks and benefits, the confidentiality of their responses, and their right to withdraw from the study without penalty or adverse consequences. Participation or nonparticipation did not affect their employment status or professional standing.

Confidentiality was maintained throughout the research process. Because written consent was documented, responses were treated as confidential rather than anonymous. Consent forms were kept separately from completed questionnaires, and access to research records was restricted to authorized members of the research team. No individual respondent or participating institution was identified in the presentation of the findings.

The study involved minimal anticipated risk, primarily the time required to complete the questionnaire and the possibility of mild discomfort when reflecting on work-related experiences. Respondents were informed of their right to discontinue participation if they experienced discomfort, and they could skip any item. Appropriate safeguards were observed in the handling, storage, retention, and disposal of research records in accordance with applicable data protection requirements and the study's data management procedures.

Printed questionnaires and related research records were stored in a locked cabinet accessible only to the researchers, with access limited to authorized research personnel. Electronic records, if any, were stored in password-protected files accessible only to the researchers. Research records will be retained for one (1) year and securely destroyed thereafter in accordance with the study's data management procedures.

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RESULTS and DISCUSSION

This study examined 93 registered nurses drawn by total enumeration from two private Level 2 hospitals in Malolos, Bulacan. All 93 eligible nurses consented and returned complete questionnaires. Coping mechanisms were measured with the Brief COPE (Carver, 1997), resilience with the Brief Resilience Scale (Smith et al., 2008), and professional quality of life with the ProQOL-5 (Stamm, 2009). Descriptive findings are presented first, followed by the bivariate relationships and the six mediation models.

Table 1

Demographic Profile of the Respondents

Variable / Category	*f*	%
Age (*M* = 33.16, *SD* = 8.73, *Mdn* = 33, range 23–53)		
Sex		
Female	82	88.2
Male	11	11.8
Highest educational attainment		
Bachelor of Science in Nursing	85	91.4
With master's units	6	6.5
Master's degree holder	2	2.2
Years of clinical experience		
Less than 1 year	9	9.7
1–3 years	44	47.3
4–6 years	11	11.8
7–10 years	8	8.6
More than 10 years	21	22.6
Area of assignment		
Medical-Surgical Ward	42	45.2
Intensive Care Unit / Critical Care	14	15.1
Emergency Department	13	14.0
Operating Room / Recovery Room	13	14.0
Obstetrics / Gynecology / Labor and Delivery	2	2.2
Outpatient Department	2	2.2
Others	7	7.5

Note. *N* = 93. Percentages may not total 100 due to rounding.

Respondents averaged 33.16 years of age (*SD* = 8.73) and were predominantly women (88.2%) holding a baccalaureate as their highest qualification (91.4%). Experience clustered at both ends of the range: 57.0% had three years or less and 22.6% more than ten. Nearly half worked in medical-surgical wards (45.2%). Obstetric services and the outpatient department each contained two respondents, so patterns involving those areas are not interpretable. This profile describes the nursing workforce of the two participating hospitals and is not presented as representative of hospital nurses in Bulacan or the Philippines.

Table 2

Levels of Coping Mechanisms and Resilience

Dimension (items)	*M*	*SD*	Verbal interpretation	α	Highest-rated item (*M*)	Lowest-rated item (*M*)
Problem-focused coping (6)	3.19	0.55	Moderately used	.806	Taking action to improve the situation (3.38)	Getting advice or help from others about what to do (3.05)
Emotion-focused coping (10)	3.02	0.52	Moderately used	.825	Praying or meditating (3.40)	Making fun of the situation (2.19)
Avoidant coping (12)	2.02	0.50	Slightly used	.855	Doing something to think about it less (3.05)	Using alcohol or other drugs to get through it (1.23)

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Resilience (6)	3.45	0.66	Normal resilience	.860	Bouncing back quickly after hard times (3.53)	Coming through difficult times with little trouble (3.30)

Note. N = 93. Dimension scores are unweighted item means. Brief COPE items were rated 1 to 4; the interpretive bands (1.00–1.75 = Not at all used; 1.76–2.50 = Slightly used; 2.51–3.25 = Moderately used; 3.26–4.00 = Highly used) are equal-interval bands constructed by the researchers. Brief Resilience Scale items were rated 1 to 5; the bands (1.00–2.99 = Low; 3.00–4.30 = Normal; 4.31–5.00 = High) apply to the six-item composite and are not applied to individual items.

Both adaptive dimensions fell in the moderate band, problem-focused coping (M = 3.19) near its upper boundary and emotion-focused coping (M = 3.02) near the midpoint. Avoidant coping was least used (M = 2.02), but unevenly: its highest-rated item, doing something to think about it less (M = 3.05), sat well above its lowest, using alcohol or other drugs to get through it (M = 1.23). Resilience averaged 3.45, mid-range within the normal band, with all six items between 3.30 and 3.53.

Prayer drew the highest rating of any of the 28 coping items (M = 3.40; Table 2). That placement is consistent with the role of religion in Filipino coping documented outside nursing: prayer featured among the stress-management practices identified in a Northern Luzon sample of 1,196 Filipinos (Fudolig et al., 2026), and religious meaning-making shaped how 20 Filipino adults with cancer interpreted illness (Ahmadi et al., 2024). Neither sample consisted of nurses, so the reach of this patterning into hospital practice remains untested. Help-seeking ranked lower within the problem-focused dimension: getting advice or help from others about what to do was its lowest-rated item (M = 3.05). This ranking reflects how often respondents reported using the strategy, not the availability or adequacy of workplace support, which the study did not measure. The substance-use item using alcohol or other drugs to get through it was rarely endorsed (M = 1.23), and making fun of the situation was the lowest-rated emotion-focused item (M = 2.19), matching the low-use pattern Yeşil and Polat (2023) reported for substance use, behavioral disengagement, and humor among 356 Turkish hospital nurses, a convergence of rank rather than magnitude given the different coping instrument.

Resilience scores are not comparable across instruments of differing length and scaling, as the RS-14 applied by Suazo Galdames et al. (2024) and the six-item scale used here illustrate. What the composite shows is that recovery capacity sat at an ordinary level (M = 3.45, SD = 0.66), neither depleted nor at ceiling. Whether resilience statistically accounted for any part of the coping-outcome associations is assessed through the *a* and *b* paths in Table 5, not through its level.

Table 3
Levels of Professional Quality of Life

Statistic	**Burnout**	**Compassion satisfaction**
Sum score M (SD)	24.19 (5.56)	37.86 (6.91)
Item mean M (SD)	2.42 (0.56)	3.79 (0.69)
Verbal interpretation	Moderate	Moderate
α	.761	.912
Highest-rated item (M)	Feeling overwhelmed by an endless caseload (3.14)	Being proud of what one can do to help (4.22)
Lowest-rated item (M)	Lost productivity from sleep disturbance after traumatic experiences (1.96)	Feeling invigorated after working with patients (2.95)
Level distribution	f (%)	f (%)
Low (≤ 22)	36 (38.7)	2 (2.2)
Moderate (23–41)	56 (60.2)	60 (64.5)
High (≥ 42)	1 (1.1)	31 (33.3)

Note. N = 93. ProQOL-5 items were rated 1 to 5. Sum-score cutoffs follow Stamm (2009). Secondary Traumatic Stress was administered but not scored.

Both dimensions fell in the moderate band but differed in shape. Burnout concentrated at moderate (60.2%) against a substantial low-burnout group (38.7%) and a single respondent at the high threshold. Compassion satisfaction also concentrated at moderate (64.5%), yet a third reached high (33.3%) and only two fell low.

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Print ISSN: 3116-3866; Electronic ISSN: 3116-3874
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Burnout's highest-rated item was feeling overwhelmed by an endless caseload (*M* = 3.14) and its lowest was lost productivity from sleep disturbance after traumatic experiences (*M* = 1.96). Within compassion satisfaction, the highest-rated item was being proud of what one can do (*M* = 4.22) and the lowest was feeling invigorated after working with patients (*M* = 2.95), a gap of 1.27 points between pride in the work and felt energy.

These levels sit close to two independent ProQOL-5 samples. Eysa et al. (2025) reported compassion satisfaction of *M* = 37.8 (*SD* = 6.3) and burnout of *M* = 24.1 (*SD* = 5.4) among 156 trauma nurses in Qatar, within 0.06 and 0.09 points of the present figures. Calegari et al. (2022) reported burnout of *M* = 24.3 (*SD* = 6.5) and compassion satisfaction of *M* = 36.4 (*SD* = 7.4) among the 95 nurses in their Italian sample, within 0.11 and 1.46 points. Against the Philippine pandemic benchmark the picture is mixed. Castillejos et al. (2025) surveyed 239 nurses through the Philippine Nurses Association and reported burnout of *M* = 23.56 (*SD* = 6.07), which the present figure exceeds by 0.63 points, alongside compassion satisfaction of *M* = 41.95 (*SD* = 5.97), which the present figure falls 4.09 points below. Note that Castillejos et al. (2025) classified 41.95 as high compassion satisfaction. Under Stamm's (2009) cutoff of 42 or above it falls 0.05 points short. The present study applies Stamm's cutoff throughout; the discrepancy is noted so both studies are read against one criterion.

The present burnout mean (*M* = 24.19, *SD* = 5.56) was descriptively higher than the mean reported by Castillejos et al. (2025) during the pandemic (*M* = 23.56, *SD* = 6.07). However, because the studies involved different samples and were not designed as a direct statistical comparison, this difference does not establish whether burnout increased or decreased following the pandemic. It nevertheless indicates that moderate burnout was also observed among the nurses included in the present study.

Two features bear on the framework. Burnout and compassion satisfaction were co-elevated: 97.8% of respondents sat at moderate or high compassion satisfaction while 61.3% sat at moderate or high burnout. Stamm (2010) conceptualized these as distinct dimensions rather than opposite poles of one scale, and this co-occurrence is the basis on which the two outcomes were modeled independently below. The graded distributions are also consistent with Neuman's framing of outcomes as degree of system stability rather than presence or absence of impairment (Neuman & Fawcett, 2011). Under the researchers' conceptual application of the model, compassion satisfaction and burnout correspond by analogy to retained stability and energy depletion; neither scale is a direct measure of system stability.

Table 4

Spearman Rank-Order Correlations Among Coping Mechanisms, Resilience, and Professional Quality of Life

Variable pair	ρ	95% CI	*p*	Decision on *H*₀
Coping and resilience				
Problem-focused coping, Resilience	.343	[.14, .52]	< .001	Reject
Emotion-focused coping, Resilience	.340	[.14, .51]	< .001	Reject
Avoidant coping, Resilience	−.070	[−.28, .14]	.503	Fail to reject
Coping and burnout				
Problem-focused coping, Burnout	−.277	[−.46, −.07]	.007	Reject
Emotion-focused coping, Burnout	−.131	[−.33, .08]	.209	Fail to reject
Avoidant coping, Burnout	.440	[.25, .59]	< .001	Reject
Coping and compassion satisfaction				
Problem-focused coping, Compassion satisfaction	.474	[.29, .62]	< .001	Reject
Emotion-focused coping, Compassion satisfaction	.375	[.18, .54]	< .001	Reject
Avoidant coping, Compassion satisfaction	−.031	[−.24, .18]	.765	Fail to reject
Resilience and professional quality of life				
Resilience, Burnout	−.497	[−.64, −.32]	< .001	Reject
Resilience, Compassion satisfaction	.454	[.27, .61]	< .001	Reject

Note. *N* = 93. Spearman rho was used because five of six variables departed from normality (Shapiro-Wilk $p < .05$). Confidence intervals were obtained by Fisher *z* transformation using the rank-correlation standard error $\sqrt{[1.06/(n - 3)]}$ (Fieller et al., 1957). Magnitude descriptors used in the text follow Cohen (1988): negligible (< .10), weak (.10–.29), moderate (.30–.49), strong (≥ .50). Bonferroni-corrected thresholds were applied within each research question (α = .017 for Objective 5, .008 for Objective 6, .025 for Objective 7). No decision changed under correction, although the problem-focused coping and burnout correlation ($p = .007$) cleared its threshold narrowly.

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The three coping dimensions related to the two outcomes along different routes. Both adaptive dimensions correlated moderately with resilience (ρ = .343 and .340) and with compassion satisfaction (ρ = .474 and .375), but only problem-focused coping related to burnout, an association that was statistically significant but weak in magnitude under the Cohen (1988) classification adopted here (ρ = −.277, p = .007). Avoidant coping reversed the pattern: unrelated to resilience (ρ = −.070) and to compassion satisfaction (ρ = −.031), yet the second-strongest correlate of burnout in the matrix (ρ = .440). The largest absolute coefficient in Table 4 was the inverse association between resilience and burnout (ρ = −.497). Resilience was also positively associated with compassion satisfaction (ρ = .454), second only to problem-focused coping (ρ = .474) among the correlates of that outcome. Four of the six coping-outcome hypotheses were rejected at α = .05, and all four decisions held under the Bonferroni-corrected threshold.

Two independent samples reproduce the avoidant pattern. Among the Turkish nurses studied by Yeşil and Polat (2023), behavioral disengagement (r = .256), denial (r = .229), and substance use (r = .210) each correlated positively with burnout, while denial (r = −.064) and mental disengagement (r = .031) were unrelated to compassion satisfaction. Their separation was not absolute, since behavioral disengagement (r = −.148) and substance use (r = −.111) did correlate weakly and negatively with compassion satisfaction. Calegari et al. (2022) found avoidance a positive predictor of burnout (β = .360, p < .001) and a negative predictor of compassion satisfaction (β = −.155, p = .037), and Eysa et al. (2025) concluded that avoidant coping was linked to higher stress and burnout among trauma nurses. The present result reproduces the burnout side of that pattern at moderate strength while diverging on the satisfaction side, where no association emerged.

The non-significant emotion-focused result warrants closer reading, because the dimension is internally mixed and two studies suggest where a split within it may lie. Yeşil and Polat (2023) found turning to religion unrelated to burnout (r = .082) but positively associated with compassion fatigue, while positive reinterpretation was associated with lower burnout (β = −.241, p = .001) and higher compassion satisfaction (β = .231, p = .001). Their study applied the 60-item COPE and the fourth version of the ProQOL (ProQOL-IV), so their subscales and outcome metric are not interchangeable with those used here. Calegari et al. (2022) reached the same division with a different instrument: transcendent orientation, comprising spirituality and religion, predicted neither burnout (β = −.071, p = .384) nor compassion satisfaction (β = .009, p = .908), whereas positive attitude, comprising acceptance, containment, and positive reinterpretation, was the strongest predictor of both (β = −.513 and .514, both p < .001). Religion and reframing both sit inside the present emotion-focused dimension and both occupied its top four items. Three readings of this null are available and this design cannot separate them; they are set out in the Limitations.

Problem-focused coping is the dimension where the evidence is least settled. Eysa et al. (2025) found problem-focused coping associated with more favorable professional quality of life among trauma nurses, consistent with the present result. Calegari et al. (2022) found the opposite on burnout: in their Italian sample of 143 nurses and physicians, problem orientation was a positive predictor of burnout (β = .404, p = .001) and of secondary traumatic stress (β = .247, p = .036), with no association to compassion satisfaction (β = .003, p = .982). The authors treated this as anomalous and attributed it to data collection in April and May 2021, reasoning that the unpredictability of the pandemic may have undermined the perceived efficacy of problem-solving. Their sample also combined two professions, and physicians reported higher compassion fatigue than nurses. Instrument, composition, and context all differ, so the divergence does not put the present finding in doubt, but it marks this relationship as one that further Philippine data should test.

Table 5

Mediation of Coping and Professional Quality of Life Relationships Through Resilience (PROCESS Model 4)

Model	*a*: coping → resilience *B* (*SE*)	*b*: resilience → outcome *B* (*SE*)	Indirect *ab* [BC 95% CI]	Direct *c′* *B* (*p*)	Total *c* *B* (*p*)	R^2(Y)	Conclusion
Burnout							
Problem-focused coping	0.534 (0.113)***	−0.400 (0.085)***	−0.214 [−0.410, −0.095]	−0.080 (.437)	−0.293 (.005)	.265	Significant
Emotion-focused coping	0.538 (0.122)***	−0.458 (0.084)***	−0.246 [−0.447, −0.117]	0.086 (.424)	−0.160 (.156)	.265	Significant
Avoidant coping	−0.133	−0.393	0.052	0.476 (<	0.528 (<	.442	Not

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Model	*a*: coping → resilience *B* (*SE*)	*b*: resilience → outcome *B* (*SE*)	Indirect *ab* [BC 95% CI]	Direct *c′* *B* (*p*)	Total *c* *B* (*p*)	R^2(Y)	Conclusion
	(0.137)	(0.067)***	[−0.053, 0.198]	.001)	.001)		significant
Compassion satisfaction							
Problem-focused coping	0.534 (0.113)***	0.389 (0.099)***	0.207 [0.088, 0.395]	0.415 (< .001)	0.622 (< .001)	.354	Significant
Emotion-focused coping	0.538 (0.122)***	0.443 (0.101)***	0.238 [0.107, 0.430]	0.301 (.023)	0.539 (< .001)	.309	Significant
Avoidant coping	−0.133 (0.137)	0.542 (0.095)***	−0.072 [−0.279, 0.072]	0.007 (.957)	−0.065 (.653)	.267	Not significant

Note. $N = 93$. PROCESS Model 4 (Hayes, 2022), 5,000 bootstrap resamples, bias-corrected 95% confidence intervals. All variables in item-mean metric. An indirect effect is inferred where the interval excludes zero. H_{04} was rejected for problem-focused and emotion-focused coping and not rejected for avoidant coping; H_{05} was rejected for problem-focused and emotion-focused coping and not rejected for avoidant coping. Mediator model R^2 = .197 (problem-focused), .176 (emotion-focused), .010 (avoidant). VIF ≤ 1.25 in all models. BC = bias-corrected; VIF = variance inflation factor. Conclusion refers to the indirect effect, judged significant when its bias-corrected interval excludes zero. The a path for avoidant coping was not significant ($t = -0.97$, $p = .337$). Full and partial mediation labels are not applied, following the recommendation against classifying mediation by the significance of the direct or total effect (Hayes, 2022). ***$p < .001$.

Resilience was significantly associated with both outcomes in all six models (*b* paths), inversely with burnout (*B* = −0.393 to −0.458) and positively with compassion satisfaction (*B* = 0.389 to 0.542). What differed was whether a coping dimension was associated with resilience and whether an indirect effect through resilience was observed. Both adaptive dimensions were positively associated with resilience (*B* = 0.534 and 0.538) and showed indirect effects whose intervals excluded zero for both outcomes. Avoidant coping was not associated with resilience (*B* = −0.133, *p* = .337), and neither of its indirect intervals excluded zero, yet it showed the largest direct coefficient among the burnout models (*c′* = 0.476, *p* < .001) in the burnout model with the highest R^2 (.442), which is the proportion of burnout variance accounted for jointly by avoidant coping and resilience in that model, not the proportion attributable to avoidant coping alone.

The two outcomes differed in composition. In the burnout models, neither adaptive dimension retained a direct effect once resilience was included. The emotion-focused model for burnout illustrates why the components are reported separately. Its indirect effect was significant (*ab* = −0.246, 95% CI [−0.447, −0.117]), while its direct effect (*c′* = 0.086, *p* = .424) and total effect (*c* = −0.160, *p* = .156) were not, and the indirect and direct components carried opposite signs. Because the total effect is the sum of the direct and indirect effects (*c* = *c′* + *ab*), components of opposite sign can offset each other, so a significant indirect effect can occur without a significant total effect. The absence of a significant direct effect is therefore not read as full mediation, consistent with the reporting approach described under Treatment of Data (Hayes, 2022). Possible readings of this pattern are set out in the Limitations. In the compassion satisfaction models, both adaptive dimensions retained a direct effect (*B* = 0.415 and 0.301) alongside significant indirect effects, so two components were present rather than one. Because all three constructs were measured on a single occasion, these are decompositions of observed association, not evidence of sequence.

A statistically significant indirect effect through resilience is consistent with the closest Philippine evidence. Labrague (2021a) found that resilience partially mediated the relationships between pandemic fatigue and mental health (β = −0.488), sleep quality (β = −0.326), and job contentment (β = −0.395, all *p* < .001) among 255 frontline clinical nurses in the Philippines, using the same six-item resilience scale applied here. Labrague and de los Santos (2021) found resilience mediating relationships between compassion fatigue and nurse work outcomes and care quality among 270 Philippine frontline nurses. The present models extend that work to coping dimensions as

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predictors rather than strain already experienced, and to the two professional quality of life dimensions modeled separately.

Two findings caution against treating resilience as a general-purpose resource. Al Yahyaei et al. (2025) found among 456 Omani oncology nurses that resilience correlated with turnover intention ($r = -.317$, $p < .001$) and independently predicted it ($\beta = -0.19$, $p < .001$), yet did not moderate the relationship between any professional quality of life dimension and turnover intention, with all four interaction terms non-significant and adding less than 1% of variance. Their reading was that resilience exerted a direct rather than a buffering effect in that context. Uteulova et al. (2026), studying 100 Kazakh oncology nurses with the same resilience scale used here, concluded that resilience did not function as a universal protective resource and that its effects were selective by coping strategy and by burnout component. Both studies tested moderation rather than mediation, so they speak to scope rather than to pathway. Read alongside the present results, the point holds across model forms: the coping dimension most strongly correlated with burnout in this sample showed no statistically significant indirect effect through resilience. The pattern for the adaptive dimensions is consistent with the researchers' application of Neuman's model, in which deeper lines of resistance are mobilized when a stressor penetrates the outer lines of defense (Neuman & Fawcett, 2011; Turner & Kaylor, 2015). The avoidant dimension did not fit that application in these data: it was associated with burnout without a statistically significant indirect effect through resilience, although resilience remained associated with burnout in the same model ($b = -0.393$).

The findings bear most directly on nursing workforce management. For nursing administrators and staff development units, they suggest that assessments of nurses' professional quality of life may be more informative when burnout and compassion satisfaction are examined separately and when avoidant coping is examined apart from adaptive coping. For hospital management, the moderate association between avoidant coping and burnout, which showed no significant indirect effect through resilience, identifies avoidant responses as a separate area for assessment, alongside the workplace conditions associated with burnout, which this study did not measure. For health workforce planners, the study adds hospital-level evidence on nurses' occupational well-being from Philippine private hospitals, a sector in which nurse shortages have been reported as more acute (Pepito et al., 2025). Because nurse burnout has been associated elsewhere with patient safety, patient satisfaction, and nurse-assessed quality of care (Li et al., 2024), these findings are relevant to service delivery; however, patient, care-quality, and safety outcomes were not measured in this study, and no claim is made about them.

Conclusions

Based on the findings of the study, the following conclusions were drawn:

1. The 93 registered nurses from the two participating private Level 2 hospitals in Malolos, Bulacan, reported moderate use of problem-focused and emotion-focused coping and slight use of avoidant coping. Their mean resilience score fell within the normal range, while both burnout and compassion satisfaction were classified at moderate levels.

2. Problem-focused and emotion-focused coping were significantly and positively related to resilience, whereas avoidant coping did not demonstrate a significant relationship with resilience. These findings indicate that the three coping dimensions were not uniformly associated with nurses' recovery capacity.

3. The relationships between coping mechanisms and professional quality of life differed according to the coping dimension and outcome examined. Problem-focused coping was significantly associated with lower burnout and higher compassion satisfaction. Emotion-focused coping was significantly associated with higher compassion satisfaction but not with burnout. Avoidant coping was significantly associated with higher burnout but not with compassion satisfaction.

4. Resilience was significantly and inversely related to burnout and positively related to compassion satisfaction. These relationships were also observed in the regression-based mediation models.

5. Resilience demonstrated statistically significant indirect effects in the relationships of problem-focused and emotion-focused coping with both burnout and compassion satisfaction. However, the indirect effects involving avoidant coping were not statistically significant. Avoidant coping remained significantly associated with burnout through its direct effect in the corresponding mediation model.

6. Overall, the findings demonstrate that coping dimensions have different patterns of association with resilience and the two professional quality of life outcomes. The results support examining burnout and compassion satisfaction separately rather than treating them as opposite ends of a single continuum. They also provide hospital-level evidence concerning coping, resilience, and professional quality of life among nurses in the participating hospitals in Bulacan.

International Journal of Clinical, Nursing, and Population Health Sciences (INCLINPHS)
Print ISSN: 3116-3866; Electronic ISSN: 3116-3874
National Book Development Board Registration as Book Publisher (Print & Digital): 6312
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7. The observed associations and indirect effects are consistent with the study's theoretical interpretation of coping mechanisms and resilience within the Neuman Systems Model and the Transactional Model of Stress and Coping. Nevertheless, because the study employed a cross-sectional design, the findings do not establish temporal sequence or causation among the variables. The proposed relationships should therefore be interpreted as statistically supported associations and indirect effects rather than demonstrated causal pathways.

Recommendations

In light of the findings and conclusions, the following recommendations are offered:

1. For nursing administrators and hospital management: Hospital administrators may consider conducting periodic assessments of nurses' professional quality of life, particularly burnout and compassion satisfaction, to identify occupational well-being concerns among their nursing personnel. The results may also inform the review of staffing conditions, workload distribution, and workplace support arrangements within their respective institutions.

2. For nursing staff development units: Staff development units may consider incorporating resilience-related activities and coping skills education into continuing professional development and employee well-being initiatives. Such activities may include stress-management education, reflective practices, problem-solving skills, and appropriate avenues for professional and peer support. The effectiveness of these initiatives may be evaluated separately rather than assumed from the present study's findings.

3. For nurses and clinical personnel: Nurses may be encouraged to reflect on their coping practices and recognize the different ways problem-focused, emotion-focused, and avoidant strategies are associated with professional quality of life. Culturally relevant coping practices, including prayer or meditation, may be acknowledged as practices reported by participants, while their individual usefulness and effects should be assessed without assuming that they produce the same outcomes for all nurses.

4. For hospital administrators and occupational well-being program developers: Because avoidant coping was significantly associated with burnout but did not demonstrate a significant indirect effect through resilience, programs may include additional components addressing behavioral disengagement, denial, self-blame, and other avoidant responses. These approaches may be evaluated to determine whether they are associated with improvements in nurses' occupational well-being.

5. For health workforce planners and policymakers: The findings may be considered as supplementary hospital-level evidence in discussions concerning nursing workforce well-being and retention. However, broader policy decisions may benefit from additional studies involving public and private hospitals, different hospital classifications, and multiple geographical regions.

6. For future researchers: Subsequent studies may employ longitudinal or repeated-measures designs to examine the temporal relationships among coping mechanisms, resilience, burnout, and compassion satisfaction. These designs may help establish whether the relationships observed in the present cross-sectional study persist or change over time.

7. For future measurement and analytical research: Researchers may examine the three Brief COPE dimensions separately at the item or subscale level and conduct appropriate construct-validation procedures using larger samples. Further research may also investigate religious coping, positive reframing, and other components of emotion-focused coping independently to determine whether their relationships with burnout and compassion satisfaction differ.

8. For future studies across healthcare settings: The investigation may be extended to government hospitals, Level 1 and Level 3 hospitals, specialty hospitals, and other healthcare facilities. Larger and more diverse samples may also improve the ability to examine small indirect effects and assess whether the present findings are applicable to other nursing populations.

Limitations

All variables were measured on a single occasion, so the results describe associations and their decomposition, not sequence or causation. With three constructs observed simultaneously, the model tested here cannot be distinguished from alternative orderings. A specification in which resilience precedes coping, or in which burnout depletes both recovery capacity and active coping, would reproduce these associations equally well. The sequence modeled rests on the theoretical argument, not on evidence internal to these data. Respondents constituted the complete eligible nursing population of two purposively selected private Level 2 hospitals in one city; non-response among eligible nurses was not observed, but the purposive selection of the hospitals and the eligibility criteria limit generalization beyond comparable settings.

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Three readings of the emotion-focused result are available and this design cannot separate them. First, its indirect and direct paths to burnout carried opposite signs (ab = −0.246; c′ = 0.086), so the non-significant total effect (c = −0.160, p = .156) may reflect paths working against each other. Second, the dimension combines religion with cognitive reframing, and Calegari et al. (2022) found these behaved differently when modeled separately, with positive attitude the strongest predictor of both burnout (β = −.513) and compassion satisfaction (β = .514) while transcendent orientation predicted neither. Religion and reframing occupied the top-rated items of this dimension, prayer highest of all 28 (M = 3.40). Third, power: this sample could detect correlations of about .29 or larger at 80% power, and ρ = −.131 falls below that.

The three-dimension Brief COPE grouping was researcher-selected and was not tested here. Confirmatory factor analysis was not attempted, since 93 cases give roughly three observations per item, and Rodrigues et al. (2022) reported poor fit or non-convergence for second-order and bifactor specifications in larger samples. Calegari et al. (2022) also used the Italian version of the COPE (COPE-NVI), which allocates humor and emotional release differently, so the comparison above is approximate. The problem-focused and avoidant dimensions were not disaggregated either, and comparable heterogeneity within them cannot be ruled out.

Three estimation choices bear on interpretation. Bivariate associations were estimated by rank correlation while the mediation models used ordinary least squares, and the mediator models imply linear associations somewhat stronger than the reported rank coefficients. Indirect effects were tested with bias-corrected rather than percentile bootstrap intervals, which can carry a higher Type I error rate. The sample was adequate for medium-sized indirect effects but underpowered for small ones (Fritz & MacKinnon, 2007), so the absence of an indirect effect for avoidant coping may partly reflect power; the non-significant path from avoidant coping to resilience (B = −0.133, p = .337) indicates that an indirect effect through resilience was not established in these data, not that one is absent. Residual-based diagnostics of the mediation models, including linearity, homoscedasticity, and regression influence statistics, are not reported, and the five retained composite-score outliers may have influenced individual path estimates.

Finally, the Burnout subscale returned the lowest reliability of the six analysis scales, all measures were self-reported by the same respondents in a single sitting, so shared method variance may have inflated the observed associations, and the Secondary Traumatic Stress subscale was not scored. The account of professional quality of life presented here is partial.

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