A Comparative Study of Professional Quality of Life

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Abstract

The aim of the present research was to study the professional quality of life of nurses in relation to depression, anxiety and coping strategies. The impact of years of work experience on the professional quality of life of nurses and its correlates was also investigated. Two hundred female nurses employed in Punjab comprised the sample for the study. The sample was categorized into two groups of 100 nurses each, based on years of work experience, i.e., 2 to 4 years and 6 to 8 years respectively. Based on Stamm's (2010) model, majority of the nurses in the study showed "positive reinforcement from work" profile. Depression emerged as a significant predictor of compassion satisfaction, burnout and secondary traumatic stress in nurses with more years of work experience explaining 19%, 31% and 4% of variance in the criterion variables respectively. Social withdrawal emerged to be a significant predictor of burnout and secondary traumatic stress explaining 3% and 17% in them respectively. Nurses with less work experience need more attention, support and guidance as they were found to be high on depression and anxiety; and low on compassion satisfaction, and social contact coping.

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Introduction and Literature Review

Nursing is a highly taxing profession which involves a number of tedious tasks as stated in the theory forwarded by Ida Jean Orlando in 1961. These tasks range from a) obtaining information from the patient, family, friends and other medical professionals; identification, detailed analysis, accurate and unbiased interpretation of the needs and problems of the patient, b) taking up of short and long term goals in order to cater to the needs and issues related to the patient, c) step by step execution of the goals and interventions as a part of the recovery program, d) thorough appraisal of the administration and effectiveness of the care interventions undertaken (Hill, 2015). Fernandes and Nirmala (2017) emphasized that the work environment of nurses is considerably stressful because of varied factors ranging from inadequate staffing, excessive amount of work, hectic routine, exposure to pain and grief of patients and risk of infection. Nursing is a helping profession, yet the people employed in it are not given the degree of respect which they truly deserve. Nurses are not treated fairly neither are they given due recognition for their self-less efforts and services. Nursing profession, unfortunately, is not accorded high social status in the Indian society (Gill, 2009). Decker (1997) reported that with greater years of experience, nurses' expectations include greater independence, acknowledgement of their contribution and avenues for growth. According to Daehlen (2008), nurses with more years of experience give greater importance to salary and job security. Letvak (2002) conducted a study on hospitals and nursing homes in North Carolina and found that very few of these medical institutions had any policies dedicated to satisfying and resolving the needs and problems of the aged professional nurses.

India is facing a shortage of nurses (Anand & Fan, 2016; Rao, Shahrawat, & Bhatnagar 2016).The nurse to patient ratio in India is unsatisfactory making India short of a whopping two million nurses (Economic Times,2019). Bhattacharya and Ramachandran (2015) explained that because urban hospitals also provide services to people living in surrounding rural areas this has led to a further increase in the workload of urban hospitals.

Pilot studies done before this present research highlighted that some nurses were planning migration to other countries, while some were trying to switch to other jobs. Another ground reality that surfaced during data collection was considerably lesser availability of nurses with more years of experience in contrast to nurses with less years of work experience. It is a concern why nurses do not continue in this profession after a certain period of time. A good professional quality of life will allow nurses to deliver quality service to the patients, may reduce their international migration and possibly ensure their longer stay in this vocation.

This study was undertaken to understand if there are any differences in the professional quality of life of nurses with less and more years of work experience in order to understand which group of nurses are more vulnerable so that ameliorative actions may be taken for them. This study will also help to understand the relationship of professional quality of life with depression, anxiety and coping strategies.

Professional quality of life is the quality a helper feels in context of his work environment. Caring for others can impact a helping professional in both positive and negative ways. Professional quality of life is therefore understood as comprising of three elements viz., compassion satisfaction, burnout and secondary traumatic stress. Compassion satisfaction is a sense of accomplishment and joy experienced by helpers when they are able to alleviate the pain of their patients and improve their condition. Burnout is an inability to deliver because of organizational challenges while secondary traumatic occurs is a result of one getting indirectly affected by a person's pain while delivering their service (Stamm, 2010).

Depression: Depression is characterized with low self-evaluations, negative expectations, self-blame and self-criticisms, indecisiveness, distorted self-image, loss of motivation and suicidal wishes (Beck & Alford, 2009). Depression is related to increased absenteeism in nursing profession. Depressed nurses have low morale, show high irritability with patients, colleagues and even with family. Depression reduces efficiency and effectiveness of nurses in task-related functioning leading to decreased work productivity and affects their interpersonal relationships (Pilette, 2005). Stamm (2010) recommended assessment and treatment of depression in professionals with 'overwhelmed' and 'most distressed' professional quality of life profile. Iacovides, Fountoulakis, Kaprinis, and Kaprinis (2003) maintained that higher degree of burnout is closer to depression. Depressive symptoms can be considered as a risk factor for burnout and secondary traumatic stress (Haber et al., 2013). Devilly et al. (2009) conducted a study on Australian mental health professionals and concluded secondary traumatic stress and burnout to be positively correlated with affective distress. Yadollahi et al. (2016) reported a negative relationship between compassion satisfaction and depression while burnout and secondary traumatic stress were found to be positively related with depression.

Anxiety: It is a "potentially debilitating category which includes a variety of functional altering verbal components (e.g., unpleasant memories, negative self-evaluations, unfavorable social comparisons, etc.) and related bodily states (e.g., autonomic arousal)" (Friman, Hayes, & Wilson, 1998, p.9). Anxiety is associated with an increased sensitivity towards environmental stimuli (Neal, Edelmann, & Glachan, 2002). Higher anxiety levels in nurses have been found to be linked with lower educational level, long work hours, fewer years of nursing experience and young age (Hegney et al., 2013). Zeidner, Hadar, Matthews, and Roberts (2013) concluded personal factor of negative affect associated with high compassion fatigue in helping professionals. Lee et al. (2015) did a cross-sectional study on practicing genetic counsellors. Regression analysis revealed that trait anxiety was a predictor of compassion fatigue. High trait anxiety in the genetic counsellors was associated with high compassion fatigue experienced by them. Hegney et al. (2013) analyzed different professional quality of life profiles and reported that anxiety remained the same when moving from the 'positive reinforcement from work profile' (high compassion satisfaction, moderate to low burnout and secondary traumatic stress) to 'at-risk' profile (high burnout, moderate to low compassion satisfaction and secondary traumatic stress) but increased when moving from 'at-risk profile' to the 'very distressed profile' (high secondary traumatic stress and high burnout with low compassion satisfaction) in the nurses.

Coping: Coping strategies refer to the actions performed with the motive to decrease or to get rid of the harmful effects of stress (Zimbardo, Johnson, & McCann, 2012). Frydenberg and Lewis (2012) posited that coping is "a set of cognitive and affective actions that arise in response to a particular concern. They represent an attempt to restore the equilibrium or remove the turbulence for the individual" (p.1). Positive coping in nurses in China has been found to be related to lesser social dysfunction, fewer sleep disturbance issues and good mental health.

Negative coping, on the other hand, is related to greater feelings of inadequacy, greater social dysfunction and poor mental health (Wong, Leung, So, & Lam, 2001). Harrison (2007) enquired from trauma therapists about the protective practices used by them against secondary traumatic stress. Respondents were found to be using active coping and problem-solving coping. They were optimistic that there was a solution to every problem which they faced at work. They handled problems at work by breaking them into smaller manageable parts. Regehr, Goldberg, and Hughes (2002) reported that paramedics resort to various coping strategies to manage the negative effects of caring. These included cognitive techniques such as visualizing the next step in a particular situation, emotionally distancing themselves from the victim or his family and "blocking out" the victims' family. Other strategies included obtaining a sense of closure about a patient's condition, positively reframing the event, keeping other aspects of their life in control, resorting to support from family and coworkers and practicing humour. Creamer (2003) examined the relationship between secondary traumatic stress and coping strategies in disaster mental health workers involved in providing relief to the victims of September 11 terrorist attacks. Maladaptive coping was significantly associated with greater secondary traumatic symptoms. An unusual finding of the study was a positive relationship between adaptive coping and secondary traumatic stress.

Hegney et al. (2013) emphasized the paucity of literature linking professional quality of life with depression and anxiety. The relationship of different components of professional quality of life with the different coping strategies as per Tobin's model needs further clarity in the Indian context. There is ambiguity in the body of knowledge regarding the relationship of years of work experience with professional quality of life. While many research investigators suggest a relation between years of work experience and professional quality of life (Edmunds,2010; Jakimowicz et al., 2017; Kaladow, 2010; Wagaman et al., 2015), there are some who report an insignificant relationship between the two (Alkema et al.,2008; Payne, 2001). Mixed empirical results have been obtained regarding levels of experience on professional quality of life (Bhandari & Kaur, 2017; Hegney et al., 2013; Hooper et al., 2010; Robins et al., 2009). Payne (2001) argued that the relationship of burnout and coping is complex as there are some problem-focused coping strategies which have a positive relationship with burnout while some have a negative relationship with it. Also, the relationship of burnout with all emotion focused coping strategies, again, is not very clearly in one direction.

OBJECTIVES OF THE STUDY

- To examine the impact of years of work experience on the professional quality of life of nurses and its correlates.
- To study professional quality of life of nurses in relation to depression, anxiety and coping strategies.

RESEARCH QUESTIONS

Following research questions have been proposed on the basis of the objectives of the research:

1. Are there any significant differences in the professional quality of life, depression, anxiety and coping strategies in nurses with less years (2 to 4) and more years (6 to 8) of work experience?
2. What is the relation of professional quality of life with depression, anxiety and coping strategies of nurses?
3. What are the predictors of professional quality of life of nurses?

HYPOTHESES:

The research questions led to the formulation of the following hypotheses:

H1: Compassion satisfaction is negatively related to depression while burnout and secondary traumatic stress are positively related to depression.

H2: Compassion satisfaction is negatively related to anxiety while burnout and secondary traumatic stress are positively related to anxiety.

H3: Compassion satisfaction is positively related to problem solving, cognitive restructuring, social contact, express emotions coping strategies and negatively related to problem avoidance, wishful thinking, social

withdrawal and self-criticism coping strategies. Burnout and secondary traumatic stress are negatively related to problem solving, cognitive restructuring, social contact, express emotions coping strategies and are positively related to problem avoidance, wishful thinking, social withdrawal and self-criticism coping strategies.

Method:

Sample: The sample for the present study comprised 200 female nurses in the age range of 23-35 years. The sample was divided into two groups of 100 nurses each, based on years of work experience, i.e., 2 to 4 years and 6 to 8 years respectively. These nurses were selected from private hospitals situated in Punjab. Purposive sampling technique was used to obtain the sample for the study.

Tests and Tools:

Following tools were used for the purpose of the study:

1. Professional Quality of Life Scale (ProQOL Version 5; Stamm, 2010) was used to measure compassion satisfaction, burnout and secondary traumatic stress in nurses. The scale consists of ten items each in each subscale. The response alternatives on the scale range from: 1 = never to 5 = very often. The scores on each subscale range from 0 to 50 points.
2. Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995) were administered to assess affective states of depression and anxiety in nurses. Both the subscales have seven items each. The response alternatives are as follows: 0=did not apply to me at all to 3 =applied to me very much or most of the time.
3. Coping Strategies Inventory 32 Item (Tobin, 1995) was used to measure problem solving, cognitive restructuring, social contact, express emotions, problem avoidance, wishful thinking, social withdrawal and self-criticism coping strategies used by nurses. The inventory has four items under each subscale. The response alternatives on each subscale range from a=not at all to e=very much. The score on each subscale range from 4 to 20 points.

Procedure: Hospital authorities were briefed about the purpose of the study and permission was obtained to interact with the nurses in their hospitals. Informed consent was obtained from nurses and they were given permission to withdraw at any stage of data collection. Nurses were personally contacted and appointments were obtained to get the questionnaires filled. It took two months to collect data for the study.

Keeping in view the objectives of the study, descriptive statistics i.e., mean and standard deviations were computed for the total sample. t-test was used to compare professional quality of life, depression, anxiety and coping strategies used by nurses with less and more years of work experience. Correlation analysis was conducted to study the correlates of professional quality of life in nurses. Stepwise forward multiple regression analysis was performed to identify the predictors of professional quality of life.

RESULTS

Table 1 showing Mean, SD and t ratios of nurses with less and more years of work experience (N=200)

Variable	Nurses with less years of work experience		Nurses with more years of work experience		t-ratio
	M	SD	M	SD	
Compassion Satisfaction	43.54	4.82	45.05	4.47	2.29*
Burnout	22.11	5.37	23.59	6.15	1.81
Secondary Traumatic Stress	25.92	6.14	23.70	6.68	0.00
Depression	12.10	11.15	8.42	8.20	2.65**

Variable	Nurses with less years of work experience		Nurses with more years of work experience		t-ratio
	M	SD	M	SD	
Anxiety	8.68	8.58	5.86	7.93	2.41*
Problem solving	16.44	3.79	17.32	3.27	1.76
Cognitive restructuring	15.80	3.30	16.61	3.10	1.79
Social contact	15.09	4.65	16.56	3.13	2.61**
Express emotions	15.15	3.89	16.13	3.78	0.56
Problem Avoidance	10.79	4.25	11.59	4.04	1.36
Wishful thinking	15.42	3.84	15.25	3.31	0.33
Social Withdrawal	11.07	4.26	10.60	4.24	0.78
Self-criticism	9.48	4.98	9.04	4.60	0.64

Note. *=significant at 0.05 level **=significant at 0.01 level

Table 2 showing Professional Quality of Life Profile of Nurses with less and more years of work experience(N=200)

Profile	**Frequency of nurses with less work experience (n=100)**	**Frequency of nurses with more work experience (n=100)**
High compassion satisfaction, moderate to low burnout and secondary traumatic stress (Positive reinforcement from work profile)	74	85
High burnout, moderate to low compassion satisfaction and secondary traumatic stress (At-risk profile)	0	0
High secondary traumatic stress with low burnout and low compassion satisfaction (Overwhelmed profile)	0	0
High secondary traumatic stress and high compassion satisfaction with low burnout (Typically unique to high- risk situations profile)	0	1
High secondary traumatic stress and high burnout with low compassion satisfaction (Very distressed profile)	0	0
Moderate compassion satisfaction with moderate to low burnout and secondary traumatic stress	25	14
High secondary traumatic stress with moderate compassion satisfaction and burnout.	1	0

Table 3 INTERCORRELATION MATRIX FOR NURSES WITH LESS YEARS OF WORK EXPERIENCE

	CS	B	STS	D	Anx	PS	CR	SC	EE	PAv	WT	SW	SCr
CS	1	-.41**	-.08	-.05	.01	.20*	.13	-.07	.01	-.10	.17	.05	-.12
B		1	.36**	.25*	.26*	-.13	-.10	.09	.03	.03	-.15	-.01	-.02
STS			1	.04	.25*	.09	.14	.04	.11	.07	.07	.08	.16
D				1	.75**	-.21*	-.13	-.00	.08	.25*	.07	.35**	.26**
Anx					1	-.10	-.04	.04	.15	.22*	.07	.37**	.25*
PS						1	.62**	.17	.29**	-.15	.38**	.11	.03
CR							1	.20	.47**	.17	.42**	.03	.06
SC								1	.52**	.24*	.08	.08	-.13
EE									1	.30**	.30**	.21*	-.01
PAv										1	.21*	.20*	.22*
WT											1	.33**	.22*
SW												1	.52**
SCr													1

Note. *=significant at 0.05 level **=significant at 0.01 level

Table 4 INTERCORRELATION MATRIX FOR NURSES WITH MORE YEARS OF WORK EXPERIENCE

	CS	B	STS	D	Anx	PS	CR	SC	EE	PAv	WT	SW	SCr
CS	1	-.52**	-.19	-.43**	-.40**	.17	.15	.25*	.07	-.05	.14	-.25*	-.19
B		1	.41**	.55**	.50**	-.17	-.25*	-.15	-.07	.14	.03	.44**	.13
STS			1	.39**	.35**	-.25*	-.20*	.02	.05	.28**	.04	.41**	.22*
D				1	.75**	-.34**	-.35**	-.21*	-.04	.15	.03	.43**	.21*
Anx					1	-.22*	-.30**	-.25*	-.05	.14	.08	.45**	.29**
PS						1	.57**	.23*	.26**	-.03	.16	-.02	-.04
CR							1	.36**	.34**	.12	.19	-.13	.01
SC								1	.29**	.09	.05	-.20*	-.14
EE									1	.09	.36**	.02	.00
PAv										1	.21*	.37**	.55**
WT											1	.36**	.25*
SW												1	.46**
SCr													1

Note. *=significant at 0.05 level **=significant at 0.01 level

Table 5 PREDICTORS OF PROFESSIONAL QUALITY OF LIFE OF NURSES WITH MORE YEARS OF EXPERIENCE(n=100)

	Predictors	R	Beta Coefficient	t	R^2	R^2 Change	F-value
Compassion satisfaction	Depression	0.43	-0.43	-4.77**	0.19	0.19	22.78**
Burnout	Depression	0.55	0.55	6.56**	0.31	0.31	42.30**
Burnout	Social Withdrawal	0.71	0.18	2.16*	0.51	0.03	19.11**
Secondary traumatic stress	Social withdrawal	0.41	0.41	4.42**	0.17	0.17	19.52**
Secondary traumatic stress	Depression	0.54	0.21	2.18*	0.29	0.04	12.30**

**Note*. *=significant at 0.05 level **=significant at 0.01 level. No significant predictors emerged for nurses with less years of work experience

DISCUSSION: Table 1 shows descriptive statistics and t-ratios of the sample. Significant differences in the level of compassion satisfaction were obtained in the two groups of nurses. Nurses with more years of work experience were found to have greater compassion satisfaction than nurses with less years of work experience. No significant differences were obtained in the levels of burnout and secondary traumatic stress in the two groups. Bhutani et al. (2012) conducted a study on clinicians working in Karnal (Haryana). Compassion satisfaction was found to be higher in clinicians with more experience as compared to those with less experience. Similar findings were earlier reported by Robins et al. (2009). Nurses differed significantly on both depression and anxiety. Nurses with less work experience scored higher on depression and anxiety as compared to nurses with more years of work experience. These findings indicate that nurses with less work experience are more vulnerable to the costs related to caring. In an earlier study, Lange, Thom, and Kline (2008) opined that less experienced nurses have relatively more death fears as compared to nurses with more experience. The two groups of nurses also differed significantly on social contact coping strategy. Nurses with more years of work experience were found to be making significantly greater use of social contact as compared to nurses with less work experience. As early as in 1982, Benner had posited that nurses acquire coping strategies with experience which help them in dealing with the sufferings of their patients.

Stamm (2010) proposed different professional quality of life profiles viz., positive reinforcement from work, at-risk, overwhelmed, typically unique to high-risk situations, very distressed etc. Table 2 shows frequency of nurses with less and more years of work experience showing different types of profiles.

Nurses with less years of work experience: Correlation analysis revealed an insignificant relationship of compassion satisfaction with both depression and anxiety however it was found to be positively related to problem solving coping strategy. This finding suggests that greater the amount of efforts by nurses at the cognitive and behavioural levels to change the stressful work environment, higher is compassion satisfaction in them.

Burnout was found to have a positive relationship with depression and anxiety. Earlier, Iacovides et al. (2003) opined that burnout has some features similar to depression eg., burnout as well as depression share a strong association with personality dimensions of neuroticism and extraversion: However, helplessness created during burnout is limited to only work setting as opposed to that created in different settings in a depressed person's life. These researchers further clarified that severe burnout has a greater overlap with depression as compared to low degree of burnout. Despite these conceptual similarities, they regarded burnout and depression as separate constructs. Gito et al. (2013) reported a positive relationship between depression and the three dimensions of burnout viz., emotional exhaustion, cynicism and professional inefficacy. Yadollahi et al. (2016) reported high burnout to be related to high degree of depression and anxiety in a sample of health professionals working in Iran. Kim and Na (2017) found anxiety to be a determinant of burnout in nurses working in Korea. Burnout, however, was found to be insignificantly correlated with all the eight coping strategies in the present study.

Correlation revealed an insignificant relationship of secondary traumatic stress with depression and coping but a positive relationship with anxiety. Figley (2002) viewed traumatic recollections of interactions with patients and sufferings to be a salient factor for the development of compassion fatigue in helping professionals. These distressing memories, he opined, could lead to the negative emotional state of anxiety. Yadollahi et al. (2016) in an empirical study confirmed high secondary traumatic stress related to high anxiety in health professionals working in a trauma hospital in Iran. Craigie et al. (2016) had reported anxiety to be a positive predictor of secondary traumatic stress in Australian nurses. In a study conducted in Korea, Kim and Na (2017) studied nurses providing care to cancer patients. Majority of the sample taken had less than six years of experience. Correlation analysis revealed secondary traumatic stress to be positively related to anxiety.

More work experience: Depression was found to be a negative predictor of compassion satisfaction explaining 19% of variance in it. Stamm (2010) advocated assessment and treatment of depression in professionals with overwhelmed and most distressed professional quality of life profiles. Hegney et al. (2013) reported that nurses with positive reinforcement from work profile exhibited less depressive symptoms while nurses with at-risk and very distressed profile were found to show high depressive symptoms. Earlier, Hegney et al. (2015) had obtained a negative relationship between compassion satisfaction and depression in a sample of nurses working in Australia.

Compassion satisfaction was found to be negatively correlated with anxiety. Kim and Na (2017) studied the relationship of compassion satisfaction and anxiety among nurses working in Korea. Nurses with high compassion satisfaction had a greater likelihood of being less anxious. Similar findings were obtained by Craigie et al. (2016) who studied nurses working in Australia. Majority of these nurses had a work experience of more than 5 years. High compassion satisfaction was found to be related to less anxiety.

Compassion satisfaction was found to have positive correlation with social contact coping strategy and a negative correlation with social withdrawal. The results indicate that greater the social contact with family, friends and others, higher is compassion satisfaction in nurses. Social contact is an emotion focused engagement coping strategy which involves seeking assistance at the emotional level from significant others through increased social interaction. Also, high compassion satisfaction was found related to low social withdrawal coping. Social withdrawal is an emotion focused disengagement coping strategy in which one avoids company of others and resists sharing feelings and problems with family/friends. Peters et al. (2012) advocated the use of constructive coping strategy of selfcare to curtail stress in nurses. Alkema et al. (2008) suggested that to enhance compassion satisfaction health professionals should concentrate more on the emotional and spiritual aspects of their lives.

Depression emerged to be the strongest predictor of burnout explaining 31% of variance in it. Nyklicek and Pop (2005) found current depressive symptoms, personal history of depressive episode and familial history of depressive episode to be predictors of all dimensions of burnout in hospital workers. Devilly et al. (2009) had also suggested high burnout to be associated with high affective distress in Australian mental health professionals.

Burnout was found to be positively correlated to anxiety. Similar results were earlier obtained by Craigie et al. (2016) and Hegney et al. 2013 in health professionals. In 2007, Gross had reported emotional exhaustion dimension of burnout to be positively related to anxiety in health workers.

Burnout was found to be negatively correlated with cognitive restructuring coping strategy and positively correlated with social withdrawal coping strategy. Social withdrawal was also found to be a significant positive predictor of burnout. Anderson (2000) studied child protection service workers with on an average around seven years of experience. Disengagement coping strategies had a positive relationship with emotional exhaustion and depersonalization dimensions of burnout and a negative relationship with personal accomplishment. Engagement coping strategies were found to have a negative relationship with depersonalization and a positive relationship with personal accomplishment. On similar lines, Baxendale (2015) too reported ineffective coping to be a positive predictor of burnout in hospice nurses.

Depression emerged to be a significant positive predictor of secondary traumatic stress. Haber and colleagues in 2013 studied physicians working in Israel. The mean age of the sample was about 35 years. Compassion fatigue was found to be positively related with depressive symptoms. Devilly et al. (2009) observed secondary traumatic stress to be positively correlated with affective distress in Australian mental health professionals. Secondary traumatic stress was also found to be positively correlated with anxiety. This finding is in line with Bride et al.'s (2004) study among social workers employed in southeastern United States. Their investigation revealed anxiety to be positively related to intrusion, avoidance and arousal and also with the total secondary traumatic stress scores of the

sample. Zeidner et al. (2013) had also found greater negative affect to be associated with greater compassion fatigue. Lee et al. (2015) observed high trait anxiety linked to high compassion fatigue in a sample of counsellors.

Secondary traumatic stress was found to be negatively correlated with problem solving, cognitive restructuring and positively correlated to problem avoidance, social withdrawal and self-criticism coping strategies. Social withdrawal also emerged to be positive predictor of secondary traumatic stress. This implied that nurses with high secondary traumatic stress did less to resolve work related problems, showed an inability to perceive them from a different perspective, withdrew from others and even somewhere held themselves responsible for the condition of patients or for other problems at work. Association of secondary traumatic stress with avoidant coping had earlier been observed by Baniewicz (2015) in mental health professionals.

CONCLUSION AND IMPLICATIONS: The review of literature conducted during this study indicated that there are few research studies on nurses with less years of work experience as compared to nurses with more years of work experience. Majority of the nurses in the study showed "positive reinforcement from work" profile. None of the nurses showed at-risk, overwhelmed or very distressed profile. Only one nurse was found to show "typically unique to high-risk situations" profile. Nurses with less work experience need more attention, support and guidance as they were found to be high on depression and anxiety; and low on compassion satisfaction, and social contact coping. Depression emerged as a significant predictor of compassion satisfaction, burnout and secondary traumatic stress in nurses with more years of work experience. It is recommended that intervention techniques to reduce symptoms of depression would enhance the professional quality of life of nurses. Educating nurses regarding the advantages of social contact coping and negative consequences of social withdrawal would help them to adopt more adaptive engagement coping behaviours.

The present study focused only on the professional quality of life of nurses working in Punjab, an interstate comparison would highlight in which state the professional quality of life of nurses is better so that such hospitals and states can be kept as benchmark for others to follow in order to enable better delivery of service across the country. A longitudinal study would throw greater light on the changing pattern of professional quality of life of nurses with time.

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