

NURSES' WELL-BEING IN IN-PATIENT AND COMMUNITY MENTAL HEALTH CARE: A COMPARATIVE STUDY

A DISSERTATION PRESENTED TO THE FACULTY OF HEALTH SCIENCES IN
PART FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE IN MASTER OF
SCIENCE IN MENTAL HEALTH STUDIES AT THE UNIVERSITY OF MALTA

BY

KIRSTIE BRINCAT

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SUPERVISOR: DR PAULANN GRECH

CO-SUPERVISOR: DR ALEXEI SAMMUT



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ABSTRACT

BACKGROUND: Nurses who work in mental health care settings frequently experience high levels of stress, burnout, and emotional weariness, all of which can have an impact on their well-being. While several studies have looked at the perceived stressors in the nursing profession, only a few studies have investigated the aspect of well-being. Furthermore, a research gap was observed when it comes to studies that compare the well-being of nurses who work in-patient, versus studies which look at community mental health care.

AIM: To investigate and compare the well-being of nurses working in the Maltese in-patient and community mental health settings.

OBJECTIVES: The study investigated whether any differences in well-being arise between nurses in in-patient versus community mental health care settings and whether different sociodemographic factors influence well-being.

DESIGN & METHODS: A descriptive cross-sectional quantitative study design was utilised for this research study. 197 nurses from the Maltese in-patients and community mental health sector completed Ryff's Scales of Psychological Well-Being survey along with sociodemographic questions, resulting in a response rate of 53.5%.

RESULTS: No statistical differences were found between nurses working in in-patients versus those working in community mental health settings. Despite this, several sociodemographic variables; namely, 'Age', 'Education', 'Nationality', and 'Grade' contributed to the well-being of this study. Nurses working in the Maltese mental health sector responded positively to five of the six subscales, implying that their well-being was positive overall.

CONCLUSION: This study delivers an enhanced understanding of the well-being of nurses working in mental health care settings. Nurses should be encouraged to perform reflective practice, undergo further training to gain better insight into their roles and improve their leadership skills. They should also have access to clinical supervision to avoid/limit certain managerial stressors and conflicts and improve their personal growth, autonomy, and self-acceptance.

KEYWORDS: Well-Being, Mental Health, In-Patient, Community, Nurses and Psychiatry.

DEDICATION

TO

My beloved parents Stephen and Mariella, my brother Matthias, and all the nurses working within the mental health sector who continuously strive to improve mental health services.

Thank you

For imparting the importance of persistence, bravery, and unwavering affection.

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LIST OF ABBREVIATIONS

ACMHN	Australian College of Mental Health Nurses
ANMF	Australian Nursing and Midwifery Federation
ANOVA	Analyses of Variance
CASP	Critical Appraisal Skill Program
CAT	Critical Appraisal Tool/s
CBI	Caring Behaviour Inventory
CET	Cognitive Evaluation Theory
CRHT	Crisis Resolution Home Treatment
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DASS21	Depression and Anxiety Stress Scale 21
EBSCO	Elton B. Stephens Company Database
FREC	Ethics Committee of the Faculty of Health Science
GWBQ	General Well-Being Questionnaire
H	Kruskal-Wallis H Test
HACSU	Health and Community Services Union
HyDi	Hydra Data Initiative
JCQ	Job Content Questionnaire
M	Population Mean
MAPN	Maltese Association of Psychiatric
MBI	Maslach Burnout Inventory
MCH	Mount Carmel Hospital
Md	Median Score
MeSH	Medical Subject Headings
MHN	Mental Health Nurse
MHNA	Mental Health Nurses Association of Unite the Union
MHPSS	Mental Health Professional Stress Scale
MUMN	Malta Union of Midwives and Nurses
N	Total Number of Participants in the Sample
OIT	Organismic Integration Theory
ONS SWBQ	Office for National Statistics (2012) Subjective Well-Being Questions
p	P-Value

PEO	Population, Exposure, Outcome
PDU	Practice Development Unit
PNMCS	PsychNurse Methods of Coping Scale
PWB	Psychological Well-Being
R	Correlation Coefficient Value
RAW	Resilience at Work
RCN	Royal College of Nursing
RMN	Registered Mental Health Nurse
RN	Registered Nurse
SD	Standard Deviation
SDT	Self-Determination Theory
SN	Staff Nurse
SSN	Senior Staff Nurse
SPSS	Statistical Package for the Social Sciences
SPWB	Ryff's Psychological Well-Being Scale
STAXI	State-Trait Anger Expression Inventory
SWB	Subjective Well-Being
SWLS	Satisfaction with Life Scale
U	Mann-Whitney U Test
UK	United Kingdom
UM	University of Malta
WEMWBS	Warwick Edinburgh Mental Well-Being Scale
WRI	Workplace Resilience Inventory

Chapter One

INTRODUCTION

1.0 INTRODUCTION

Globally, mental health nursing is recognised as a rigorous and possibly high-risk profession. This could be attributed to the fact that mental health nurses (MHNs) are often subjected to emotional challenges as a result of several work-related stressors that involve intense emotional situations and interpersonal demands. They encounter, address, and participate in complex interpersonal interactions with patients, caregivers, and colleagues who exhibit distress, confrontational, or harmful behaviours such as self-harm, suicide or aggression (McTiernan & McDonald, 2015).

Furthermore, several other work-related stressors arise from practice, team, and organisational issues. These include, among others, the use of seclusion and restraint methods, conflicts in professional relationships, and other work demands which reduce MHNs' time and ability to care for and engage with service users and their caregivers (Kipping, 2000).

Delgado et al. (2021) stated how recurring exposure to intense and traumatic events, also known as emotional adversity, can have a great impact on the well-being of MHNs. This can result in mental distress, stress, burnout, and compassion fatigue. Indeed, stress is primarily experienced when a person's environment is perceived as being threatening to their well-being, leading to a sense of being unable to cope. Zeng et al. (2020) explain 'Burnout' as a term coined by Freudenberger in 1977, referring to it as a result of stress that is not managed well, leading to physical and emotional exhaustion. Burnout is often linked to compassion fatigue in nurses, which refers to the physical, emotional, and psychological impact of helping others, often in stressful or traumatic situations (Zhang et al., 2018).

Burnout, inevitably, reduces MHNs' ability to be empathetic and therapeutic in their work interactions, negatively affecting patient and caregiver outcomes. Strengthening the workplace resilience of MHNs will likely alleviate the consequences of emotional adversity on their psychological well-being and practice (Ye-won & Bong-sil, 2021).

1.1 BACKGROUND OF THE STUDY

Whilst there is no concrete description of 'Well-Being', it is believed that it encompasses the occurrence of enjoyable feelings and moods, life satisfaction, fulfilment, positive functioning and the absence of undesirable emotions (Huppert & So, 2013).

According to Stankus et al. (2017), a person's sense of well-being can impact their overall health. In fact, a nurse who is considered healthy is normally described as someone who actively focuses on maintaining a balance and synergy of various dimensions of well-being, including physical, emotional, intellectual, personal, social, spiritual, and professional well-being. Very often, this balance can be disrupted by high levels of occupational stress, which in turn leads to job dissatisfaction, absenteeism, low resilience, and unhealthy coping mechanisms. This can result in chronic health problems which could consequently negatively impact work performance and quality of care.

Additionally, in 2021, Søvold et al. listed five pillars which mainly constitute well-being: emotional, physical, social, workplace, and societal well-being. Moreover, they explained the importance of self-care for individuals working in the health sector, which often entails using different tactics to manage stress, burnout, and/or compassion fatigue.

Engaging in such actions to maintain personal emotional and mental well-being has been linked to various beneficial results. These benefits include increased life and job satisfaction, an improved work environment, and a better quality of care and safety towards the patients (Raziq & Maulabakhs, 2015). Different organisations worldwide have recognised the importance of their staff's well-being, and consequently, they have introduced a holistic approach wherein nurses are encouraged to ask themselves "What is important to me?" rather than solely focusing on the challenges they face in their work (Joseph-Williams, 2015).

Despite this, in 2006, Holmes emphasised how a large number of MHNs have been facing an identity crisis due to conflicting ideologies regarding their professional roles. The researcher elaborated on how the biomedical model focuses on the biological aspect of mental illnesses and thus focuses on the patient's management and pathology; meanwhile, on the other hand, the humanistic perspective encourages collaboration with the client. Because of these two ideologies, nurses have often been struggling to express their emotions, and sometimes suppress their own feelings to be able to deliver high-quality care.

Joseph-Williams (2015) discussed how MHNs are more susceptible to experiencing higher levels of stress when compared to their colleagues who work in general healthcare wards. This was further explained by claiming that MHNs ought to utilise their therapeutic communication techniques and themselves as therapeutic tools, to be able to provide high-quality nursing care to

their service users. As a result, they must develop and manage their internal resources to prevent experiencing intense emotional labour, especially because of the closed hierarchical organisational culture found in most hospitals. Moreover, Imai et al. (2004) discovered that community psychiatric nurses had a higher prevalence of burnout than public health nurses. The Centre for Workforce Intelligence (2012) also reported that the vacancy rate for MHNs was the highest among all nursing professions, which could potentially result in a supply and demand imbalance for MHNs in the United Kingdom (UK).

Jenkins & Elliott (2004) also argued how nurses in hospital and community settings experience distinctive types of stressors. For instance, it was reported that MHNs working in-patient wards are fraught with pressure and chaos. They have to deal with crises, involuntary admissions, and acutely unwell patients with complex needs, as well as aggressive behaviours. McTiernan & McDonald (2015), elaborated that hospital nurses are also concerned with organisational issues such as shortage of staff and rosters. Meanwhile, Hill et al. (2006) stated that community mental health teams tend to experience more exhaustion than their in-patient counterparts which often results from professionals working unaccompanied, receiving less organisational support, and having less opportunities for role confirmation. It was also revealed that the prominent stressor for Community MHNs was inadequate services to refer patients to. According to Ellis & Hartley (2004), other stressors for mental health nurses comprise of unsuitable referrals, inadequate supervision, safety problems, role conflict, and communication barriers.

In view thereof, the overall tendency appears to be that more emphasis is placed on nurses' stress and burnout, rather than their well-being from a positive psychology standpoint (Meyer & Malin, 2010). Positive psychology techniques have much to give to health care, fitting well with the recovery-oriented approach, which focuses on recognising and increasing what is functioning rather than focusing on pathology and responding to distress. Such an approach promotes the biopsychosocial paradigm and views people holistically (Rapp & Goscha, 2011).

1.2 THE LOCAL SCENARIO

In recent years, there has been an increased focus on mental health in Malta. Community mental health services, including child and adolescent services, all appear to be inclined towards a more holistic and community-based approach. The new Mental Health Act and the publication of the Psychiatric Mental Health Nursing Standards by the Maltese Association of Psychiatric Nurses

(MAPN) display a commitment to refining the quality of care provided by the mental health sector (Galea et al., 2017). The Mental Health Strategy for Malta 2020-2030 also shows a long-term vision for mental health care in the country (Borg, 2022).

In 2021, Crisis Resolution Home Treatment (CRHT) was also introduced (Abbas Shalan, 2021). This was followed by the 24/7 governmental Helpline which opened in 2022 to provide additional support for individuals going through a crisis or a difficult time in their lives (Diacono, 2022). Moreover, the refurbishment of different wards in Mount Carmel Hospital (MCH) reflects an ongoing effort to improve the physical environment for patients and staff (Xuereb, 2022). These developments all show a positive direction for mental health in Malta, with the aim of continuously improving and innovating the Mental Health Services in order to meet the evolving needs of individuals with psychiatric difficulties.

In addition to this, the University of Malta strives to deliver ongoing education and training through its undergraduate and postgraduate Degree programmes in mental health. Additionally, the Department of Mental Health has initiated various campaigns to promote these programmes and increase awareness about mental health job opportunities. The development of mental health services and the plans of opening a new state mental health hospital further highlight the growing need for specialised MHNs (Calleja, 2022). Delivering ongoing training and education can also help reduce burnout and stress among nurses, ultimately leading to better service user outcomes and a more positive work environment (Hayward et al., 2016). Moreover, the local Practice Development Unit (PDU) is constantly striving to better mental health services by organising programmes for nurses who work in the mental health sector in order to advance their training in psychiatric care.

Currently, the number of students graduating with an undergraduate qualification in mental health nursing does not adequately cover the number of nurses required in Mental Health Services. Consequently, students graduating with a general nursing qualification are being placed in a mental health setting in lieu of specialised nurses. Currently, the number of general nurses working in psychiatric care is higher than MHNs due to the shortage of the latter (Farrugia, 2018).

Nurses are known to be the most populous professional group in the healthcare sector, including in mental health care. Despite this, in 2019 the European Union only recorded around 4,000 active nurses working in the Maltese healthcare system. It is believed that this number has also decreased

since then. Thus, this shows that the deficiency of nurses is a collective difficulty in Malta (Malta Daily, 2021).

Nurses employed in the mental health sector are also eligible to be part of the Malta Union of Midwives and Nurses (MUMN). In 2021, Mr Paul Pace, president of MUMN, claimed that around three nurses resign every week from Mater Dei Hospital, the general state hospital. The current situation in the mental health sector is worsened by burnout, stress, and a lack of new recruitment, which further exacerbates the personnel issue in the health system (Farrugia, 2021).

Meanwhile, the Mental Health Strategy for Malta aims to transition mental health care delivery towards a more community-based approach. Studies have revealed that nurses working in community mental health care face frequent emotional challenges, including managing high-emotional situations and meeting interpersonal expectations. The Mental Health Strategy for Malta recognises that a significant proportion of health workers in Malta (more than 11% of nurses) come from other countries (Borg, 2022). Therefore, the strategy emphasises the need for training programmes for nurses, including language skills in Maltese, as well as the recruitment of cultural mediators to support foreign professions, to enhance the quality of care.

According to Pace (2023), Malta's healthcare system is currently short of approximately 500 nurses. He emphasised that the ideal ratio of nurses to patients is 1:4, but in reality, there are only 3-4 nurses for every 24 patients. On average, a nurse works 46 hours per week. However, the shortage of nurses results in nurses inevitably being unable to take time off unless a replacement is found (Agius, 2023). Pace also commented on the infrastructural state of MCH, stating that it has become too small. Additionally, he noted that over the past eight years, each ward that had been closed for refurbishment was never reopened. Furthermore, he claimed that despite promises of a new mental health hospital, nothing has been delivered as of yet (Times of Malta, 2021).

1.3 AUTHOR'S PERSPECTIVE

Working in Mount Carmel's Community Outreach Team and CRHT, the researcher understands how certain job-related situations can be considered stressors and affect the individual's well-being. These situations include understaffing, lack of resources, and poor communication among health professionals. Additionally, the researcher observed a lack of knowledge with respect to community mental health in general and the general perception that in-patient settings are

prioritised over community settings despite the accepted shift towards community-based mental health care.

Upon reflecting on the research title “Nurses’ Well-Being in In-Patient and Community Mental Health Care: A Comparative Study”, two research questions were set, as follows:

- What is the prevalence of nurses’ well-being in the Maltese mental health sector?
- Are there differences in well-being between nurses working in in-patient versus community mental health care?

To address these questions, this study aims to explore several variables that have been identified in the above-cited literature. For this reason, the researcher decided to concentrate on the well-being of nurses working in both in-patient and community mental health settings, with the aim of gaining insight into their well-being.

1.4 RESEARCH METHOD

To investigate the research questions, a quantitative, cross-sectional survey design was employed. This involved collecting statistical data by surveying nurses who work in their respective mental health settings. Ethical approval and necessary permissions were obtained prior to distributing the questionnaires.

The Ryff’s Psychological Well-Being Scale (SPWB), a validated data collection tool, was selected to gather data. A section with demographic variables was included in order to analyse the results with respect to each demographic variable.

The process of distributing and gathering the questionnaires was overseen by two intermediaries in their respective settings. The intermediaries themselves returned the completed questionnaires to the researcher in sealed envelopes. The data collected was analysed through the Statistical Package for the Social Sciences (SPSS), with a significance level of ≤ 0.05 . Descriptive analyses were conducted to examine each demographic variable and the six subscales. The Mann-Whitney U Test and the Kruskal-Wallis H Test were used to explore variations between variables. Finally, the Spearman-Rank Correlation Test was utilised to determine the relationship between each subscale.

1.5 OVERVIEW OF DISSERTATION

Different phases of this study will be categorised into different sections. Chapter 2 will deliver a comprehensive literature review and identify any research gaps that this study aims to address. Chapter 3 will discuss the research methodology. Chapter 4 will present this study's findings and interpret the data analysis. Chapter 5 will discuss the findings in relation to existing literature. Finally, Chapter 6 will provide an overall conclusion and recommendations based on the study's results.

1.6 CONCLUSION

The aim of this study is to investigate the well-being of nurses in in-patient and community mental health services and to analyse the variables that affect their well-being. By understanding their well-being, this study aims to ease the development of strategies to address well-being and improve the nursing profession in Malta.

The following chapter will provide a comprehensive review of the literature related to this study, as well as the theoretical framework which will be utilised in this research study.

Chapter Two

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter provides a critical review of literature related to the well-being of nurses in community and in-patient mental health settings. In order to achieve this goal, a systematic search strategy was implemented, which involved the use of specific keywords that were deemed appropriate for the literature review. The theoretical framework aided in the critical analysis of the research articles, and it was instrumental in developing a robust and coherent literature review. The chapter then presents an in-depth critical evaluation of studies examining the well-being of nurses in mental health care settings, where key findings, ethical considerations, research gaps and methodological limitations were discussed. Overall, this chapter serves as a foundation for the subsequent research project, by providing a comprehensive understanding of the current state of knowledge regarding the well-being of nurses in the mental health care sector.

2.1 SEARCH STRATEGY

A literature search was carried out using a range of electronic databases for approximately five months, from June to November 2022. The focus of the search was on the well-being of nurses in both in-patient and community mental health settings.

2.1.1 KEY TERMS & ABBREVIATIONS

Xiao and Watson (2019) emphasised how using the appropriate terminology while doing keyword searches is the most efficient technique to identify pertinent research across numerous databases.

To guide the literature search, the research question was formulated using the PEO Framework. This also served as the source of the study's keywords. The PEO Framework, which stands for 'Population', 'Exposure', and 'Outcomes', was used to identify the most relevant and credible evidence during the literature search (Bettany-Saltikov, 2016).

Key components were integrated in order to be able to find the appropriate information. A set of keywords were utilised to broaden and focus the search. Alternative words for each element, such as synonyms and abbreviations, were found using brainstorming, thesauri, articles retrieved through the search, and Medical Subject Headings (MeSH) keywords extracted from the PubMed database (PubMed, 2019). By using alternate phrases, the search was made more inclusive while

still retaining relevant data. The PEO elements and their corresponding synonyms are outlined in ‘Table 2.1 Key Terms & Their Respective Synonyms’.

Table 2.1 Key Terms & Their Respective Synonyms

PEO Element	Key Terms	Synonyms
Population	Nurses	Nursing Personnel Registered Nurses Mental Health Nurses Psychiatric Nurses Nursing Staff Nurses
Exposure	In-Patient Community	Mental Health Sector In-Patient Mental Health Services Psychiatric Hospital Mental Health Hospital
	Community	Community Mental Health Setting Community Mental Health Services Community Mental Hygiene Services Psychiatric Outpatients
Outcome	Well-Being	Wellbeing Welfare Health Happiness Contentment

2.1.2 SEARCH TOOLS

In order to narrow the search and eliminate unrelated information, Boolean phrases were utilised. By using these commands, less relevant articles are not included in the primary results. In this search, the ‘AND’ and ‘OR’ operators were used. The ‘AND’ operator commands the database to only display articles that contain both entered phrases and the ‘OR’ instructs the database to display either one keyword or another (Bramer et al., 2018).

The use of wildcards, such as the truncation sign (*) and the question mark (?), further refined the search. ‘Table 2.2 Wildcards Terms’ represents the use of Wildcards during the literature search.

Table 2.2 Wildcards Terms

Wildcard Terms	Words Included
Well?being	Wellbeing Well-Being Well Being
In?patient	In-Patient In-patient
Nurs*	Nursing Nurses Nursing Personnel
Mental Health Se*	Mental Health Setting Mental Health Services

Limiters were next applied to the search so as to lessen the number of retrieved articles to more manageable levels. These limiters included language, with English being chosen due to the large number of articles in the English language, and the author's familiarity with the language. The second limiter involved selecting articles published within the last ten years to ensure that the most recent and relevant data were included. Studies that were still in progress and/or that focused on nurses working in a general healthcare setting were excluded by limiters. Finally, only peer-reviewed articles were chosen to ensure the quality and scientific merit of the articles.

These limiters defined and established the inclusion and exclusion criteria for the search. An eligibility criterion was formulated to pre-define the inclusion and exclusion criteria, providing a framework for the search.

The inclusion criteria included studies on the well-being of nurses working in both a community and in-patient mental health setting, as well as in a community mental health setting and/or in an in-patient mental health setting as illustrated in 'Table 2.3 Eligibility Criteria'.

Table 2.3 Eligibility Criteria

The Eligibility Criteria	
Inclusion Criteria	Exclusion Criteria
Research conducted in the English language	Studies conducted in languages other than English
Peer-reviewed studies published not more than ten years	Studies which were not peer-reviewed, were still in progress and/or were published more than ten years ago
Studies which centered on the well-being of nurses working in in-patient and community mental health settings	Studies that centered on nurses working in general healthcare settings and/or focused on other professionals
Peer Reviewed Articles	Non-Peer Reviewed Articles

2.1.3 DATABASES & RESOURCES ACCESSED

To conduct the literature search, several online databases were accessed. Five main database hosts that contain literature on health sciences were used to search for relevant papers, namely: Elton B. Stephens Company Database (EBSCO); ProQuest, PubMed; Scopus; and Science Direct. Furthermore, the Hydra Data Initiative (HyDi) and the University of Malta's (UM) online e-library platform e-library were also accessed. Google Scholar was used as a supplementary source to retrieve full-text literature that was not available in other databases.

Finally, additional articles were acquired from the reference lists of previously selected articles. This is known as the 'references of references technique' (Werner & Brand, 2001). A search through local and foreign dissertations and/or books that were deemed relevant to the research study was also conducted. 'Table 2.4 An Audit of the Literature Search Strategy' explains how the articles were retrieved for this study, including duplicated results, irrelevant material, and relevant materials.

Table 2.4 An Audit of the Literature Search Strategy

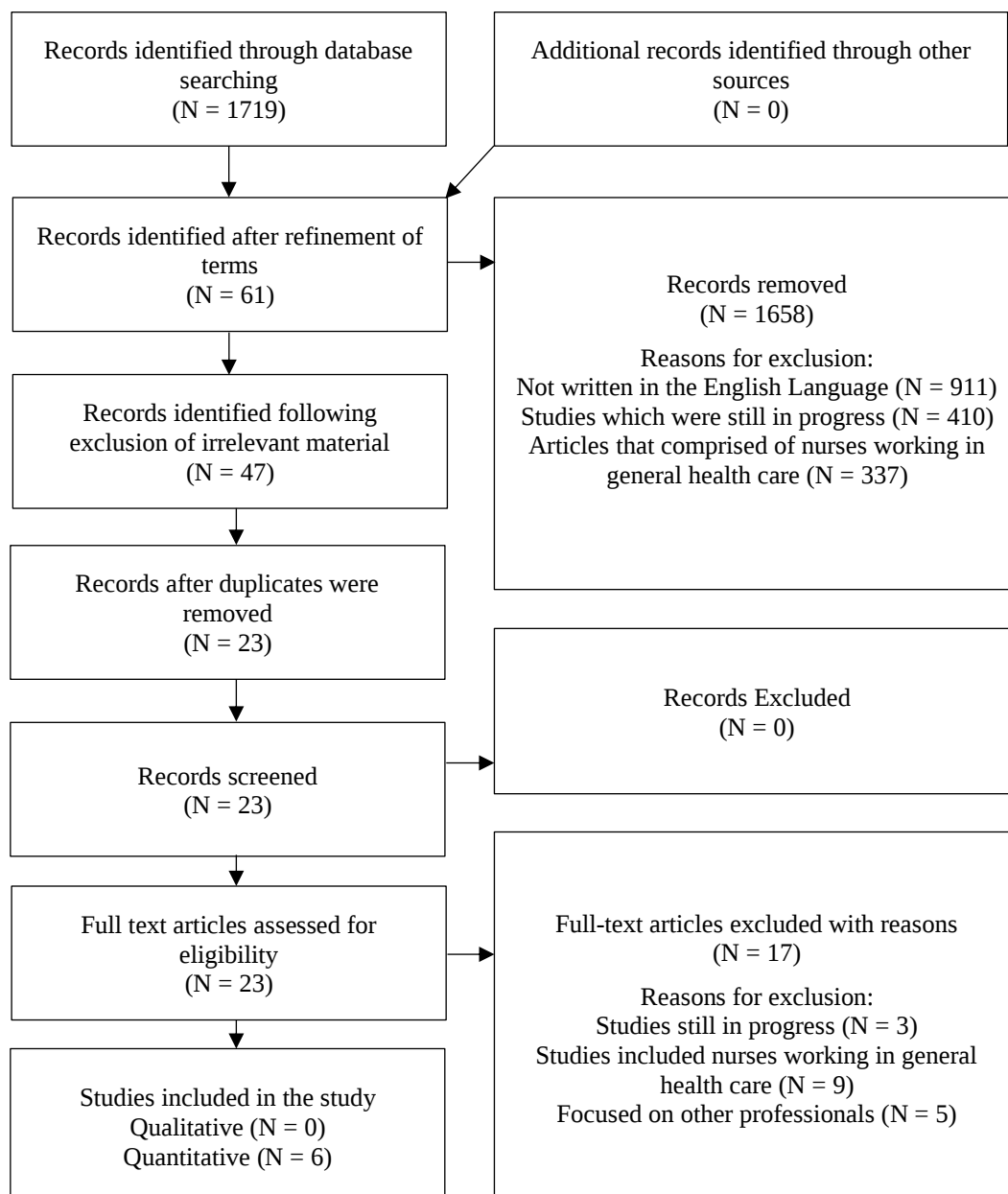
Search Terms Combination	Limiters	Fields Searched	Database	Changes Implemented	Hits	Relevant Articles
Nurses* Well being OR Wellbeing OR Well-Being AND Mental Health Care OR Psychiatric Hospital	Publication Dates: Last 10 Years Languages: English Species: Human	Title & Abstract	PubMed Search Engine	Changed the Keyword 'Psych* Hospital' to 'Psychiatric Hospital'	231	11
Nurs* OR Psych* Nurses AND Psychological OR Well Being AND Mental Health Sector OR Psychiatric Care	Publication Dates: Last 10 Years Languages: English Species: Human	Title & Abstract		Added the Key Terms 'NOT COVID'	205	3
Nurs* OR Psychiatric Nurses AND Mental Health OR Psychiatr* OR Psychiatric Hospital OR Psychiatric Facility OR Community Mental Health AND Well-being[	Publication Dates: Last 10 Years Languages: English Species: Human	Title		-	6	4
Nurses AND Psychological OR Wellbeing AND Psychiatric Care	Publication Stage: Final Languages: English Publication Dates: Last 10 Years	Title & Abstract	Scopus	-	33	2
Staff Nurse OR Nurs* AND Emotional Well-Being OR Psych* Well-Being AND Psych* Care OR Mental Health Care	Publication Stage: Final Languages: English Publication Dates: Last 10 Years	Title & Abstract		Added the Keyword 'Psych* Care'	174	5
Nursing Staff OR Nurs* OR Mental Health Nurse AND well-being AND Mental Health Facility OR Psychiatric Care	Publication Stage: Final Languages: English Publication Dates: Last 10 Years	Title & Abstract		-	193	3
Nurse OR Psychiatric Nurses AND Well-Being AND Psychiatric Care OR Mental Health Care	Publication Dates: Last 10 Years	Abstract	ScienceDirect	-	209	4

	Language: English					
Nursing OR Nurses AND Wellness AND Psychiatric In-Patient OR Community Mental Health Care	Publication Dates: Last 10 Years Language: English	Abstract		-	224	2
Staff Nurs* OR Nursing Personnel AND Wellness OR Well-Being AND Psychiatric OR Mental Health	Publication Dates: Last 10 Years Language: English	Abstract		-	276	6
Nurs* OR Psychiatric Nurs* AND Well-Being AND Psychiatric OR Mental Health Care	Publication: Last 10 Years Language: English Access: Open Text Type: Peer Reviewed	Title	ProQuest (Accessing: Consumer Health Database; Health & Medical Collection; Medline; Healthcare Administration Database; Nursing & Allied Health Database; PTSDpubs; Public Health Database & Psychology Database)	-	3	2
Nurses OR RMN AND Well-Being OR Wellness AND Mental Health Or Psych*	Publication: Last 10 Years Language: English Access: Open Text Type: Peer Reviewed	Title		Added the Keyword 'Psych*'	21	4
Nursing Personnel OR Nurs* AND Wellness AND Psychiat* OR Mental Health	Publication: Last 10 Years Language: English Access: Open Text Type: Peer Reviewed	Title	-	-	90	4
Nurse OR Nurses AND Wellbeing OR Well-being AND	Publication: Last 10 Years Language: English Access:	Title	EBSCO (Accessing: Academic Search Complete; CINAHL Complete; Cochrane	Removed the Keyword 'RMN'	31	7

Mental Health OR psychiatr* OR Psychiatric Hospital OR Psychiatric Facility OR Community Mental Health	Open Text		Central Register of Controlled Trials; Cochrane Methodology Register; Cochrane Database of Systematic Reviews; APA PsychInfo; Medline Complete & CINAHL Complete)			
Nurs* OR Psych* Nurs* AND Well-being AND Psychiatric Care OR Mental Health	Publication: Last 10 Years Language: English Access: Open Text	Title		-	15	3
Staff Nurs* OR Nursing Personnel AND Wellness OR Well-Being AND Psychiatric Ward OR Mental Health	Publication: Last 10 Years Language: English Access: Open Text	Title		-	8	5
Full Search Strategy Plan					61	1719

A total of 1719 articles were retrieved, of which 61 were relevant to the research questions. After narrowing down the criteria to specifically target nurses employed in the field of mental health care, a total of 840 articles were eliminated. To align all chosen articles with the inclusion criteria, another 834 papers were also excluded, some of which were duplicates, or focused on other health professionals. In the end, a total of six studies were identified as relevant to the research question, exploring the well-being of nurses working in mental health. ‘Figure 2.1 The PRISMA Flow Diagram’ illustrates a summarised PRISMA Flow Diagram, which is a tool that ensures transparency in the literature search process and shows different stages of a systematic analysis where the inclusion and exclusion criteria were applied (Selçuk, 2019).

Figure 2.1 The Prisma Flow Diagram



2.2 CRITIQUE OF RELEVANT LITERATURE

Al-Jundi and Sakka (2017) explained critical appraisal as a process of systematically and objectively evaluating evidence for the validity, reliability, and relevance of any given article. This process involves assessing the quality, design, conduct and results of research to determine whether its results are reliable and can be generalised to other populations and/or settings. It also aims to identify the strengths and limitations of a study (Maggio et al., 2016).

After evaluating the literature, a thorough analysis of each relevant study was essential. A Critical Appraisal Tool (CAT) was used for this purpose. The Critical Appraisal Skill Programme (CASP) offers a broad spectrum of checklists for a variety of study methodologies (Buccheri & Sharifi, 2017). These tools offer a comprehensive yet general set of questions that assess the validity, applicability, and suitability of a study. The appropriate CASP checklist was utilised to evaluate the credibility of the selected articles.

The following sections present a critique of the six articles that were identified in the general literature. The aforementioned articles which mainly focus on nurses' well-being were grouped into three sections: nurses' well-being in mental health settings, nurses' well-being in in-patient versus community mental health settings, and nurses' well-being in in-patient mental health settings.

2.2.1 NURSES' WELL-BEING IN MENTAL HEALTH SETTINGS

'Table 2.5 Studies Focusing on Nurses Working in a Mental Health Setting' illustrates details of three articles which make no distinction between in-patient and community mental health settings. Instead, researchers mainly focused on having their participants as nurses that work in a mental health setting.

Table 2.5 Studies Focusing on Nurses Working in a Mental Health Setting

Title	Author(s), Date of Publication & Country	Methodology & Instruments Uses	Sample Size	Findings & Conclusion
Subjective Well-Being of Mental Health Nurses in the United Kingdom: Results of an Online Survey	Oates, Jones & Drey 2017 United Kingdom	A Quantitative Approach using a Descriptive & Correlational Research Design. Data was collected through Questionnaires involving: Demographic Questions; Office for National Statistics Subjective Well-Being Questions (ONS SWBQ); Satisfaction with Life Scale (SWLS); and Warwick Edinburgh Mental Well-Being Scale (WEMWBS).	225 Mental Health Nurses The majority were female, were in age bracket of 40-49 years old, were British nationals, and worked on a full-time basis. The average number of years in the profession was 14.8 years and the years in post was that of 5.6 years.	There was consistency between the three measures whereas overall nurses had a low subjective well-being. Demographic and workplace factors did not correlate with subjective well-being, however being a male, living alone and being aged 40-49 years were associated with lower mean scores.
Workplace Stressors, Psychological Well-Being, Resilience, and Caring Behaviours of Mental Health Nurses: A Descriptive Correlational Study	Foster, Roche, Giandinoto & Furness 2020 Australia	A Quantitative Approach using a Descriptive & Correlational Research Design. Data was collected through Questionnaires involving: Demographic Questions; Ryff's SPWB; Self-Regulatory Processes Subscales of the Workplace Resilience Inventory (WRI); and Caring Behaviour Inventory (CBI). Workplace Stressors were identified through a free text response.	498 Nurses Working Within the Mental Health Sector. The majority of participants were female, within the age range of 21-29, located in metropolitan areas of Victoria, and were Registered Nurses (RNs). The majority had been working in mental health for a minimum of 10 years. and the vast majority worked in both in-patient and community mental health settings.	Across all categories of stressors, there were varying levels of positive relationships, ranging from weak to strong, between workplace resilience and PWB. PWB was moderately high overall, but nurses who identified consumer/carer-related stressors as their most challenging reported lower PWB. The relationships between workplace resilience and PWB were found to be weak to moderate, while no significant relationship was observed between resilience and caring behaviours. Additionally, younger nurses exhibited lower levels of workplace resilience.
Mental Health Nurses' Psychological Well-Being, Mental Distress, and Workplace, Resilience: A Cross-Sectional Survey	Delgado, Roche, Fethney & Foster 2021 Australia	A Quantitative Approach using a Descriptive & Correlational Research Design. Data was collected through Questionnaires involving: Demographic Questions; Ryff's SPWB-18, Depression and Anxiety Stress Scale 21 (DASS21); and Resilience at Work (RAW) Scale	482 Nurses Working Within the Mental Health Sector. The majority of the participants were female, held a clinical role, and worked in the public sector. The average age of participants was 44.6 years, held specialist postgraduate mental health nursing qualifications, and received clinical supervision. Only a small minority of the participants had previously participated in	The mean scores for PWB and workplace resilience were 85.38 and 70.27, respectively, indicating that more than half of the participants reported levels above the average. However, a portion of the participants scored in the severe to extremely severe categories for depression, anxiety, or stress. PWB exhibited strong positive associations with workplace resilience and negative associations with depression. Notably, having a postgraduate specialist qualification showed a positive association with PWB.

			workplace resilience building training or activities.	
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AIM

In the study conducted by Oates et al. in 2017, the researchers' aim was to measure the SWB of MHNs working in the UK. The researchers sought to detect whether demographic and workplace factors would correlate with SWB's measure scores. Similarly, the purpose of Foster et al.'s study in 2020 was to identify the primary stressors that MHNs experience in their workplace, evaluate their PWB, workplace resilience and level of caring behaviours, analyse the correlation between these variables and examine the differences in workplace resilience across sociodemographic characteristics. Meanwhile, Delgado et al. (2021) also investigated PWB, mental distress, and workplace resilience among MHNs working in Australia, and explored any correlations between these variables.

ETHICAL CONSIDERATIONS

The studies of Oates et al. (2017), Delgado et al. (2021), and Foster et al. (2020) all took ethical considerations and followed established guidelines to safeguard that their research was conducted in a responsible and respectful manner. Each study obtained the necessary approval from relevant ethics committees, namely: City University London School of Health Sciences ethics committee for Oates et al. (2017), Australian Catholic University's Human Research Ethics Committee for Delgado et al. (2021), and the University Human Research Ethics Committee for Foster et al. (2020).

Moreover, in each study participants were well-aware about the nature of the study, their rights as participants, and any potential risks or benefits related with their participation. They were also provided the option to decline participation without any negative consequences, as well as the ability to revoke from the study at any time. Participant-identifiable data were not collected, except from those participants who provided their email details for part two of the Oates et al.'s (2017) study. All participants' particulars were kept in a password-protected file, which was accessible to the researchers only.

RESEARCH DESIGN

Since the main aim of Oates et al. (2017) study was to measure the SWB of MHNs in the UK, a quantitative research approach was used. As for the research design, the researchers opted for a descriptive research design. This able the researchers to investigate the state of a variable at the

time of identification and seeks to offer an in-depth analysis of a specific subject matter. The use of questionnaires, a form of systematic data collection, is often adopted when opting for this research design, as these observational tools are not able to influence the variables (Edmonds & Kennedy, 2016).

Cross-sectional surveys were a common research method for Oates et al., Foster et al., and Delgado et al.'s studies. Oates et al. and Foster et al. both employed quantitative research approaches with correlational and descriptive research designs, while Delgado et al. focused on measuring PWB, mental distress, and workplace resilience using a similar quantitative approach. These methods facilitated researchers' data collection.

FINAL SAMPLE SIZE

The studies done by Oates et al. (2017), Foster et al. (2020), and Delgado et al. (2021) evaluated the PWB of MHNs in the UK and Australia. Oates et al. (2017) final sample size was 225 MHNs, which represented approximately 23% of the total UK's MHNs population, leading to a potential decrease in statistical power and introduced bias (Singh & Masuku, 2014). In Foster et al.'s (2020) study, 498 nurses working in the mental health sector were recruited through emails and websites of relevant professional bodies. The authors did not clarify if this sample was representative of all nurses in the sector, raising concerns about transparency and accountability (Grafström & Schelin, 2014). Delgado et al. (2021) had a total sample size of 482 nurses recruited through various methods, including snowball sampling. While these methods allowed for a larger sample size, they may introduce bias and ethical implications. Overall, these studies had a relatively small population sample, which might have hindered the studies' results from being generalisable and increased certain biases (Miller, 2003).

DATA COLLECTION

Oates et al. (2017) collected their data through an online questionnaire involving demographic questions and validated tools. The researchers made use of three well-established measures widely used in research, namely: Office for National Statistics Subjective Well-Being Questions (ONS SWBQ); the Satisfaction with Life Scale (SWLS); and the Warwick Edinburgh Mental Well-Being Scale (WEMWBS).

The reliance on self-reporting introduces the potential for response bias. Additionally, the use of online questionnaires may limit the sample to individuals who are more comfortable with

technology, potentially introducing selection bias. The limitations of self-report measures and the need for diverse samples to enhance the generalisability of the findings should therefore be considered when using questionnaires.

An additional set of demographic questions was included in the questionnaire, which consisted of 'Sex', 'Age', 'Ethnicity', 'Number in Household', 'Years in Profession', 'Years in Role', and 'Work Status'. This allowed for a better comprehensive assessment on well-being.

The validated tools' scales had specific rating systems and scoring methods, apart from ONS SWBQ. The ONS SWBQ is a research tool which asks four questions mainly focusing on: 'Life Satisfaction', 'Happiness', 'Anxiety', and whether 'Life is Worthwhile'. Questions were to be rated by participants on a scale that ranged from 0 to 10. The ONS SWBQ does not compile the measures into a single result, instead, responses are reported individually for each question (Tinkler & Hicks, 2011).

The SWLS is a five-item scale which assesses a person's overall global evaluation of their life satisfaction using the individual's personal standards. Participants specify their level of agreement or disagreement with each of the five statements using a seven-point Likert scale (Pavot & Diener, 2008).

Furthermore, WEMWBS is a 14-item scale created by the Universities of Warwick and Edinburgh. All items in the scale are positively phrased and scored according to the occurrence in the past two weeks, where the options include: 'None', 'Rarely', 'Some', 'Often' and 'All of the Time' (Tennant et al., 2007).

Meanwhile, Foster et al. (2020) retrieved their data through an online survey including demographic questions, three measuring tools being; Ryff's Psychological Well-Being (SPWB) Scale; Self-Regulatory Processes Subscales of the Workplace Resilience Inventory (WRI); and Caring Behaviour Inventory (CBI). To identify the most challenging workplace stressors, a free text response was available to the participants.

Demographic questions were similar to the aforementioned study, and thus, they mainly focused on: 'Gender', 'Age', 'Location', 'Professional Role', 'Specialist MHN Postgraduate Qualification', 'Current Setting', 'Years Working in the Current Setting', and 'Years Working in Mental Health'.

In this study, Ryff's SPWB 18-item was applied to measure well-being. The scale comprises of six subscales, being: 'Autonomy', 'Environmental Mastery', 'Personal Growth', 'Positive Relations with Others', 'Purpose in Life', and 'Self-Acceptance'. Each subscale is composed of three items and includes reverse-phrased items. Participants were instructed to provide a rating on a Likert scale (Lee et al., 2019).

'Workplace Resilience' was measured using the Self-Regulatory Processes subscales of the WRI. Self-Regulatory Processes refer to the mechanisms associated with understanding, controlling, and regulating negative and futile emotions, behaviours, and thoughts in response to unpleasant scenarios through Likert scale behaviour, emotions, and thoughts (McLarnon & Rothstein, 2013).

The 24-item Care Behaviour Inventory (CBI), which comprises of four subscales: 'Respect', 'Connectivity', 'Knowledge and Competence', and 'Assurance', was employed to assess caring behaviours. The items included reverse-phrased items and were rated on a Likert scale (Romero Martín, 2019).

The data collection for Oates et al.'s (2021) study was also conducted using an online questionnaire, which included demographic questions and three research tools: Ryff's SPWB-18-item, Depression and Anxiety Stress Scale 21 (DASS21), and Resilience at Work (RAW) Scale.

The demographic questions pertained to the following information: 'Gender', 'Age', 'Years of Experience Working in Mental Health', 'Primary Role', 'Specialist Mental Health Nursing Qualifications', and 'Receipt of Clinical Supervision'.

Similarly to Foster et al.'s (2020) study, Ryff's SPWB 18-item Scale was used by Oates et al.'s to measure the well-being of MHNs in their research study.

The DASS21 is a 21-item research instrument that evaluates the strength and frequency of symptoms related to mental distress, including 'Depression', 'Anxiety', and 'Stress'. It is divided into three subscales, each containing seven items and is scored on a four-point Likert scale (Coker et al., 2018).

The RAW scale was then used to measure workplace resilience in the study. It is made up of a 25-item self-report tool that assesses seven domains related to workplace resilience: 'Building Networks', 'Finding Your Calling', 'Interacting Cooperatively', 'Living Authentically', 'Maintaining Perspective', 'Managing Stress', and 'Staying Healthy'. Each domain is a subscale that is rated on a seven-point Likert scale (Winwood et al., 2013).

ANALYSIS

The data gathered from Oates et al. (2017) was statistically analysed through SPSS. Descriptive statistics, containing mean, standard deviation (SD) and median were also analysed by the researchers. Differences between groups were evaluated using t-tests and one-way analyses of variance (ANOVA); whereas Chi-squared χ^2 -tests were used to find associations. Two-way ANOVA was used to estimate how a mean of a quantitative variable alternates according to the levels of two categorical variables (Wilcox, 2022) and standard multiple regression was also applied in order to model the linear relationship between one dependent variable and two or more independent variables (Osborne & Waters, 2002).

Similarly, the data collected by Foster et al. (2020) was also subjected to statistical analysis using SPSS. Descriptive statistics such as count (N), mean, and standard deviation were used to characterise 'PWB', 'Workplace Resilience, and 'Caring Behaviours'. To examine differences and correlations, one-way ANOVA, Kruskal–Wallis ANOVA and/or independent t-tests were performed.

Oates et al. (2021) also analysed their data using SPSS. Scale and subscale scores were calculated in accordance with the recommendations provided by each tool's developer. Missing data were treated as missing. Descriptive statistics were computed for demographic data and levels of PWB, Depression, Anxiety, Stress, and Workplace Resilience. The strength and direction of the relationship, as well as the effect size, and variables, were determined using Pearson's Correlation Coefficient.

PARTICIPANTS' CHARACTERISTICS

Through the results, Oates et al. (2017) found that most of the participants were female (71%), were in the age range of 40-49 years old (35.4%), were British nationals (85.5%) and worked on a full-time basis (79.8%). The average number of years in the profession was 14.8 years and the years in post was that of 5.6 years.

Foster et al. (2020) also revealed that the majority of participants were female (74%). Most participants were within the age range of 50-59 (29%), located in urban areas of Victoria (65%), and were Registered Nurses (RNs) (88%). A significant proportion of the nurses had been working in mental health for a minimum of 10 years (64%), and the vast majority worked in both in-patient and community mental health settings (85%).

Upon analysing the data, the majority of the participants in the study by Delgado et al. (2021) were also female (79%). Participants held a clinical role (82%), and worked in the public sector (90.4%). The average age of participants was 44.6 (SD=12.32) years, 52% held specialist postgraduate mental health nursing qualifications, and 60% received clinical supervision. Only 12.4% of the participants had previously participated in workplace resilience-building training.

All three studies showed that the female gender dominated the samples. As stated by Davis & Holguín in 2022, women hold 76% of all healthcare jobs and thus results can be generalisable to the total population. Furthermore, an average age range of 40-50 can be seen throughout the studies, which may suggest that fewer individuals are going into the nursing profession, and the workforce is ageing (Butler, 2022).

FINDINGS

Oates et al. (2017) presented the findings of each tool and the demographic questions respectively. The results of the ONS SWBQ indicated that participants had a mean score of 6.17 (SD=2.29) on life satisfaction, a mean score of 5.85 (SD=2.63) on happiness experienced the previous day, a mean score of 3.42 (SD=2.77) on feelings of anxiety the previous day, and a mean score of 7.19 (SD=2.27) on the perception that life is worthwhile. These findings suggest that MHNs had a low level of life satisfaction, low levels of happiness, and a moderate sense of the worthwhileness of life.

Statistics of SWLS revealed that the mean score for participants was 21.69 (SD=7.49) out of 35, which indicated that MHNs were 'Slightly Satisfied' with life.

WEMWBS scores represented a mean score of 47.57 (SD=8.32) of 70. Although the WEMWBS lacks a cut-off score, through their study of English adults in 2010, Taggart et al. (2015) concluded that the WEMWBS score may simply be related to the mean score of 50.9 (Taggart et al., 2015).

The associations between individual demographic and workplace factors and the three measures of well-being were examined separately. Demographic factors such as: 'Gender', 'Age', and 'The Number Of Individuals In The Household', as well as 'Workplace Factors' like 'Employment Status', 'Years in the Profession', and 'Years in the Current Role', were evaluated in relation to scores on the well-being measures. The analysis revealed that women scored consistently higher than men across the well-being measures, although this difference was statistically significant only for the measure of whether 'Life is Worthwhile'. Researchers noted that respondents aged between 40-49 years consistently scored lower across the well-being measures. A statistically significant correlation ($p < 0.05$) was noted between being aged 40-49 years and scoring lower on the measure of whether 'Life is Worthwhile'. Despite this, Oates et al. stated that there was no statistically significant correlation between the number of 'Individuals in the Household' and well-being scores, nonetheless, those living alone had lower average scores across well-being measures, particularly in the domain of 'Anxiety'. Fusar-Poli et al. (2022) suggest that such results could have arisen due to loneliness. Furthermore, examination of work-related factors such as 'Employment Status', 'Years in the Profession', and 'Years in Current Role' showed no significant association with scores on well-being measures.

Meanwhile, Foster et al.'s (2020) study observed that the most frequently reported workplace stressor was the 'Organisational Service' category, comprising 37% (N=152), primarily due to time constraints and workload demands at 66%. The second most prevalent stressor was the 'Consumer/Carer' category, which accounted for 28% (N=116) and primarily pertained to violence and aggression (75%). The participants reported a moderate level of PWB, with a mean score of ≥ 4.3 for all subscales. Results for 'Workplace Resilience' were moderate, with a mean score ranging from 3.1 to 3.3. 'Positive Caring Behaviours' were reported, with mean scores greater than 5.0 for all subscales.

The study found weak to moderate positive relationships between 'Workplace Resilience' and 'PWB' (Correlation Coefficient $[r]=0.306$, $p \leq 0.01$; $r=0.549$, $p \leq 0.01$ respectively). No relationship was found between 'Workplace Resilience' and 'Caring Behaviour'. For the Colleague Stressor category, a strong positive correlation was observed between 'Workplace Resilience' (Cognitive subscale) and 'PWB' (Autonomy subscale) ($r=0.750$; $p \leq 0.01$). A moderate positive relationship was found between 'Workplace Resilience' (Cognitive subscale) and 'PWB' (Environmental Mastery subscale) for the 'Organisational Service' category ($r=0.529$; $p \leq 0.01$).

The results showed that 'PWB' (Autonomy subscale) was lower for participants who reported consumer/carer-related stressors (Mean (M)=4.1, SD=1.0) as the most stressful workplace challenge compared to those who reported colleague-related (M=4.6, SD=0.9) and organisational service-related (M=4.4, SD=0.8) stressors. Nonetheless, there were no other significant differences between the stressor category and other outcome measures ($p > 0.05$).

Foster et al. discovered that there were statistically significant differences in 'Workplace Resilience' ($p \leq 0.05$) based on 'Years of Experience' working in mental health and the 'Age' of the nurses. Specifically, 'Workplace Resilience' (Self-Regulatory Processes; Cognitive subscale) was lower for nurses with less experience (M=2.7, SD = 1.0; $P=0.01$) when compared to nurses with '5-9 Years of Experience' (M=3.2, SD=0.7) and those with 10 years or more of experience (M=3.1, SD=0.8). Additionally, 'Workplace Resilience' (Self-Regulatory Processes; Cognitive subscale) was lower for younger nurses (M=2.8, SD=0.8; $p=0.03$) compared to those aged '40 Years or Older' (M=3.1, SD=0.9). However, no other statistically significant differences were found between sociodemographic characteristics and 'Workplace Resilience'. Lastly, Delgado et al. in 2021, also presented the findings of each tool and demographic questions respectively.

The overall mean score for Ryff's SPWB-18-item was 85.38 (SD=11.81). About half of the participants (N=244, 50.6%) had higher levels of PWB. The 'Personal Growth' subscale had the highest mean score (M=15.15, SD=2.27) and 'Autonomy' had the lowest (M=13.41, SD=2.69), indicating that participants demonstrated a higher level of self-development, personal growth, and the realisation of their own potential compared to their ability to engage in self-evaluation, rely on their own judgment to make decisions, and exercise self-determination.

The study found that over two-thirds of participants (N=318, 70.7%) reported DASS21 scores within the 'normal' clinical cut-off scores for 'Depression', (N=336, 74.7%) for 'Anxiety', and (N= 339, 75.3%) for 'Stress'. About 5% of participants fell into the very severe category for both 'Depression' (N= 21, 4.7%) and 'Anxiety' (N= 23, 5.1%). Only 1% of participants (N= 6) scored in the very severe category for 'Stress'. The 'Stress' exhibited the highest average score (M=10.48, SD=8.26) with 'Depression' ranking next in terms of the mean score (M=7.05, SD=8.57), and 'Anxiety' had the lowest (M=4.86, SD=6.29).

The mean score for the 'Resilience at Work Scale' (RAW) was 70.27 (SD=11.53) with over half of the participants (N=258, 53.52%) scoring above the mean, demonstrating a higher level of

resilience. The 'Living Authentically' subscale exhibited the highest mean score of 79.12 (SD=12.30), while the 'Maintaining Perspective' subscale had the lowest mean score of 52.44 (SD=16.93). These findings indicate that participants had a lower proficiency in focusing on solutions, reframing challenges, and managing negative thoughts in the workplace, in contrast to their ability to demonstrate emotional awareness and self-regulation.

The results of the correlation analysis revealed a weak to strong, statistically significant negative association between the DASS21 and SPWB-18 subscales. The weakest correlation was observed between 'Anxiety' and 'Personal Growth', with a Correlation Coefficient of 0.148, while the strongest correlation was between 'Depression' and 'Environmental Mastery', with a coefficient of $r=0.548$. Additionally, moderate to strong, statistically significant negative associations were found between the DASS21 subscales (Depression, Anxiety, and Stress) and overall PWB, suggesting that as the levels of mental distress increase, the overall PWB decreases and vice versa.

The results of Delgado et al.'s (2021) study revealed a correlation between the DASS21 and Ryff's SPWB subscales, where an increase in mental distress was found to be associated with a decrease in PWB across all subscales. The associations were found to be weak to strong, with the strongest correlation being between 'Depression' and 'Environmental Mastery'. Additionally, overall 'Resilience' was found to have a strong positive association with overall PWB. Furthermore, the study found positive associations between the RAW subscales and Ryff's SPWB subscales, with the exception of the RAW 'Building Networks' subscale which did not have a significant association with Ryff's SPWB Scale 'Autonomy' subscale. These findings indicate that as participants' resilience increases, their PWB also increases, and vice versa.

The results of the study revealed a negative correlation between overall 'Resilience & Depression', 'Anxiety', and 'Stress', as indicated by the Coefficients of Correlation (r) of 0.506, 0.321, and 0.46, respectively. These findings suggest that an increase in resilience is accompanied by a decrease in mental distress and vice versa. Furthermore, the analysis of the correlation between the DASS21 and RAW subscales revealed weak to strong statistically significant negative associations, ranging from $r=0.113$ between 'Anxiety' and 'Staying Healthy' to $r=0.559$ between 'Stress' and 'Maintaining Perspective'. With the exception of the anxiety subscale, which did not demonstrate a statistically significant association with the RAW 'Building Networks' subscale ($r=0.079$), all DASS21 and RAW subscales displayed statistically significant negative relations. This pattern of

results supports the conclusion that higher levels of resilience are related with lower levels of mental distress and vice versa.

Delgado et al.'s findings show that factors associated with overall PWB include 'General Resilience', 'Depression', 'Anxiety', and holding a speciality licence in mental health nursing. Particularly, it was discovered that 'Overall Resilience' ($p=0.001$) and having a specialist 'Mental Health Nursing Qualification' ($p=0.008$) were positively associated with overall PWB, suggesting that as participants' resilience improved, and their PWB also increased for those who had a specialist mental health nursing qualification. On the other hand, 'Anxiety' and 'Depression' were inversely correlated with PWB as a whole ($p=0.047$ and $p=0.001$, respectively), suggesting that as these mental health problems increased, individuals' PWB decreased. The component with the highest total score among those under study, overall resilience, showed a considerable correlation with overall PWB.

The present study failed to discover any statistically significant interactions between DASS21 subscales and overall PWB. Furthermore, the examination of the 'Workplace Resilience' effects on the relationship between the DASS21 subscales and overall PWB produced insignificant results. This suggests that 'Workplace Resilience' does not play a moderating role in the correlation between 'Depression', 'Anxiety', 'Stress' and overall PWB.

LIMITATIONS

Oates et al. (2017) proposed that methodological limitations were present in their research study, due to a correlational cross-sectional design, which did not allow for the determination of responses. Furthermore, the research design presented various limitations, including a small sample size, that limits the generalisability of the findings, and the likelihood of a low response rate, which was challenging to establish due to the use of online methods and emails, were also noted.

Similarly, Foster et al. (2020) acknowledged that the aim of the study was limited to a cross-section of MHNs working in one specific region in Australia, and therefore, the findings may not be generalisable to other settings. Additionally, the study did not gather in-depth information on the practice environment of MHNs, thus the impact of factors relating to the work setting is indeterminate. Furthermore, the study design did not include the collection of longitudinal data, thus the influence of contextual and personal traits on outcomes remains uncertain.

Delgado et al. (2021) also argued that the utilisation of a convenience sample of MHNs surveyed at a specific point in time may have hindered the generalisability of the results. The chosen sample methodology also precluded the determination of the response rate. Furthermore, the study omitted the collection of information regarding occupational stressors or environmental factors that could have adversely affected the MHNs' PWB and/or contributed to their experience of mental distress.

CONCLUSION

Oates et al. (2017) concluded that this research was the first study to specifically investigate the SWB of MHN in the UK, the research found that MHNs in the UK exhibit low levels of SWB as measured by three commonly used SWB tools. The findings regarding the impact of demographic and workplace factors on SWB in nurses were inconsistent and not conclusive. However, previous research in other populations has revealed that factors such as gender, sex, and household size can be influential. Although the current study did uncover certain variations based on age and sex, these were restricted to the 'Life Worthwhile' measure from the ONS SWBQ.

In conclusion, Foster et al. (2020) emphasised that the identified workplace stressors in this study have substantial insinuations for MHNs, who constitute the largest group in the Australian mental health workforce and provide critical care to meet the needs of mental health service users. The study highlights a significant shortage of MHNs in Australia, which can be attributed to various stressors such as verbal and physical aggression, high patient acuity, clashes among workmates, bullying, and a large amount of workload.

Lastly, Delgado et al. in 2021 that resilience in the workplace is a significant predictor of PWB and has an opposing relationship with mental distress. Thus, a higher level of 'Workplace Resilience' is related to an increased likelihood of PWB and a reduced risk of negative mental distress. Additionally, the study discovered that as mental distress increases, MHNs' ability for positive adaptation and PWB decreases. The researchers proposed that higher education may serve as a preventative measure to improve MHNs' well-being.

2.2.2 NURSES' WELL-BEING IN IN-PATIENT VS COMMUNITY MENTAL HEALTH SETTING

‘Table 2.6 Studies Focusing on Nurses Working in In-Patient VS Community Mental Health Setting’ presents information on a study which makes a distinction between in-patient and community mental health settings.

Table 2.6 A Study Focusing on Nurses Working in In-Patient VS Community Mental Health Setting

Title	Author(s), Date of Publication & Country	Methodology & Instruments Uses	Sample Size	Findings & Conclusion
Occupational Stressors, Burnout and Coping Strategies Between Hospital and Community Psychiatric Nurses in a Dublin region	McTiernan & McDonald 2015 Dublin	A Quantitative Approach using a Descriptive & Correlational Research Design. Data was collected through Questionnaires involving: demographic questions and three measuring tools being: the Maslach Burnout Inventory (MBI), the PsychNurse Methods of Coping Scale (PNMCS), and the Mental Health Professional Stress Scale (MHPSS).	69 Psychiatric Nurses The sample comprised of 8 men and 61 women. Ages ranged from under 25 years to 60 years. The majority of participants were staff nurses followed by clinical nurse specialists and clinical nurse managers. 36 participants were hospital based and 33 were working in the community. Time worked in the particular setting ranged from 8 months to 26 years.	Nurses were functioning within a moderately stressful setting, with the primary stressors identified as insufficient resources, workload, and organisational structures/processes. Hospital nurses exhibited higher depersonalisation scores, while community nurses experienced a stronger sense of personal accomplishment. It is noteworthy that the personal accomplishment scores of hospital nurses fell below the norms observed for mental health professionals.

AIM

McTiernan and McDonald in 2015 aimed to investigate the range and intensity of stressors experienced by MHNs in a specific Dublin region. The study also aimed to contrast the occupational stress, coping strategies, and burnout of hospital nurses with that of community nurses.

ETHICAL CONSIDERATIONS

McTiernan and McDonald (2015) study was in accordance with ethical standards. The research received approval from the appropriate mental health management team as well as the ethics committee at Trinity College Dublin demonstrating a commitment to ethical standards. Information and questionnaire packets were given to research participants, and participation was entirely optional. The researchers' sensitivity to ethical issues was further highlighted by the preservation of anonymity throughout the investigation.

RESEARCH DESIGN

The researchers adopted a qualitative approach in order to explore and compare stress, coping strategies, and burnout among hospital and community MHNs. A descriptive and correlational research design was employed, utilising cross-sectional surveys as the research instrument.

Data was collected via convenience sampling, with both groups completing identical questionnaires but operating in different clinical settings-one group in a hospital setting and the other in the community. Nurses working in both settings were offered to participate in the study which took place over a 14-day period.

FINAL SAMPLE SIZE

Sixty-nine participants made up the final sample size, including nurses from 13 community settings which comprised of both outpatient clinics and day centres. Access was approved to four wards within the hospital setting, which included two wards that delivered care to patients with long-term difficulties and two that were acute psychiatric units. Information related to the study was provided to participants which also included questionnaire packages.

DATA COLLECTION

Data was obtained through the administration of questionnaires to the nurses which were then collected. The questionnaire consisted of demographic questions and three assessment tools, namely the Maslach Burnout Inventory (MBI), the PsychNurse Methods of Coping Scale (PNMCS), and the Mental Health Professional Stress Scale (MHPSS).

The MHPSS is a tool that consists of 42-items, which identify detailed causes of stress that pertain to mental health professionals in seven categories namely: 'Workload', 'Client-Related Difficulties', 'Organisational Structures/Processes', 'Relationships and Conflicts with Other Professionals', 'Lack Of Resources', 'Professional Self-Doubt', and 'Home-Work Conflict'. Participants recorded each potential source of stress on a Likert scale varying from 0 'Does Not Apply to Me' to 3 'Does Apply to Me'.

The MBI is another self-report instrument that consists of 22-items, which are grouped into three subscales: 'Emotional Exhaustion', which measures feelings of being emotionally strained and tired by one's work tasks, 'Depersonalisation', which evaluated detached responses towards service users, and personal accomplishment, which evaluates feelings of being competent and feelings of work achievement. Responses for each subscale were calculated and classified as low, moderate, or high burnout, based on normative data obtained from the sample.

According to the scoring system of the MBI, a score over 27 on the 'Emotional Exhaustion' scale suggesting of high levels of 'Emotional Exhaustion' and 'Burnout'. Similarly, a score over 13 on the 'Depersonalisation' scale is indicative of a high level of depersonalisation and burnout. On the other hand, a score below 31 on the 'Personal Accomplishment' scale suggests a diminishment of personal accomplishment and high burnout. It was noted that the 'Personal Accomplishment' scale was scored in the opposite direction to the other two scales.

The PNMCS tool was created with the purpose of measuring the coping strategies used by psychiatric nurses. It is a more appropriate tool than generic coping scales as it is specific to the population of interest. It is made up of 35-items that assess five different coping mechanisms: 'Redirecting Focus', 'Self-Regulation and Self-Perception', 'Social Support within the Workplace', 'A Positive Mindset Towards One's Job', and 'Emotional Support'. Participants responded to each question on a Likert scale, with a range of 1 indicating 'Never' to 5 indicating 'All The Time', to indicate the frequency of usage of each coping strategy.

ANALYSIS

The collected data were processed and analysed through SPSS. The statistical tests applied were two-tailed and the results were considered to be significant at a p-value of less than 0.05. Out of the 90 surveys disseminated, 69 were returned, resulting in a response rate of 76.6%.

PARTICIPANTS' CHARACTERISTICS

In this study, a total of 69 MHNs from psychiatric services in a Dublin region contributed. The sample included 8 male nurses (11.6%) and 61 female nurses (88.4%). Participants ages differed from under 25 years to 60 years. The participants were 'Staff Nurses' (65.2%), 'Clinical Nurse Specialists' (18.9%), and 'Clinical Nurse Managers' (15.9%). Thirty-six participants worked in the hospital setting, while 33 worked in the community. Participants' time spent in their current setting ranged from 8 months to 26 years, with a mean of 4.06 years and a standard deviation of 4.82.

FINDINGS

Analyses showed that there were no significant associations between 'Gender' and 'Location' or between 'Age' and 'Location' among the participants (N=69). However, a Chi-Squared test for independence revealed a significant association between nursing 'Grade' and 'Location'. Specifically, more nurses with higher grades were working in a community-based setting.

The study found no significant differences in the mean coping scores between hospital and community nurses. Additionally, no significant differences were identified when analysing coping strategies in relation to variables such as 'Age', 'Gender', or 'Grade'. The most commonly used coping strategies among the participants were 'Looking Forward to Going Home at the End of Each Day' (M= 4.43, SD= 0.72) and 'Having a Stable Home Life that is Separate From Work Life' (M= 4.43, SD= 0.95). On the other hand, the least utilised strategies were 'Having Confidential one to one Supervision' (M=2.18, SD= 1.33) and 'Having Team Supervision' (M=2.6, SD=1.44).

The results of the study indicate that neither group of nurses, those working in hospitals and those working in the community, were facing high levels of burnout. The mean score for depersonalisation was found to be higher for nurses working in a hospital setting compared to nurses working in the community, nevertheless, both groups were categorised as having low scores. Additionally, data revealed that hospital nurses had a significantly higher median score for

depersonalisation compared to community nurses. On the other hand, community nurses had significantly greater scores for personal accomplishment in comparison to hospital nurses. Overall, the majority of the sample had low scores for 'Emotional Exhaustion' and 'Depersonalisation'. However, a notable proportion of 40.3% showed the nurses were lacking in personal accomplishment.

A preliminary analysis of the data showed that the assumptions of normality, linearity, multicollinearity, and homoscedasticity were not violated. The results of the analysis revealed that the Mental Health Problem Screening Scale (MHPSS) was able to predict emotional exhaustion with an overall explanatory power of 70%. The workload and home-work conflict subscales were found to be statistically significant predictors, with the workload subscale having a higher beta value (Beta=0.44, $p < .05$) than the home-work conflict subscale (Beta=0.29, $p < 0.05$).

LIMITATIONS

The researchers mentioned certain methodologies throughout the study. The research design used is cross-sectional and the findings may not be generalisable to other settings or populations. The sample consisted primarily of female nurses; thus, the results may not be generalisable to male nurses. Additionally, the specific context of psychiatry within which the nurses were working may have influenced their level of burnout. It is also possible that nurses who were experiencing burnout may have left their positions or requested time off due to health reasons, resulting in a lower overall burnout score. Additionally, information about non-respondents was not collected and the use of Likert scales to measure burnout may limit the interpretation of the results. Furthermore, self-reported data is based on perceptions and may not take into account other variables that may affect burnout. Additionally, the study does not explain why certain demands are perceived as stressful.

CONCLUSION

McTiernan and McDonald (2015) concluded that while the MHNs in the study were working in a moderately stressful and challenging environment, they were not experiencing high levels of burnout. However, issues with personal accomplishment and the lack of social support were identified. The authors underline the importance of identifying and managing occupational stressors to be able to support nurses and ensure high-quality care.

2.2.3 NURSES' WELL-BEING IN IN-PATIENT MENTAL HEALTH SETTINGS

‘Table 2.7 Studies Focusing on Nurses Working in In-Patient Mental Health Settings’ demonstrates details of two articles which focus solely on in-patient mental health settings.

Table 2.7 Studies Focusing on Nurses Working in In-Patient Mental Health Settings

Title	Author(s), Date of Publication & Country	Methodology & Instruments Uses	Sample Size	Findings & Conclusion
Investigating the Impact of Psychosocial Risks and Occupational Stress on Psychiatric Hospital Nurses' Mental Well-Being in Japan	Leka, Hassard & Yanagida 2012 Japan	A Quantitative Approach using a Descriptive & Correlational Research Design. Data was collected through Questionnaires involving: demographic questions and two measuring tools being: Job Content Questionnaire (JCQ); and the General Well-Being Questionnaire (GWBQ)	361 Nurses working within Psychiatric Hospitals The majority of the sample consisted of females. The age of participants ranged from 21-72 years, with an average age of 43.1 years. The average length of time in their current job position was 6.1 years, with a mean job tenure of 16.36 years and an average length of employment at the same hospital of 8.05 years. A small proportion of participants held positions as head nurses or senior nursing officers, occupying chief nursing positions within the nursing department, while the remaining participants held various nursing jobs. Just below half of the sample reported working 160 hours or fewer per month, while 35.7% reported working over 160 hours per month, with an average of 160.78 hours..	Younger age, high psychological demands combined with low social support in the workplace, job strain, and job strain combined with low social support were identified as predictors of high rates of emotional exhaustion in nurses. Similarly, high rates of feeling tense or uptight were associated with high psychological job demands, low psychological job control, low social support in the workplace, high job strain, and high job strain combined with low social support. The study also revealed a significant relationship between demographic factors, work and organisational stressors, and poor mental health among Japanese psychiatric nurses.
Factors Influencing the Psychological Well-Being of Psychiatric Nurses	Ye-Won & Choi Bong-Sil 2021 Korea	A Quantitative Approach using a Descriptive & Correlational Research Design. Data was collected through Questionnaires involving: the Emotional Labour Tool; State-Trait Anger Expression Inventory (STAXI), and Ryff's SPWB-22-item	255 Nurses working within Psychiatric Hospitals Nationwide for Over 6 Months No information was available with regards to participants' characteristics.	The emotional labour, anger expression, and PWB scores of psychiatric nurses were 3.06, 23.04, and 3.41 points, respectively. Significant negative correlations were observed between PWB and both emotional labour and anger expression, while a significant positive correlation was found between PWWB and anger control. Subfactors of anger expression and the mismatch of emotions, which is a subfactor of emotional labour, were identified as influential factors affecting PWB.

AIM

The purpose of the study conducted by Leka et al. (2012) was to examine the relationship between work-related stressors and demographic characteristics which indicate poor mental health among MHNs. Meanwhile, the main aim of Ye-Won and Choi Bong-Sil's study conducted in 2021 was to evaluate the association between emotional labour, anger expression, and PWB among MHNs and the impact of emotional labour and anger expression on their PWB.

ETHICAL CONSIDERATIONS

Ye-Won and Choi Bong-Sil (2021) and Leka et al. (2012) both carried out investigations that complied with ethical standards. The research ethics committees at each of the six hospitals that participated in Leka et al.'s study, as well as the authors' home department, approved the study. The study's findings were communicated to the nurses by the researchers through presentations and a letter that included a questionnaire. The use of anonymous self-administered questionnaires in all six hospitals assured anonymity throughout the data gathering and reporting procedure.

Similarly to this, N University's institutional review board (IRB), which intended to protect the ethical considerations of the subjects, approved Ye-Won and Choi Bong-Sil's (2021) study. The study's goals, consent withdrawal, end of participation, and assurance of anonymity were all fully explained to participants during the researchers' personal visits to the hospitals. Prior to the data collection, several actions were performed to make sure ethical standards were satisfied.

RESEARCH DESIGN

Both studies conducted by Leka et al. (2012) and by Ye-Won and Choi Bong-Sil employed quantitative approaches to explore the association between workplace and demographic factors and indicators of poor well-being among MHNs. Leka et al. (2012) utilised descriptive and correlational research designs to examine this correlation, while Ye-Won and Choi Bong-Sil employed a cross-sectional survey as their research instrument, along with descriptive and correlational research designs suitable for their study objectives.

FINAL SAMPLE SIZE

In the study by Leka et al. (2012), a sample of 361 nurses working in six psychiatric hospitals in Japan was gathered. The participants were provided with informational presentations, and an

information letter accompanied by the questionnaire was distributed to all nurses working in the participating hospitals.

Meanwhile, Ye-Won and Choi Bong-sil (2021), employed a convenience sampling method to select the subjects, specifically nurses who had been employed at 16 psychiatric hospitals nationally for at least 6 months. A total of 260 subjects were initially selected, taking into account a dropout rate of 20%. A questionnaire was disseminated to each subject and ultimately, 255 valid copies were collected out of the 260 distributed.

DATA COLLECTION

In Leka et al. study, a Japanese-translated version of two research tools the Job Content Questionnaire (JCQ), and the General Well-Being Questionnaire (GWBQ) were included together with demographic questions in the questionnaires provided to participants in order to be able to gather data. The demographic questions were focused on work characteristics and well-being including; 'Gender', 'Occupational Status', 'Age', 'Number of Work Hours per Month', 'Employment Tenure at Hospital', and 'Length of Employment' in their current job position.

The JCQ is a self-administered tool that is utilised to evaluate the psychosocial work environment. The questionnaire comprises of 22 items, which are divided into three subscales: psychological demand, decision latitude, and social support. The psychological demand scale is a weighted sum of five items that assess the level of psychological demands in the workplace. The decision latitude scale is a weighted sum of nine items which measure the level of skill discretion and decision-making authority at work. The remaining eight items are used to measure the level of support provided in the workplace, with half of the items assessing support from a supervisor and the other half assessing support from colleagues (Karasek et al., 1998).

The GWBQ is a research tool that evaluates an individual's health through self-report questions. Participants indicate the frequency of various behavioural, cognitive, emotional, and physical symptoms they have experienced over the past 6-month period. The questionnaire is presented as a symptom checklist that participants are requested to rate on a 5-point scale, ranging from 'Never' to 'Always'. A higher score on the questionnaire indicates a lower level of well-being. The scale is composed of two dimensions reflecting 'Fatigue, Emotional Fragility, and Confusion', and 'Tension, Anxiety, and Agitation'. The GWBQ has been shown to be sensitive to fluctuations in well-being associated with the emotional experience of stress at work (Wheeler, 1991).

Ye-Won and Choi Bong-sil gathered data through a structured questionnaire which was dispersed to participants. The questionnaire involved demographic questions and three research measuring tools: the Emotional Labour Tool, State-Trait Anger Expression Inventory (STAXI), and Ryff's SPWB-22-item. The demographic questions included: 'Age', 'Marital Status', 'Highest Level Of Education', 'Profession', 'Job Title', 'Total Years Of Service', 'Department', 'Schedule', 'Duration Of Sleep', 'Satisfaction with Sleep', and 'Satisfaction with Workplace'.

In this study, the researchers utilised the Emotional Labour Tool to assess the levels of emotional labour among their participants. This tool consisted of three components, namely, 'Frequency of Emotional Labour', 'Attentiveness of Emotional Display', and 'Mismatch of Emotions'. Participants were asked to rate the level of agreement with each statement on a 5-point Likert scale, with 1 being 'Strongly Disagree' and 5 being 'Strongly Agree'. The total scores of the tool ranged from 9 to 45, with higher scores demonstrating a higher intensity of emotional labour (Nam et al., 2018).

Similarly, the study also utilised the STAXI tool, developed by Spielberger (Korean version). This tool is designed to measure trait anger, state anger, and anger expression. In this study, only the 24 questions on anger expression were used, along with its 3 subfactors: Anger-In, Anger-Out, and Anger Control. The tool utilises a 4-point Likert scale, with scores ranging from 1, indicating 'Strongly Disagree' to 4 points, signifying 'Strongly Agree'. The total index of anger expression is calculated by 'anger-in + anger-out - anger control + 16' and ranges from 0 to 72 points. The total scores obtained from the subfactors range from 8 to 32 points, with lower scores of 'Anger-In' and 'Anger-Out' and higher scores of 'Anger Control' indicating positive anger expression (Fuqua et al., 1991).

To calculate the participants' level of PWB, the researchers used Ryff's SWPB 22-item. This tool has been previously utilised in Foster et al.'s (2020) and Delgado et al.'s (2021) study.

ANALYSIS

Leka et al., utilised SPSS for statistical data processing. Various statistical tests and techniques were utilised to investigate the research aims and objectives. One-way ANOVA was used to investigate the association between psychosocial risks, occupational stress, and nurses' SWB.

The data collected by Ye-Won and Choi Bong-sil was also analysed using SPSS. They also used descriptive statistics and Pearson's Correlation Coefficient. Additionally, a stepwise multiple regression analysis was conducted to identify the factors that have an impact on the PWB of the subjects.

PARTICIPANTS' CHARACTERISTICS

Leka et al., sample of the study consisted of 85.3% female participants (N=308) with an age range of 21 to 72 years and a mean age of 43.1 years. The participants had an average job tenure of 16.36 years, with an average length of employment at the same hospital being 8.05 years, and an average length of current job position being 6.1 years. Among the respondents, 9.1% of them worked as 'Head Nurses' or 'Senior Nursing Officers', 13.3% had 'Chief Nursing' positions in the nursing department, and the rest, 75.4% had nursing jobs outside those specified. Approximately 43.8% of the sample reported working 160 hours or less per month and 35.7% worked over 160 hours per month, with 74 invalid cases accounting for the remaining 20.5%. The number of working hours per month was M=160.78 hours.

Ye-Won and Choi Bong-sil's survey, demographic questions included 'Age', 'Marital Status', 'Highest Level Of Education', 'Profession', 'Job Title', 'Total Years Of Service', 'Department', 'Schedule', 'Duration of Sleep', 'Satisfaction with Sleep', and 'Satisfaction with the Workplace', however, no results were published. Participants were all nurses working within psychiatric hospitals for over six months as mentioned in their inclusion criteria.

FINDINGS

Leka et al. (2012) reported that the sample mean for 'Psychological Demand', 'Job Control' and 'Workplace' support were 32.37, 67.58 and 23.27 respectively. In total, 20.8% of the sample size was identified as experiencing high job strain. Consequently, participants were classified into four groups: high job strain with low social support (13.6%, N=49), high 'job strain' with high 'Social Support' (7.5%, N=27), low 'Job Strain' with low 'Social Support' (37.1%, N=134), and low 'Job Strain' with high 'Social Support' group (41.8%, N=151). The mean scores for the two constructs of 'Well-Being', 'Worn-Out and Uptight', were 16.03 and 7.46 respectively.

A significant difference in 'Emotional Exhaustion' was observed between age groups, with the youngest age group exhibiting the highest mean score (M=18.35). The average emotional exhaustion score decreased across older age groups, displaying a downward trend in emotional

exhaustion scores across age groups, with a slight plateau observed from '40-60 Years' of age. No significant variations were noticed across the remaining demographic variables, including 'Feeling Uptight' and 'Tense'.

Participants who reported high levels of 'Psychological Demands' ($p=0.000$), low workplace 'Social Support' ($p=0.004$), high 'Job Strain' ($p=0.000$) and 'Job Strain' paired with low 'Social Support' ($p=0.000$) had higher levels of emotional exhaustion in relation to feeling worn-out. However, no significant differences were observed in self-reported emotional exhaustion across nurses with high or low psychological control.

The study revealed that nurses who reported high 'Job Demands' ($p=0.007$), low 'Job Control' ($p=0.019$), low workplace 'social support' ($p=0.018$), high levels of 'job strain' ($p=0.048$) and 'Job Strain' paired with low 'Social Support' ($p=0.043$) reported significantly higher levels of feeling 'Uptight and Tense'.

Results in Ye-Won and Choi Bong-sil's study were presented in sections; the levels of the subjects' emotional labour, anger expression, and PWB, correlations among 'Emotional Labour', 'Anger Expression', and PWB; and factors affecting PWB.

LIMITATIONS

Leka et al. (2012) stated that various limitations were acknowledged within their research. They explained how the Japanese version of the GWBQ has not been thoroughly inspected. Furthermore, the cross-sectional design of the current research study did not allow for a clear understanding of the association between the risk factors and their impact on well-being.

Although Ye-Won and Choi Bong-sil's study did not mention any limitations with regards to the methodology. The results of the study cannot be generalised to the whole population. Additionally, the quantitative approach used in the study does not allow for further examination of the results.

CONCLUSION

In conclusion, Leka et al. study revealed a high occurrence of occupational stress MHNs and identified correlations between work-related psychosocial risk factors and poor mental health. Results from both measures of the well-being of nurses showed that psychological demands were the most prevalent predictor of feelings of being uptight and worn out. The study emphasised the

importance of evaluating psychosocial work characteristics when formulating intervention initiatives and highlighted some of the primary determinants that should be of primary concern: 'Psychological Demands', 'Occupational Stress', and 'Workplace Support'.

Lastly, Ye-Won and Choi Bong-sil's study intended to investigate the relationship between 'Emotional Labour', 'Anger Expression', and 'PWB' in MHNs. It was noted that the subfactor of anger expression known as 'Anger-In' had the most significant impact on PWB, followed by the subfactors of 'Anger Control' and 'Mismatch of Emotions'. These findings suggest that controlling negative emotions, such as those resulting from emotional labour, may have a positive impact on the PWB of MHNs. Thus, the study recommended that programs should be developed to provide education on emotion management and problem-solving techniques, as well as specialised training tailored to the specific needs of individual hospitals.

2.3 THEORETICAL FRAMEWORK

The current study adopted the Self-Determination Theory (SDT) as its guiding theoretical framework. Originating from the seminal works of Edward L. Deci and Richard M. Ryan in 1985, SDT postulates a connection between personality, human motivation, and optimal performance. The theory proposes that human behaviour is shaped by two distinct types of motivation, intrinsic and extrinsic, and seeks to explain how these motivations influence an individual's actions (Deci, & Ryan, 1980).

Extrinsic motivation refers to behaviour that is driven by external factors such as rewards, or recognition from others. It results in external rewards and is reliant upon external validation. On the other hand, intrinsic motivation originates from within and is driven by factors such as personal values, interests, and an internal sense of morality. It is characterised by a sense of personal fulfilment and satisfaction derived from within (Sheldon et al., 2008).

SDT also distinguishes between autonomous and controlled motivation. Autonomous motivation encompasses both intrinsic and extrinsic sources that have been internalised, leading to a sense of self-determination and autonomy. Meanwhile, controlled motivation is inspired by external regulation and is driven by external rewards or fear of punishment, lacking autonomy. A variation of controlled motivation, referred to as introjected regulation, occurs when motivation is partially internalised and driven by a desire to avoid shame (Ryan, 2009).

Ryan and Deci stated that motivation can vary daily and exist on a range from non-self-determined to self-determined. At the non-self-determined end of the spectrum lies 'Amotivation', where individuals lack any sense of autonomy or regulation and have no drive or motivation to meet their needs (Deci & Olafsen, 2017).

As stated by Deci & Olafsen in 2017, between non-self-determined and self-determined lies extrinsic motivation, which has four subcategories:

- External Regulation: motivation is solely driven by external factors;
- Introjected Regulation: characterised by partially internalised motivation and driven by self-control, ego protection, and internal rewards or punishments;
- Identified Regulation: motivation is partially internal and driven by conscious values;
- Integrated Regulation: behaviour is guided by intrinsic factors and a desire for self-awareness.

SDT posits that intrinsic motivation is a form of self-regulation in which an individual is driven by personal interest or enjoyment in an activity. The satisfaction derived from the behaviour is inherent and originates from within the individual, rather than being externally imposed (Sheldon et al., 2008).

According to SDT as explained by Sheldon et al., in 2008, both external and internal motivations play a significant role in shaping behaviour, and they influence an individual's satisfaction with three basic psychological needs: Autonomy, Competence, and Relatedness:

- Autonomy refers to a desire for self-endorsed behaviour and a sense of control over one's life;
- Competence encompasses feelings of mastery and effectiveness in performing tasks;
- Relatedness involves a sense of belonging and the improvement of affectionate relationships with others.

SDT posits that personality differences stem from varying levels of satisfaction with the three basic needs, which are influenced by two key factors: 'Causality Orientations' and 'Aspirations'. These two aspects shape an individual's tendencies towards self-regulation and motivation, leading to differences in personality traits and behaviour patterns (Adams et al., 2017).

Causality orientations describe an individual's adaptation to their environment and the extent to which they are self-determined. There are three main causality orientations: 'Autonomous', 'Controlled', and 'Impersonal'.

- Autonomous: Individuals have the satisfaction of all three basic needs;
- Controlled: Individuals have some satisfaction with competence and relatedness, but lack autonomy;
- Impersonal: Individuals have no satisfaction with the three needs.

Aspirations or life goals serve as guides for behaviour and are categorised as either 'Intrinsic Motivation' or 'Extrinsic Motivation'. While they drive an individual's actions, they are considered learned desires rather than the three basic needs of 'Autonomy', 'Competence', and 'Relatedness'. SDT recognises that individuals' aspirations and life goals play a significant role in shaping their motivations and behavioural patterns (Deci et al., 2013).

Self-determination theory includes two sub-theories, Cognitive Evaluation Theory (CET) and Organismic Integration Theory (OIT), which offer a deeper understanding of intrinsic and extrinsic motivation. CET focuses on the social factors that influence intrinsic motivation, while OIT evaluates contextual factors that shape extrinsic (Adams et al., 2017). In conclusion, SDT holds that individuals have fundamental psychological needs for autonomy, competence, and relatedness and that satisfying these needs leads to increased well-being and fulfilment.

Utilising Ryff's SPWB-42 tool in the current study offers a thorough understanding of well-being and measures important concepts such as autonomy, personal growth, positive relationships, and more, all of which offer a comprehensive examination of mental health nurses' well-being (Lee et al., 2019). By opting for SDT as a theoretical framework and using Ryff's SPWB-42 in the study, it provides an in-depth understanding of nurses' well-being in a mental health setting, and how it is influenced by different factors (Adams et al., 2017).

2.4 CONCLUSION

In this chapter's literature review, the focus was on the well-being of nurses working in in-patient mental health facilities and community mental health services. The theoretical framework was also briefly outlined in the chapter. It also offered a number of new perspectives on the SWB. The findings show that nurses working in the mental health field have varying degrees of well-being

and that demographics and well-being-related factors at work also have an influence. The current study thus tries to address these challenges by exploring the impact of various demographics on well-being. In view of this, one of the aims of this study is to address the importance of promoting well-being in the local scenario. Moreover, this study contributes to the general literature by exploring the well-being of nurses working in both the in-patient and community mental health sectors.

Throughout the literature review, a research gap was noted that no studies were solely focused on the well-being of nurses in a community mental health setting. Therefore, the author of this study intends to address this gap in the local literature.

The next chapter will delve into the research design and methodology, discussing the sample population and data collection, research instruments, ethical considerations, and data analysis methods.

Chapter Three

RESEARCH METHODOLOGY

3.0 INTRODUCTION

The following chapter will provide an explanation of the methodology used in this research study. A descriptive cross-sectional design was implemented to collect data about the nurses' well-being in both in-patient and community mental health settings. The aims and objectives, operational definitions and rationale for the research design were discussed along with internal and external validity, and research reflexivity. This is followed by a description of the target population used within this research, where the inclusion and exclusion criteria were adopted. The research instrument is then thoroughly discussed together with the demographic variables. Thereafter, the pilot study conducted prior to the actual study is discussed, where ethical issues and associated considerations, data collection and data analysis are considered.

3.1 AIMS & OBJECTIVES

Having a well-defined aim is necessary to determine the purpose and objectives of a study, guiding its design and execution, and increasing its chances of success, credibility, and impact. A clear aim enhances focus and direction in research and can lead to greater generalisability of findings. This, in turn, contributes to the advancement of the field of study (Schober & Vetter, 2019).

The objective of this research study is to evaluate, compare and contrast the well-being of nurses working in in-patient and community mental health settings. The following objectives were established:

- To explore the levels of well-being experienced by nurses working in in-patient and community mental health settings;
- To determine whether nurses' well-being level is influenced by different variable demographics.

Additionally, a hypothesis was formulated whereas specific predictions were made about the correlations between variables tested in the study (Toledo et al., 2011). The following research hypotheses were produced:

- Nurses working in the community mental health setting experience better well-being than those working in an in-patient mental health setting;
- Nurses' education impacts their overall well-being;
- Nurses working regular shifts experience lower-level well-being;

Upon reflecting on the research title, two research questions were set, as follows:

- What is the prevalence of nurses' well-being in the Maltese mental health sector?
- Are there differences in well-being between nurses working in in-patient versus community mental health care?

3.2 OPERATIONAL DEFINITIONS

In a research study, it is crucial for the reader to be able to understand different terms. To achieve this, 'Table 3.1 Operational Definitions of Terms Used in the Study' provides a set of operational definitions.

Table 3.1 Operational Definitions of Terms Used in the Study

Terms	Operational Definition
Well-Being	Refers to a state of contentment, satisfaction, and fulfilment with one's life and experiences (Diener et al., 2002)
Mental Health Setting	Incorporates the following settings: acute and chronic wards in a psychiatric hospital and mental health community settings which include outpatients' services.

3.3 RATIONALE FOR THE RESEARCH DESIGN

A quantitative approach was deemed to be the most suitable research approach as it offers a large sample size and standardised instruments such as surveys and questionnaires. The researcher aims to measure and analyse the prevalence of nurses' well-being in the mental health sector both community and in-patient mental health settings. Therefore, a quantitative approach was ideal for presenting numerical data and analyses, providing concrete results. Additionally, a quantitative approach allows for the generalisability of the findings and the ability to test hypotheses and make statistical inferences (Anderson et al., 2018).

The study employed a descriptive cross-sectional survey research design. This approach entails gathering important data at a specific moment in time (Kesmodel, 2018). The same author elaborated how a cross-sectional design does not involve trials or any interventions, but the main objective is to gather systematic information on a specific topic, without interfering with any

substantial variables. When a cross-sectional design is employed in a study, various advantages and disadvantages arise.

Cross-sectional designs do not require any follow-ups. Provided that only one-time point is under consideration, the data can be investigated after it has been collected from the entire study cohort. This approach offers the advantage of gaining valuable insights without incurring potentially high initial costs. In utilising cross-sectional designs, researchers are able to exert greater control over the ascertainment process, as these investigations do not involve long-term follow-up. Additionally, since implementing controls is less complicated in this type of research, the collected data can be readily computed and extrapolated to broader population groups (Connelly, 2016).

Wang & Cheng (2020) explained how cross-sectional research methods offer another key benefit; the ability to generate data that can be employed in subsequent secondary data analyses. As such, information gathered about a broad population group retains its utility, and the investment value of the data is optimised. Furthermore, cross-sectional studies enable researchers to examine diverse effects and exposures concurrently, providing a basis for future research. Consequently, such investigations may reveal valuable insights about distinct demographic groups that can be leveraged to facilitate other types of studies, such as investigating the prevalence of a disease or determining the factors that favour particular data points.

Lastly, although any research methodology may overlook critical data points, the likelihood of this occurring in a cross-sectional study is considerably diminished. This advantage can be attributed to the nature of the study design, which involves analysing an entire population group at a single time point, leading to maximised comprehensiveness of primary data points. The potential for errors or variations is reduced since data collection occurs simultaneously for all variables (Spector, 2019).

Despite their advantages, cross-sectional studies come with several limitations. Firstly, they cannot establish causality due to their inability to determine cause and effect. They are also unsuitable for analysing behaviour over time as they only provide a snapshot of a particular moment (Wang & Cheng, 2020). Additionally, MacDonald (2011) stated how there is a risk of social desirability bias, where participants may provide answers that are socially acceptable rather than truthful, potentially affecting the study's outcomes. It can also be challenging to capture emotions and feelings

accurately through surveys. Finally, participants may provide careless responses, or experience survey fatigue, leading to inaccurate data.

3.4 TARGET POPULATION

The sample population is comprised of the entire section of the population that is of interest to the researcher. To reduce sampling errors, quantitative studies require a substantial number of participants (Majid, 2018). For this investigation, all 368 nurses working in mental health settings were eligible to participate, and a total of 270 questionnaires were returned, providing a response rate of 73%. Out of the 270 questionnaires, 2 were considered invalid and 71 were left empty, narrowing down the percentage of valid questionnaires to 53.5% (N=197). Though the population as a whole was contacted, 46.5% did not reply or validly reply, and since those who did not reply were self-selected and were not randomised, this inevitably rather weakens the external validity of the findings when applied to the total population.

3.4.1 INCLUSION & EXCLUSION CRITERIA

Every type of research that examines characteristics of a specific subset within a population needs to establish inclusion and exclusion criteria. This aids to have a clear vision of the study's reliability, consistency, and objectives of the study population by researchers (Connelly, 2020).

The inclusion criteria for nurses to be able to participate in this study were made up of:

- Nurses working in Malta's in-patient mental health settings;
- Nurses working in Malta's community mental health settings.

Meanwhile, the exclusion for this study entailed:

- Nurses working in Gozo & non-governmental mental health settings;
- Nurses working in any settings not related to mental health;
- Any other professionals who are not nurses.

3.5 RESEARCH INSTRUMENTS

To be able to collect, assess, compare and contrast a variable within a study, the use of a research instrument is suggested (Taherdoost, 2016). Prior to choosing the most suitable research instrument for this study, the researcher carried out an intensive literature search on different

research instruments that measure the well-being of nurses working in the mental health sector. Together with the assistance of the research supervisor, the researcher chose the most suitable research tool based on the aim and objective of the study, and by examining the validity and reliability of each tool considered.

The following section delivers a detailed explanation of the demographic characteristics collected from study participants and the research tool used in the study, namely; Ryff's Psychological Well-Being Scale (SPWB).

3.5.1 DEMOGRAPHIC CHARACTERISTICS

When gathering data, careful consideration must be given to the demographic variables requested, as they can significantly impact the targeted sample population and the results of the study (Connelly, 2013). With regard to this study, different variables were gathered and participants had to tick the right boxes. Demographic variables were listed as follows: 'Age', 'Gender', 'Nationality', 'Education', 'Grade', 'Years of Experience as a Nurse', 'Working Place', 'Working Shift', and 'Working Hours'.

3.5.2 RYFF'S SCALES OF PSYCHOLOGICAL WELL-BEING

To be able to assess, compare and contrast the well-being of nurses working in in-patient and community mental health settings, Ryff's SPWB was utilised as it overall matched the inclusion and exclusion criteria of the present study. This validated research tool has been utilised with a wide population sample. Research showed that Ryff's SPWB has also been utilised for nurses working in the mental health sector (Foster et al., 2020; Delgado et al.'s, 2021; Choi Bong-Sil, 2021).

Prior to 1989, an extensive academic inquiry was devoted to examining the concept of 'Well-Being', which was concurrent with the emergence of the positive psychology movement. The primary emphasis of this research centred around aspects that are currently understood as related concepts of contentment, overall life fulfilment, and positive emotional experiences (Ryff, 2014).

In 1989, the concept of 'Psychological Well-Being' was introduced by Ryff, and it contained positive human functioning prevailing at the time. Subsequently, in 1995, the PWB instrument underwent revision and produced an unexplored framework, comprising of six factors: 'Self-

Acceptance', 'Positive Relations with Others', 'Autonomy', 'Environmental Mastery', 'Personal Growth', and 'Purpose in Life' (Ryff & Keyes, 1995). This instrument, known as Ryff's Psychological Well-being Scale (SPWB), gained recognition and became widely used in the field of PWB measurement. Several scale variations exist, including the 8-item, 42-item, 54-item, and 84-item scales. For the purpose of this study, the 42-item scale was employed. Each question on the scale provided response formats that ranged from 'Strongly Disagree' (1) to 'Strongly Agree' (6).

Although research on related concepts such as well-being and optimal functioning identified common themes, none of these fully captured the concept of PWB in its entirety. PWB is considered a distinct construct, which comprises six fundamental dimensions (Ryff & Keyes, 1995). In the 42-item scale adapted from Ryff and Keyes (1995), seven questions are posed for each dimension. A definition of each dimension and their measurements are illustrated in 'Table 3.2 Description & Measurements of Ryff's PWB Subscales'.

Table 3.2 Description & Measurements of Ryff's PWB Subscales

Subscale	Description	Measurements
Self-Acceptance	Self-acceptance is often defined as individuals' attitude towards themselves, and whether they acknowledge and accept both their good and bad qualities without self-criticism, being at peace with themselves (Bernard, 2014).	This particular subscale measures the extent to which individuals agree with possessing a favourable self-perception, recognising and embracing various aspects of themselves (both positive and negative), and feeling optimistic about their past experiences.
Positive Relations with Others	This is characterised as the person's capacity to build enduring, reliable relationships with other people while really caring about their well-being. This involves the ability to feel intense empathy, compassion, and closeness as well as a grasp of how relationships work on a mutually beneficial basis (Ryff, 1989).	The subscale 'Relation with Others' explores the degree to which individuals report experiencing nurturing, gratifying, and trustworthy connections with others. It assesses their level of concern for the well-being of others, their capacity for empathy, affection, and intimacy, as well as their understanding of the reciprocity inherent in human relationships.
Autonomy	Autonomy is the ability to take independent decisions and exercise self-determination without taking into consideration any external social pressures and being able to control one's own conduct and personal values. When being autonomous, decisions are often taken depending on one's moral standards, and personal goals, always being accountable for one's own deeds (Oshana, 2016).	The 'Autonomy' subscale assesses participants' level of self-determination and independence. It examines their ability to resist external influences and societal pressures that dictate thoughts and actions. Furthermore, it evaluates their capacity to regulate their behaviour based on internal motivations and to assess themselves according to personal standards.
Environmental Mastery	This refers to individuals feeling competent in their environment, being able to feel in control of certain external activities, and having the capacity to choose according to their needs and values (Garcia et al., 2014).	This particular subscale evaluates the extent to which participants express a moderate level of agreement regarding their sense of mastery and competence in navigating their surroundings. It examines their ability to exert control over a diverse range of external activities, effectively utilise available opportunities, and select or create environments that align with their personal needs and values.
Purpose in Life	The purpose in life refers to the ability to set goals and feel purposeful, the perception that one's history and present have significance, and the presence of ideas that give life meaning and serve as the basis for goals and objectives for a living (Scheier, 2006).	The subscale measured measures whether participants perceive their life as purposeful and imbued with a sense of significance. This dimension captures their beliefs, motivations, and understanding of their overall purpose, values, and the pursuit of meaningful goals.
Personal Growth	Personal growth entails emotions of ongoing growth and expansion, receptivity to new experiences, self-realisation and the perception of gradual progress in one's self and behaviour, a transformation that shows increased self-awareness and effectiveness (Vittersø & Straume, 2020).	The personal growth subscale indicates the extent to which study participants perceive themselves as undergoing continuous personal development and growth. It examines their openness to new experiences and their recognition of their own potential. Additionally, it assesses their belief in self-improvement and positive changes in behaviour over time, as well as their efforts to align their actions with increased self-awareness and effectiveness.

The definitions provided above would illustrate an individual who obtained a high score on the well-being dimension. Conversely, there are six definitions that correspond to those who score low on this construct. For instance, an individual who obtains a low score on the 'Personal Growth' dimension may encounter emotions associated with personal stagnation, perceiving a lack of progress or advancement over time. They may experience feelings of boredom, a diminished sense of control, and a perceived inability to adopt new attitudes and behaviors (Ryff, 1989a).

Ryff's six dimensions of PWB were originally developed based on research conducted in the context of ageing. Ryff (1989b) recognised various limitations of previous research, such as a lack of theoretical frameworks, a focus on negative aspects of mental health, a failure to theorise well-being as a dynamic, and a lack of cultural and value-based differences with regards to what constitutes well-being. To address these limitations, Ryff (1989b) synthesised multiple established theories from the realm of lifespan development, personal growth, and mental health to suggest six dimensions that constitute PWB. This was then used to formulate Ryff's SPWB, which nowadays is applied to various age groups and demographics.

3.5.3 VALIDITY & RELIABILITY OF RESEARCH INSTRUMENT

As stated by Taherdoost in 2016, reliability and validity determine the quality of a research instrument as they help to identify and prevent the spread of false and/or misleading information, which can lead to incorrect findings. Ensuring a successful quantitative analysis necessitates a thorough evaluation of the research instrument. Reliability and validity are two essential criteria that affect how accurate an evaluation is. Reliability refers to the precision of the research instrument. Meanwhile, validity describes the extent to which a notion may be measured.

Two kinds of validity exist; internal and external validity, both of which are important considerations in research design and interpretation of results. When these two characteristics are combined, it is then possible to show how accurately various results from the same research equipment may be acquired at various times. Internal validity refers to the degree to which a study is capable of establishing causal relationships between the independent variable (the manipulated factor), the dependent variable (the measured outcome), and the observed effects. On the other hand, external validity pertains to the extent to which the findings of a study can be applied to different populations, settings, and conditions beyond the original study's scope (Connelly, 2016).

Ryff's (1989a) initial study indicated that the six scales of PWB demonstrate internal consistency within an acceptable range, with alpha values ranging from .93 to .86. Moreover, the test-retest reliability coefficients, which were gathered over six weeks, ranged from .88 to .81, indicating that the questionnaire was stable over time without any intervention conducted. These results collectively suggest that the questionnaire has adequate reliability.

To evaluate the validity of Ryff's (1989a) SPWB, 'Convergent' and 'Discriminant' Validities were examined. 'Convergent Validity' was evaluated by resembling the scales against other measures of positive and negative functioning, including the Self-Esteem Scale, Life Satisfaction Index, and Zung's Depression Scale. According to Ryff (1989a), the results indicated significant and expected correlations between the scales, demonstrating that the SPWB possess convergent validity.

Despite the significant correlations found between Ryff's SPWB and pre-existing measures of positive and negative functioning, factor analysis revealed a 'general well-being' factor that was responsible for these high correlations. This indicates that the scales may not be entirely distinct from existing measures. Nevertheless, other analyses, such as multivariate, mean-level, and factor analysis, have supported the scales' distinctiveness from other measures. Since the development of the scales, numerous studies have utilised them to investigate the concept of PWB in relation to personality, behaviour, and life stages (Ryff, 1989a).

3.6 PILOT STUDY

Van Teijlingen and Hundley (2010) emphasised the significance of conducting a pilot study to assess the study design and research tool prior to a larger group being tested. The pilot study aims to determine any potential difficulties while filling out the questionnaires, assess the practicality of the research procedure and design, and determine the method of administration and data collection. The pilot study results provide feedback on the utility of the research plan and help eliminate any encounters that may arise during the actual study, ensuring a smoother process.

To assess the questionnaire on a small scale, a pilot study was conducted on ten general health nurses working in hospitals or in the community, who were not eligible for the actual study. The participants were requested to highlight any statements that were difficult to comprehend and document the time it took to fill in the survey. The feedback obtained from the pilot study was positive, with all participants finding the instructions and questions easy to understand.

Respondents required approximately 15 minutes to complete the questionnaire. These results provided the researcher with sufficient feedback to proceed with the study and distribute the questionnaire through intermediaries as planned.

3.7 ETHICAL ISSUES & CONSIDERATIONS

When embarking on a new research project, each phase of research entails ethical considerations. As stated by Ingham-Broomfield in 2017, most researchers in the healthcare profession are often involved in the research process itself, which can lead to various ethical implications.

Therefore, permission to initiate data collection was granted by the Ethics Committee of the Faculty of Health Science (FREC) at the University of Malta (UM) (Appendix D). Additionally, permissions were requested and granted by the administration and the senior management of the local psychiatric hospital, MCH. Permissions were granted by the Chief Executive Office, the Chief Nursing Manager, the Data Protection Officer (Appendix E), and the intermediaries who kindly agreed to aid with the distribution and gathering process of the surveys and information letters (Appendix F). Lastly, permission to use Ryff's SPWB has also been requested from the researcher herself, who granted permission via email (Appendix B).

Ethical considerations are crucial when it comes to research and involves four ethical principles which should be considered whilst conducting a research project (Page, 2012). The ethical principles are mentioned and discussed in 'Table 3.3 Ethical Principles & Their Respective Description'

Table 3.3 Ethical Principles & Their Respective Description

Ethical Principle	Description
Autonomy	Similar to Ryff's (2014) explanation with regards to the 'Autonomy' subscale; Autonomy is the ability to take independent decisions and exercise self-determination without taking into consideration any external social pressures and being able to control one's own conduct and personal values (Oshana, 2016). This concept is similarly applied in ethical considerations where every participant has a right to be fully aware of what the study entails and is able to choose whether to would like to participate in the study without feeling obliged to do so, keeping in mind that there are no negative consequences if they decline participation (Gillon, 2003). Therefore, an information letter was provided with the questionnaire to all participants eligible to take part in this research, explaining what the focal objective of this study was, and reminding them about their rights. Furthermore, the information letter contained clear information that submitting a completed questionnaire implied that consent to participate was being provided. Participants who did not wish to take part in the study had the option of refraining from filling in and/or submitting their questionnaires with no repercussions. Lastly, all questionnaires which were not properly filled or complete, and/or had any recognisable data which in turn could disclose the participants' identity were deemed invalid and were discarded from the study.
Non-Maleficence	Non-Maleficence involves the prevention of intentional or non-intentional physical and/or psychological harm towards the target population (Elton, 2021). The current research adhered to such a crucial principle from the very start; evidently, the intention was to prioritise the well-being of all participants, and that throughout the research project, no harm was inflicted upon any of them.
Beneficence	Beneficence refers to any benefit gained by the participants and/or society from the research conducted (Beauchamp, 2008). Whilst participants were informed through the information letter that no immediate benefit was to be derived from the study, it was stated that its result will aid in providing a greater understanding of the well-being nurses experience in both community and in-patient mental health care.
Justice	Justice implies that every individual is treated equally with no bias (Spencer, 2021). The researcher was mindful that no eligible participant could have felt to be treated unequally and this was evident throughout the research since all nurses working within the mental health sector were included in the study irrelevant of their race, gender, age or any other factors.

Following these principles, the researcher was aware of the responsibilities to safeguard and ensure participants' anonymity and confidentiality. This was made possible through the use of intermediaries. The researcher had no direct contact with participants and the information letter clearly stated that participation is strictly voluntary and questionnaires were to be filled anonymously. Moreover, certain demographic characteristics were categorised in ranges to ensure participant anonymity. To further safeguard the anonymity of participants, only the researcher had access to the completed questionnaires which are to be destroyed on completion of the study.

3.8 DATA COLLECTION

Once all approvals were obtained, data collection for the actual research project started. Data collection is an important process which involves gathering relevant information for analysis through the use of standard techniques (Rutten, 2015).

Each eligible participant received an information letter (Appendix C) and the questionnaire (Appendix A). The data collected from the questionnaires was subsequently stored in an encrypted format on a computer that was password-protected, ensuring that only the researcher had authorised access to it. In order to be able to distribute the questionnaires and the information letters without having any direct contact with the participants, intermediaries were appointed after they provided their written consent (Appendix F). This was also done in order to enhance the participation rate as claimed by Polit and Beck in 2014. Since the researcher works as a nurse within the Mental Health Services, and certain eligible participants are her colleagues. Therefore, the intermediaries also safeguarded the anonymity of the participants. Two intermediaries were appointed to distribute the information letters and questionnaires; one intermediary was responsible to disseminate this content within the mental health community service, and another within in-patient mental health settings.

3.9 DATA ANALYSIS

Once all data was collected, it was first placed on an Excel sheet and then analysed through SPSS. A significance value of ≤ 0.05 was applied throughout the study. Descriptive analyses, such as Frequency Distributions were used to analyse demographic data. Frequency Distributions indicate how often each variable shows in a set of data (Hinton, 2014). Each demographic variable was examined against each of the six subscales, whereas through the use of SPSS, the distribution,

significance and mean were calculated and displayed, providing a visualisation of the differences between each group.

The Mann-Whitney U Test was then employed in order to discover variations between independent variables; which do not exceed two variables, in this case being the working place in this current research study. The Mann-Whitney U Test is a non-parametric statistical test which determines any significant differences between two independent groups. It also compares two samples' median scores instead of mean scores. Since it is a non-parametric test, it does not assume that the data input follows a normal distribution. Such a test ranks the data in the two groups and determines the probability that the two groups originate from the same distribution (Nachar, 2008). The Mann-Whitney U Test was used for the demographic variable of 'Working Place' whereas participants had the option to choose 'In-Patient Care' or 'Community Care'.

Kruskal-Wallis H Test was used to analyse dissimilarities between variables of three or more groups. Thus, the demographic variables tested with Kruskal-Wallis H Test were 'Age', 'Gender', 'Nationality', 'Education', 'Grade', 'Years of Experience as a Nurse', 'Working Shift', and 'Working Hours'. Similarly to the Mann-Whitney U Test, it is a non-parametric statistical test which determines the probability that independent variables are derived from the same distribution. It is often used when data does not meet the assumptions of parametric Analysis Of Variance (ANOVA). Kruskal-Wallis H Test ranks each group's data and measures their differences (Ostertagova, 2014). The resulting p-value indicates whether there is a significant difference in the medians of the groups being compared. Since the Kruskal-Wallis H Test does not indicate the stochastic dominance to establish the partial order between random variables, and how many groups are impacted. The Mann-Whitney U Test was additionally used to analyse individual groups in Post Hoc research. The resulting p-value indicates the results of Post-Hoc Tests to determine which specific groups or levels within a factor have significantly different means from each other (Mehotcheva, 2008).

The Spearman-Rank Correlation Test was then utilised to determine the correlation between each subscale of the research tool. It is also a non-parametric statistical method which measures the degree of association between two variables. This is based on ranks of the variables rather than numerical values, whereas the test assesses whether the association increases or decreases when two variables are associated. The Spearman-Rank Correlation Test produces a Coefficient Value

between -1 and 1, with values closer to -1 or 1 suggesting a strong relationship between the variables. A value of 0 indicates no correlation (Zar, 2014).

3.10 CONCLUSION

This chapter presented a thorough description of the current research methodology and research tool with regard to data collection and analysis. It described how the mentioned approach was utilised in order to investigate, compare and contrast the well-being of nurses within the mental health sector. As previously mentioned, due to the large population, a quantitative study design was considered to be the most suitable to obtain the most accurate findings.

Ryff's SPWB was used as the research instrument of choice throughout this study, where participants had to answer 42 questions related to their well-being, by marking the most appropriate response. The research instrument that adopted the format of a questionnaire was distributed in English and has been validated to be used in different clinical settings.

The questionnaire was distributed to 368 eligible participants pertaining to nurses working in mental health community settings and nurses working in in-patient mental health settings. An information letter was also attached to the questionnaire. The participants of this study were reached via intermediaries, following approval from FREC, MCH's administration and managerial staff. Participation was strictly voluntary and anonymity was guaranteed as per university guidelines. Data collection was followed by SPSS analysis. The following chapter will present and describe the research findings collated by the study.

Chapter Four

FINDINGS

4.0 INTRODUCTION

This chapter presents the results gathered using Ryff's SPWB (Ryff, 2014). The tool was used to measure different characteristics which affect the well-being of nurses working in a Maltese mental health setting. The questionnaire contained 42-items which were distributed over six domains, namely: 'Autonomy', 'Environmental Mastery', 'Self-Acceptance', 'Positive Relations with Others', 'Purpose in Life', and 'Personal Growth'. The demographic characteristics of all nurses working in the Maltese mental health sector who participated in the study were also obtained and analysed. This was done in order to identify whether any particular variables influenced their responses. The variables analysed consisted of the following: 'Age', 'Gender', 'Nationality', 'Education', 'Grade', 'Years of Experience as a Nurse', 'Working Place', 'Working Shift', and 'Working Hours'. This data was compiled and then processed through SPSS.

This chapter will illustrate the sample's demographic characteristics, the overall scores of the participants on Ryff's SPWB, the tests of normality and SPSS data analysis with regards to demographics, the association of Ryff's PWB subscales with the demographic characteristics, and the inter-correlation of Ryff's PWB subscales.

4.1 RESPONSE RATE

A total of 368 questionnaires were distributed to all eligible participants in both community and mental health settings. A total of 270 questionnaires were returned, providing a response rate of 73%. Out of the 270 questionnaires, 2 were considered invalid and 71 were left empty, reducing the percentage of valid questionnaires to 53.5%.

4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS

The scores for 'Working Place' were distributed into two subgroups, whilst 'Gender', 'Nationality', 'Working Shift' and 'Working Hours' were distributed into three subgroups. Meanwhile, 'Age', 'Education', and 'Years of Experience as a Nurse' were divided into five subgroups. Lastly, the 'Grade' variable was distributed into six subgroups.

Findings show that most participants were female (N=168, 63.5%), and were working in an in-patient setting (N=123, 65.5%). The majority worked on a full-time basis (N=196, 99.5%) with regular shifts (N=118, 59.9%). The most common age range was that of 21–30-year-olds (N=58,

29.4%) and held a Senior Staff Nurse position (N=75, 38.1%). Most of the participants had a Degree in Mental Health Nursing (N=63, 32%) and had 0-5 years of experience (N=66, 33.5%). The Maltese nationality had a percentage of 89.3% (N=76), making it the most prevalent nationality.

The sample data was analysed and presented as a frequency distribution as presented in ‘Table 4.1 Frequency Distribution According to Sample Characteristics’.

Table 4.1 Frequency Distribution According to Sample Characteristics

Demographic Data	N (%)
Age	
18-20 Years	4 (2%)
21-30 Years	58 (29.4%)
31-40 Years	50 (25.4%)
41-40 Years	46 (23.4%)
51+ Years	39 (19.8%)
Gender	
Males	71 (36%)
Females	123 (63.5%)
Other	1 (0.5%)
Nationality	
Maltese	176 (89.3%)
European	5 (2.5%)
Non-European	16 (8.1%)
Education	
Diploma in Nursing	49 (24.9%)
Degree in General Nursing	51 (25.9%)
Degree in Mental Health Nursing	63 (32%)
Master’s	34 (17.3%)
Grade	
Enrolled Nurses	6 (3%)
Staff Nurses	72 (36.5%)
Senior Staff Nurses	75 (38.1%)
Registered Mental Health Nurses	23 (11.7)
Charge Nurses	21 (10.7%)
Years of Experience as a Nurse	
0-5 Years	66 (33.5%)
6-10 Years	26 (13.2%)
11-15 Years	20 (10.2%)
16-20 Years	24 (12.2%)
21+ Years	61 (31%)
Working Place	
In-Patient Care	129 (65.5%)
Community	68 (34.5%)
Working Shift	
Regular Shift	118 (59.9%)
Day Shift Only	77 (39.1%)
Night Shift Only	2 (1%)
Working Hours	
Full Time	196 (99.5%)
Reduced Hours	1 (0.5%)

4.3 STATISTICAL ANALYSIS & SCORE ON RYFF'S SCALES OF PSYCHOLOGICAL WELL-BEING

The theoretical range and subscale midpoint, mean, standard deviation (SD) and minimum-maximum scores of Ryff's SPWB were illustrated for all the subscales. Each result for every individual subscale was computed following calculations of the survey items, as recommended by Ryff (2014). The scores which were retrieved from the descriptive statistical analysis for all subscales are illustrated in 'Table 4.2 The 6 Subscales' Scores'.

Table 4.2 The 6 Subscales' Scores

Subscales	Mean Score (SD)	Min – Max Score	Theoretical Range (Subscale Midpoint)
Autonomy	28.20 (3.46)	19-37	7-42 (24.5)
Environmental Mastery	26.69 (3.59)	18-37	7-42 (24.5)
Personal Growth	25.60 (2.96)	19-34	7-42 (24.5)
Positive Relations With Others	27.49 (3.28)	17-38	7-42 (24.5)
Purpose In Life	24.13 (3.32)	18-36	7-42 (24.5)
Self-Acceptance	26.96 (2.86)	21-36	7-42 (24.5)

The 'Autonomy' subscale yielded the highest mean score of 29.2, with a standard deviation of 3.46. This indicates a higher score than the midpoint, which according to Ryff (2014) shows that participants demonstrate self-determination and independence, exhibiting the capacity to resist societal influences that dictate their thoughts and actions. They possess the internal regulation of their behaviour and a heightened ability to evaluate themselves based on personal standards.

Meanwhile, 'Environmental Mastery' produced a mean of 26.69 (SD=3.59). This suggests that participants express a moderate level of agreement regarding their sense of mastery and competence in navigating their environment. They demonstrate the ability to effectively control a diverse range of external activities, make optimal use of available opportunities, and have the capacity to select or create contexts that align with their personal needs and values (Ryff, 2014).

Results show a mean score of 25.60 (SD=2.96) for the 'Personal Growth' subscale. According to Ryff (2014), this suggests that nurses who participated in this study see themselves growing and continuously developing themselves, are open to new experiences, and realise their potential. Additionally, participants perceive growth and advancement in themselves as well as their behaviour over time. They actively strive to modify their ways in order to embody increased self-knowledge and effectiveness.

With regard to 'Positive Relations with Others', individuals scored a mean of 27.49 with a standard deviation of 3.28. Ryff (2014) argues that a higher than midpoint score suggests that individuals experience nurturing and gratifying relationships with others, characterised by warmth, trust, and satisfaction. They exhibit genuine concern for the well-being of others and possess a strong capacity for empathy, affection, and intimacy. Moreover, they comprehend the reciprocal nature of human relationships, understanding the dynamics of giving and receiving within these interactions.

'Purpose in Life' had the lowest mean score of 24.13 (SD=3.32). The mean scored very close to the midpoint; thus this has been regarded as having an average score. This implies that participants perceive themselves as having life goals and a sense of purpose. They also believe that there is significance in their present and past experiences, hold beliefs that provide meaning to their lives, and have specific aims and objectives. However, since the score falls slightly below the midpoint, there is a potential for participants to experience a lack of meaning in life, few goals or objectives, a lack of direction, a diminished sense of purpose in their past experiences, and/or a absence of beliefs that give meaning to life (Ryff, 2014).

'Self-Acceptance' demonstrates a mean score of 26.96 (SD=2.86). As stated by Ryff (2014), this illustrates that the majority of respondents expressed agreement with having a positive self-attitude. Moreover, this indicates that participants are capable of recognising and embracing various aspects of themselves, including both positive and negative qualities, and hold a positive outlook on their past experiences.

4.4 TEST OF NORMALITY

To assess the normality of the generated results, two tests were conducted: the Kolmogorov-Smirnov Test and the Shapiro-Wilk Test. These tests were used to determine whether the data followed a normal distribution. These tests ascertain whether parametric or non-parametric tests were required for further analysis. The Kolmogorov-Smirnov Test is a non-parametric test which compares the distribution of a sample to the normal distribution, and since it is a non-parametric test, it does not assume normality (Tutorials, 2021). Meanwhile, the Shapiro-Wilks Test is a parametric test which computes a test statistic that measures the correlation between the sample and the normal distribution, since it is a parametric test, it assumes normality. For all six subscales, the test of normality scored ≤ 0.05 , meaning that non-parametric tests were required for this study

(Kim & Park, 2019) as outlined in ‘Table 4.3 Test of Normality Results’ below, which presents the results obtained from Kolmogorov-Smirnov and Shapiro-Wilks Tests.

Table 4.3 Test of Normality Results

Subscale	Kolmogorov-Smirnov <i>A Lilliefors Significance Correlation</i>			Shapiro-Wilks		
	Statistic	df	p-Value	Statistic	df	p-Value
Autonomy	0.127	197	<0.001	0.975	197	0.002
Environmental Mastery	0.108	197	<0.001	0.974	197	<0.001
Personal Growth	0.111	197	<0.001	0.971	197	<0.001
Positive Relations with Others	0.133	197	<0.001	0.966	197	<0.001
Purpose in Life	0.119	197	<0.001	0.970	197	<0.001
Self-Acceptance	0.149	197	<0.001	0.965	197	<0.001

Two non-parametric tests were deemed as the most appropriate for data analysis; The Mann-Whitney U Test (represented as ‘U’ in tables) and the Kruskal-Wallis H Test (represented as ‘H’ in tables). Both tests are non-parametric statistical tests which compare groups (Delmo & Refugio, 2018). The Mann U Test was utilised to analyse data between two independent groups, whilst the Kruskal-Wallis H Test was applied to analyse data between three or more independent groups (Vargha & Delaney, 1998).

The next section will discuss the analyses of the six domains of Ryff’s SPWB against the demographic variables.

4.5 ASSOCIATION OF RYFF’S SPWB WITH DEMOGRAPHIC VARIABLES

The six domains of Ryff’s SPWB were analysed individually against the demographic variables, in order to establish whether demographic variables impact any of the subscales. ‘Age’, ‘Gender’, ‘Nationality’, ‘Education’, ‘Grade’, ‘Years of Experience as a Nurse’, ‘Working Place’, ‘Working Shift’ and ‘Working Hours’ were tested against ‘Autonomy’, ‘Environmental Mastery’, ‘Personal Growth’, ‘Positive Relations with Others’, ‘Purpose in Life’ and ‘Self-Acceptance’. All results were illustrated with their respective subscales as follows.

4.5.1 AUTONOMY SUBSCALE

‘Table 4.4 Demographic Variables against Autonomy Subscale Results’ presents the results of the analysis of demographic variables compared to the ‘Autonomy’ subscale.

Table 4.4 Demographic Variables against Autonomy Subscale Results

AUTONOMY			
Demographic Variable	Mean Rank	U (Z)	p-Value
Working Place* In-Patient Care Community Care	98.83 99.93	4363.500 (-0.060)	0.952
Demographic Variable	Mean Rank	H (Degree of Freedom)	p-Value
Age 18-20 Years 21-30 Years 31-40 Years 41-50 Years 51+ Years	36.63 106.84 97.43 92.39 103.54	6.888 (4)	0.142
Gender Males Females Other	94.75 101.68 65.50	1.030 (2)	0.597
Nationality Maltese European Non-European	98.60 101.00 102.78	0.086 (2)	0.958
Education Diploma in Nursing Degree in General Nursing Degree in Mental Health Nursing Master's	116.35 93.20 96.54 87.26	6.719 (3)	0.081
Grade Enrolled Nurses Staff Nurses Senior Staff Nurses Registered Mental Health Nurses Charge Nurses	111.25 112.00 82.33 109.35 99.12	11.350 (4)	0.023
Years of Experience as a Nurse >1-5 Years 6-10 Years 11-15 Years 16-20 Years 21+ Years	112.44 93.58 108.05 82.23 90.40	7.985 (4)	0.092
Working Shift Regular Shift Day Shift Only Night Shift Only	99.17 97.07 163.25	2.667 (2)	0.264
Working Hours Full Time Reduced Hours	99.45 10.50	2.457 (1)	0.117

** This Variable has been Analysed using Mann-Whitney U Non-Parametric Test*

The results of Kruskal-Wallis H Test show a statistically significant difference in the 'Grade' variable on the 'Autonomy' subscale [$H(4)=11.350$, $p=0.02$]. Thus, this was followed by a Mann-Whitney U Test for in-between the 'Grade' subgroups namely 'Enrolled Nurses' (Mean Rank=111.25), 'Staff Nurses' (Mean Rank=112.00), 'Senior Staff Nurses' (Mean Rank=82.33), 'Registered Mental Health Nurses' (Mean Rank=109.35) and 'Charge Nurses' (Mean Rank=99.12). Furthermore, this revealed a statistical significance between the 'Senior Staff Nurses' subgroup and

‘Staff Nurses’ [U=1885.50, Z=-3.181, p=<0.01] as well as ‘Registered Mental Health Nurses’ [U=634.50, Z=-1.924, p=<0.05].

These findings suggest that ‘Staff Nurses’ and ‘Registered Mental Health Nurses’ exhibit a higher sense of self-determination and independence. They are more capable of resisting societal pressures to conform to specific thoughts and actions, regulating their behaviour based on internal motivations, and evaluating themselves according to personal standards. In comparison, ‘Senior Staff Nurses’ appear to have relatively lower levels of self-determination and independence. No other subgroups from the ‘Grade’ variable showed any statistical differences with the ‘Autonomy’ subscale.

No other statistically significant correlations were established when Autonomy was compared with ‘Age’ [H(4)=6.888, p=0.14], ‘Gender’ [H(2)= 1.030, p=0.60], ‘Nationality’ [H(2)=0.086, p=0.96], ‘Education’ [H(3)=6.719, p=0.08], ‘Years of Experience as a Nurse’ [H(4)=7.985, p=0.09], ‘Working Shift’ [H(2)=2.667, p=0.26], and ‘Working Hours’ [H(1)=2.457, p=0.12].

The Mann-Whitney U Test was also used to compare the different two groups of ‘Working Place’; being Community Care and In-Patient Care. No statistically significant correlations were found in relation to ‘Autonomy’ and ‘Working Place’ [U=4363.500, Z=-0.060, p=0.95] which consisted of ‘Community Care’ and ‘In-Patient Care’.

4.5.2 ENVIRONMENTAL MASTERY SUBSCALE

‘Table 4.5 Demographic Variables against Environmental Mastery Subscale Results’ illustrates the results produced when demographic variables were compared to the ‘Environmental Mastery’ subscale.

Table 4.5 Demographic Variables against Environmental Mastery Subscale Results

ENVIRONMENTAL MASTERY			
Demographic Variable	Mean Rank	U (Z)	Significance Level
Working Place* In-Patient Care Community Care	99.40 98.25	4335.000 (-0.135)	0.893
Demographic Variable	Mean Rank	H (Degree of Freedom)	Significance Level
Age 18-20 Years 21-30 Years 31-40 Years 41-50 Years 51+ Years	96.25 105.85 97.55 94.87 95.82	1.253 (4)	0.869
Gender Males Females Other	96.60 101.04 14.50	2.503 (2)	0.286
Nationality Maltese European Non-European	98.89 132.60 89.96	2.182 (2)	0.336
Education Diploma in Nursing Degree in General Nursing Degree in Mental Health Nursing Master's	99.68 79.04 100.50 125.18	13.582 (3)	0.004
Grade Enrolled Nurses Staff Nurses Senior Staff Nurses Registered Mental Health Nurses Charge Nurses	107.83 96.63 93.79 97.65 124.69	5.215 (4)	0.266
Years of Experience as a Nurse 0-5 Years 6-10 Years 11-15 Years 16-20 Years 21+ Years	109.73 107.60 90.43 91.48 89.50	5.537 (4)	0.236
Working Shift Regular Shift Day Shift Only Night Shift Only	98.96 97.65 153.50	1.886 (2)	0.389
Working Hours Full Time Reduced Hours	99.34 32.00	1.400 (1)	0.237

** This Variable has been Analysed using Mann-Whitney U Non-Parametric Test*

The results produced from the Kruskal-Wallis H Test show that there were no statistically significant differences when 'Age' [H(4)=1.253, p=0.87], 'Gender' [H(2)=2.503, p=0.29], 'Nationality' [H(2)= 2.182, p=0.34], 'Grade' [H(4)=5.215, p=0.27], 'Years of Experience as a Nurse' [H(4)=5.537, p=0.24], 'Working Shift' [H(2)=1.886, p=0.39] and 'Working Hours' [H(1)=1.400, p=0.24] were analysed on the 'Environmental Mastery' subscale.

However, the 'Education' variable [$H(3)=13.582$, $p<0.01$] showed a statistical significance difference on the 'Environmental Mastery' subscale. Consequently, a Mann-Whitney U Test was conducted for in-between subgroups of the 'Education' variable, namely on 'Diploma in Nursing' (Mean Rank=99.68), 'Degree in General Nursing' (Mean Rank=79.04), 'Degree in Mental Health Nursing' (Mean Rank=100.50), and 'Master's Degree' (Mean Rank=124.69). This showed that the 'Master's Degree' subgroup was a common denominator which statistically differed from both 'Degree in General Nursing' [$U=436.00$, $Z=-3.888$, $p<0.01$] and 'Degree in Mental Health Nursing' subgroup [$U=797.00$, $Z=-2.084$, $p=0.04$]. Furthermore, the 'Degree in Mental Health Nursing' statistically differed from 'Degree in General Nursing' [$U=1245.500$, $Z=-2.071$, $p=0.04$] on the 'Personal Growth' subscales.

This suggests that participants who held a 'Degree in Mental Health Nursing' felt more in control of their external environment when compared to those with a 'Degree in General Nursing'. Moreover, participants who had obtained a 'Master's Degree' were more inclined to agree that they possess a sense of mastery and competence in managing their environment. They demonstrated the ability to control a diverse range of external activities, effectively utilise available opportunities, and select or create contexts that align with their personal needs and values. In comparison, participants with a 'Degree in General Nursing' and a 'Degree in Mental Health Nursing' were relatively less likely to hold these perceptions of mastery and competence. No other subgroups from the 'Grade' variable showed any statistical differences with the 'Environmental Mastery' subscale.

A between-group comparison was then analysed using the Mann-Whitney U Test which showed no statistically significant differences for 'Working Place' [$U= 4335.000$, $Z=-0.135$, $p=0.89$].

4.5.3 PERSONAL GROWTH SUBSCALE

'Table 4.6 Demographic Variables against Personal Growth Subscale Results' shows that the results were created when demographic variables were compared to the 'Personal' Growth subscale.

Table 4.6 Demographic Variables against Personal Growth Subscale Results

PERSONAL GROWTH			
Demographic Variable	Mean Rank	U (Z)	Significance Level
Working Place* In-Patient Care Community Care	95.06 106.49	3877.000 (-1.346)	0.178
Demographic Variable	Mean Rank	H (Degree of Freedom)	Significance Level
Age 18-20 Years 21-30 Years 31-40 Years 41-50 Years 51+ Years	70.25 90.34 105.44 82.14 126.45	16.259 (4)	0.003
Gender Males Females Other	91.94 103.08 89.50	1.779 (2)	0.411
Nationality Maltese European Non-European	97.93 53.70 124.91	6.605 (2)	0.037
Education Diploma in Nursing Degree in General Nursing Degree in Mental Health Nursing Master's	101.46 100.48 91.37 107.37	2.011 (3)	0.570
Grade Enrolled Nurses Staff Nurses Senior Staff Nurses Registered Mental Health Nurses Charge Nurses	138.92 92.22 102.68 94.22 102.93	4.591 (4)	0.332
Years of Experience as a Nurse 0-5 Years 6-10 Years 11-15 Years 16-20 Years 21+ Years	92.68 87.58 98.48 88.31 115.08	7.649 (4)	0.105
Working Shift Regular Shift Day Shift Only Night Shift Only	96.50 102.58 108.25	0.591 (2)	0.744
Working Hours Full Time Reduced Hours	99.30 41.00	1.054 (1)	0.305

** This Variable has been Analysed using Mann-Whitney U Non-Parametric Test*

Results gathered from the Kruskal-Wallis H Test highlighted a statistical significance for the 'Age' variable on the 'Personal Growth' subscale [$H(4)=16.259$, $p<0.01$]. The Mann-Whitney U Test was then utilised to analyse any statistical differences for in-between subgroups of the 'Age' variable. This revealed that the age group of '51+ Years' was a common denominator which statistically differed from the '21-30 Years' [$U=703.500$, $Z=-3.164$, $p<0.01$] and '41-50 Years' [$U=497.000$, $Z=-3.558$, $p<0.01$] age groups on the 'Personal Growth' subscale. Moreover, a statistical difference was explored between the '31-40 Years' and '41-50 Years' age groups

[$U=874.00$, $Z=-2.042$, $p=0.04$]. The remaining subgroup of '18-20 Years' (Mean Rank=70.25) showed no statistical difference with the 'Personal Growth' subscale.

The Kruskal-Wallis H Test showed another statistical difference for the 'Nationality' variable on the 'Personal Growth' Subscale [$H(2)=6.605$, $p=0.04$]. Hence the 'Nationality' variable was analysed for its in-between subgroups for any statistical differences on the 'Personal Growth subscale'. The Mann-Whitney U Test was used in order to perform the in-between subgroups analyses, namely the 'Maltese' (Mean Rank=97.93), 'European' (Mean Rank=53.70) and 'Non-European' (Mean Rank=124.91). A statistically significant difference resulted from the 'European' and 'Non-European' [$U=11.000$, $Z=-2.487$, $p=0.01$]. No other subgroups from the 'Nationality' variable showed any statistical differences with the 'Personal Growth' subscale.

This implies that participants within the age group of '51+ Years' felt a better sense of personal growth when compared to participants in the age groups of '21-30 Years' and '41-50 Years'. Moreover, participants in the age group '41-50 Years' see themselves growing and continuously developing themselves, are open to new experiences and realise their potential. In addition, these participants perceive personal growth and positive changes in their behaviour over time. They actively strive to align their actions with increased self-awareness and effectiveness, especially when compared to individuals in the age group of '31-40 Years'. Furthermore, participants of non-European backgrounds also exhibit a strong belief in continuous self-development and the realisation of their potential, surpassing the level observed among European participants.

Meanwhile, no statistically significant results were found between the 'Personal Growth' subscale with 'Education' [$H(3)=2.011$, $p=0.57$], 'Grade' [$H(4)=4.591$, $p=0.33$], 'Years of Experience as a Nurse' [$H(4)=7.649$, $p=0.11$], 'Working Shift' [$H(2)=0.591$, $p=0.74$], and 'Working Hours' [$H(1)=1.054$, $p=0.31$].

The Mann-Whitney U Test was then used for a between-group comparison for the 'Working Place' [$U=3877.000$, $Z=-1.346$], $p=0.18$]. The test showed no statistically significant difference against the 'Personal Growth' subscale.

4.5.4 POSITIVE RELATIONS WITH OTHERS SUBSCALE

‘Table 4.7 Demographic Variables against ‘Positive Relations with Others’ Subscale Results’ reveals the results obtained when demographic variables were compared to the ‘Positive Relations with Others’ subscale.

Table 4.7 Demographic Variables against Positive Relations with Others Subscale Results

POSITIVE RELATIONS WITH OTHERS			
Positive Relations With Others	Mean Rank	U (Z)	Significance Level
Working Place*			
In-Patient Care	96.31	4038.500 (-0.919)	0.358
Community Care	104.11		
Positive Relations With Others	Mean Rank	H (Degree of Freedom)	Significance Level
Age			
18-20 Years	138.00	3.031 (4)	0.553
21-30 Years	98.30		
31-40 Years	103.78		
41-50 Years	91.68		
51+ Years	98.54		
Gender			
Males	89.00	3.520 (2)	0.172
Females	104.52		
Other	118.50		
Nationality			
Maltese	99.30	1.390 (2)	0.499
European	122.10		
Non-European	88.47		
Education			
Diploma in Nursing	94.08	2.185(3)	0.535
Degree in General Nursing	95.96		
Degree in Mental Health Nursing	107.64		
Master's	94.63		
Grade			
Enrolled Nurse	73.67	6.583 (4)	0.160
Staff Nurse	97.11		
Senior Staff Nurse	92.50		
Registered Mental Health Nurse	114.70		
Charge Nurse	118.74		
Years of Experience as a Nurse			
0-5 Years	105.59	3.898 (4)	0.420
6-10 Years	94.65		
11-15 Years	113.45		
16-20 Years	87.65		
21+ Years	93.45		
Working Shift			
Regular Shift	94.61	3.933 (2)	0.140
Day Shift Only	104.05		
Night Shift Only	163.75		
Working Hours			
Full Time	98.99	0.001 (1)	0.979
Reduced Hours	100.50		

* This Variable has been Analysed using Mann-Whitney U Non-Parametric Test

No statistical significance was found when this subscale was compared to all the variables, namely 'Age' [H(4)=3.031, p=0.55], 'Gender' [H(2)=3.520, p=0.17], 'Nationality' [H(2)=1.390, p=0.50], 'Education' [H(3)=2.185, p=0.54], 'Grade' [H(4)=6.583, p=0.16], 'Years of Experience as a Nurse' [H(4)=3.898, p=0.42], 'Working Shift' [H(2)=3.933, p=0.14], and 'Working Hours' [H(1)=0.001, p=0.98]. Thus, no in-between variable analyses using the Mann-Whitney U Test needed to be performed.

However, the Mann-Whitney U Test was still utilised for a between-group comparison for the 'Working Place' [U=4038.500, Z=-0.919), p=0.36]. The test also showed no statistically significant difference against the 'Personal Growth' subscale.

4.5.5 PURPOSE IN LIFE SUBSCALE

'Table 4.8 Demographic Variables against 'Purpose in Life' Subscale Results' shows that the results were created when demographic variables were compared to the 'Purpose in Life' subscale.

Table 4.8 Demographic Variables against Purpose in Life Subscale Results

PURPOSE IN LIFE			
Demographic Variable	Mean Rank	U (Z)	Significance Level
Working Place*			
In-Patient Care	96.39	4049.500 (-0.889)	0.374
Community Care	103.95		
Demographic Variable	Mean Rank	H (Degree of Freedom)	Significance Level
Age			
18-20 Years	91.75	7.737 (4)	0.102
21-30 Years	95.31		
31-40 Years	98.41		
41-50 Years	87.05		
51+ Years	120.08		
Gender			
Males	109.82	4.079 (2)	0.130
Females	92.81		
Other	104.00		
Nationality			
Maltese	100.13	3.029 (2)	0.220
European	55.40		
Non-European	100.19		
Education			
Diploma in Nursing	119.69	22.549 (3)	<0.001
Degree in General Nursing	88.17		
Degree in Mental Health Nursing	78.70		
Master's	123.04		
Grade			
Enrolled Nurses	146.17	6.958 (4)	0.138
Staff Nurses	93.41		
Senior Staff Nurses	99.67		
Registered Mental Health Nurses	88.83		
Charge Nurses	113.45		
Years of Experience as a Nurse		7.005 (4)	0.136

0-5 Years	89.38		
6-10 Years	90.29		
11-15 Years	89.90		
16-20 Years	111.08		
21+ Years	111.35		
Working Shift			
Regular Shift	95.24	4.018 (2)	0.134
Day Shift Only	106.32		
Night Shift Only	39.25		
Working Hours			
Full Time	98.97	0.008 (1)	0.930
Reduced Hours	104.00		

** This Variable has been Analysed using Mann-Whitney U Non-Parametric Test*

A statistical significance difference was observed in the 'Education' variable [$H(3)=22.549$, $p<0.01$] on the 'Purpose of Life' subscale when the Kruskal-Wallis H Test was used. The Mann-Whitney U Test was then utilised for in-between subgroups of the 'Education' variable, namely 'Diploma in Nursing' (Mean Rank=119.69), 'Degree in General Nursing' (Mean Rank=88.17), 'Degree in Mental Health Nursing' (Mean Rank=78.70) and 'Master's Degree' (Mean Rank=123.04).

This showed that 'Diploma in Nursing' statistically differed from 'Degree in General Nursing' [$U=866.000$, $Z=-2.656$, $p<0.01$] and 'Degree in Mental Health Nursing' [$U=944.000$, $Z=-3.533$, $p<0.01$] on the 'Purpose of Life' subscale. Moreover, 'Degree in General Nursing' differed from 'Master's Degree' [$U=526.000$, $Z=-3.081$, $p<0.01$], whilst 'Degree in Mental Health Nursing' also differed from 'Master's Degree' [$U=563.500$, $Z=-3.863$, $p<0.01$] on the 'Purpose of Life' subscale. No other subgroups from the 'Education' variable showed any statistical differences with the 'Purpose of Life' subscale.

This suggests that participants with a 'Degree in General Nursing' and 'Degree in Mental Health Nursing' had a better purpose in life when compared to participants with a 'Diploma in Nursing'. Furthermore, participants who possess a 'Master's Degree' express a stronger sense of having life goals and a clear sense of direction. They perceive meaning in both their present and past experiences, hold beliefs that provide purpose to their lives, and have specific aims and objectives. In comparison, participants with a 'Degree in General Nursing' and/or 'Degree in Mental Health Nursing' exhibit a relatively lower degree of these aspects related to goal-setting and life direction.

No other statistical significance was found for the 'Purpose in Life' subscale when compared to demographic variables of 'Age' [$H(4)=7.737$, $p=0.10$], 'Gender' [$H(2)=4.079$, $p=0.13$], 'Grade'

[H(4)=6.958, p=0.14], ‘Years of Experience as a Nurse’ [H(4)=7.005, p=0.14], ‘Working Shift’ [H(2)=4.018, p=0.13], and ‘Working Hours’ [H(1)=0.008, p=0.93].

The Mann-Whitney U Test was then used for the ‘Working Place’ [U=4049.500, Z=-0.889, p=0.37] variable which showed no significance when compared against the ‘Purpose in Life’ subscale.

4.5.6 SELF-ACCEPTANCE SUBSCALE

‘Table 4.9 Demographic Variables against ‘Self-Acceptance’ Subscale Results’ displays the results produced when demographic variables were associated with the ‘Self-Acceptance’ subscale.

Table 4.9 Demographic Variables against Self-Acceptance Subscale Results

SELF-ACCEPTANCE			
Demographic Variable	Mean Rank	U (Z)	Significance Level
Working Place In-Patient Care Community Care	98.26 100.40	4291.000 (-0.252)	0.801
Demographic Variable	Mean Rank	H (Degree of Freedom)	Significance Level
Age 18-20 Years 21-30 Years 31-40 Years 41-50 Years 51+ Years	70.13 89.92 94.94 113.11 104.03	5.971 (4)	0.201
Gender Males Females Other	103.63 97.05 14.00	2.885 (2)	0.236
Nationality Maltese European Non-European	97.80 59.00 124.75	5.904 (2)	0.052
Education Diploma in Nursing Degree in General Nursing Degree in Mental Health Nursing Master’s	118.21 103.44 81.21 97.62	12.239 (3)	0.007
Grade Enrolled Nurses Staff Nurses Senior Staff Nurses Registered Mental Health Nurses Charge Nurses	88.67 105.18 97.79 83.74 101.81	2.824 (4)	0.588
Years of Experience as a Nurse 0-5 Years 6-10 Years 11-15 Years 16-20 Years 21+ Years	90.73 105.73 96.73 90.40 109.21	4.362 (4)	0.359
Working Shift Regular Shift Day Shift Only Night Shift Only	99.72 98.01 94.75	0.054 (2)	0.973

Working Hours			
Full Time	99.36	1.541 (1)	0.214
Reduced Hours	29.00		

** This Variable has been Analysed using Mann-Whitney U Non-Parametric Test*

The results of the Kruskal-Wallis H Test demonstrated a statistical significance between the 'Education' variable [$H(3)=12.239$, $p=<0.01$] and the 'Self-Acceptance' subscale. A Mann-Whitney U Test was performed for the in-between groups of the 'Education' variable on the 'Self-Acceptance' subscale, namely 'Diploma in Nursing' (Mean Rank=118.21), 'Degree in General Nursing' (Mean Rank=103.44), 'Degree in Mental Health Nursing' (Mean Rank=81.21), 'Master's Degree' (Mean Rank=97.62).

A statistically significant difference was found between the in-between groups of the 'Education' Variables where 'Degree in Mental Health Nursing' was a common denominator which differed from 'Diploma in Nursing' [$U=993.500$, $Z=-3.253$, $p=<0.01$] and 'Degree in General Nursing' [$U=1213.000$, $Z=-2.272$, $p=0.02$] on the 'Self-Acceptance' subscale. No other subgroups from the 'Education' variable showed and statistical differences with the 'Self-Acceptance' subscale.

These findings indicate that nurses with a 'Degree in Mental Health Nursing' demonstrated a relatively lower positive attitude towards themselves and a lesser acceptance of various aspects of life. In comparison, participants with a 'Diploma in Nursing' and a 'Degree in General Nursing' expressed a positive attitude towards themselves, acknowledged and accepted multiple facets of their identity, including both positive and negative qualities, and held positive sentiments towards their past experiences.

The Mann-Whitney U Test did not reveal any statistically significant difference when the 'Working Place' [$U=4291.000$, $Z=-0.252$, $P=0.80$] was compared to the 'Self-Acceptance' subscale. Furthermore, no other significant differences were seen when the 'Self-Acceptance' subscale was compared with 'Age' [$H(4)=5.971$, $p=0.20$], 'Gender' [$H(2)=2.885$, $p=0.24$], 'Nationality' [$H(2)=5.904$, $p=0.05$], 'Grade' [$H(4)=2.824$, $p=0.59$], 'Years of Experience as a Nurse' [$H(4)=4.632$, $p=0.36$], 'Working Shift' [$H(2)=0.054$, $p=0.97$], 'Working Hours' [$H(1)=1.541$, $p=0.21$].

4.6 INTERCORRELATIONS BETWEEN RYFF'S PWB SUBSCALES

The Spearman-Rank Correlation Test was utilised in order to examine the inter-correlations gathered in Ryff's SPWB (Ryff, 2014). 'Table 4.10 Results of the Intercorrelations between Ryff's PWB Subscales' illustrates the results produced using the Spearman-Rank Correlation Test.

Table 4.10 Results of the Intercorrelations between Ryff's PWB Subscales

Subscales	Autonomy	Environmental Mastery	Personal Growth	Positive Relations with Others	Purpose in Life	Self-Acceptance
Autonomy Spearman's Correlation Difference	1.000 00.000	0.368** <0.001	0.157 0.028	0.303* <0.001	0.339** <0.001	0.420** <0.001
Environmental Mastery Spearman's Correlation Difference	0.368** <0.001	1.000 00.00	0.290** <0.001	0.407** <0.001	0.214** 0.002	0.300** <0.001
Personal Growth Spearman's Correlation Difference	0.157* 0.028	0.290** <0.001	1.000 00.00	0.191** 0.007	0.323** <0.001	0.370** <0.001
Positive Relations with Others Spearman's Correlation Difference	0.303** <0.001	0.407** <0.001	0.191** 0.007	1.000 00.00	0.092 0.199	0.252** <0.001
Purpose in Life Spearman's Correlation Difference	0.339** <0.001	0.214** 0.002	0.323** <0.001	0.092 0.199	1.000 00.00	0.286** <0.001
Self-Acceptance Spearman's Correlation Difference	0.420** <0.001	0.300** <0.001	0.370** <0.001	0.252** <0.001	0.286** <0.001	00.00 197
** Correlation is significant at the 0.01 level (2-tailed) * Correlation is significant at the 0.05 level (2-tailed)						

Significant positive inter-correlations with each subscale were identified. This showed that all subscales have a positive correlation with each other.

4.7 CONCLUSION

The results obtained in this chapter highlight the findings gathered by using Ryff's SPWB (Ryff, 2014) compared to the demographic variables. The six subscales were discovered to correlate with each other. Moreover, all participants responded positively to five of the six subscales: 'Autonomy', 'Environmental Mastery', 'Personal Growth', 'Positive Relations with Others' and 'Self-Acceptance'. The subscale of 'Purpose in Life' was just below the midpoint, but still very close. Therefore, this implies that the well-being of nurses working in the Mental Health Service is overall positive.

After conducting the test of normality, which showed that data was not normally distributed ($p \leq 0.05$), non-parametric tests seemed more appropriate to use for data analysis. Various significant differences were shown between the six subscales and the demographic variables, namely the 'Grade', 'Education', 'Age' and 'Nationality' variables. Only one subscale, the 'Positive Relations with Others', had no significant differences when compared to the socio-demographic characteristics. Lastly, it was revealed that an intercorrelation amongst each of the six subscales was present between each other.

No statistical significance was observed between community and in-patient settings when compared to Ryff's PWB subscales. Therefore, the hypothesis that nurses working in the community mental health setting experience better well-being than those working in an in-patient mental health setting was rejected. Additionally, no significance occurred between the 'Shift' variables, thus the hypothesis that nurses working regular shifts experience lower-level well-being, was also rejected.

The next chapter will construe and critically analyse the results. The findings will also be compared with the international literature and their implications will be discussed in relation to the well-being of nurses working in the community and in-patient mental health settings.

Chapter Five

DISCUSSION

5.0 INTRODUCTION

The findings reported in the previous chapter will be thoroughly discussed throughout this chapter. The discussion will analyse, contrast, and critically assess the PWB of nurses working in Malta's community and in-patient mental health sectors; by using Ryff's SPWB on this research study's participants and comparing the results to existing literature. The analysis of the demographic factors in relation to the local context and relevant literature will also be reviewed and discussed.

5.1 MALTESE NURSES' WELL-BEING IN IN-PATIENT & COMMUNITY MENTAL HEALTH CARE

Research shows that occupational pressures and expectations frequently have an influence on nurses' well-being (Loukzadeh & Bafrooi, 2013). Previous studies on the well-being of nurses that utilised Ryff's SPWB mainly focused on the experiences of nurses in in-patient and/or community settings. Few studies namely, Oates et al. (2017); Foster et al. (2020); Delgado et al. (2021); McTiernan & McDonald (2015); Ye-Won & Choi Bong-Sil (2021); and Leka et al. (2012) have explored the use of Ryff's SPWB with nurses working in a psychiatric setting.

The well-being of nurses working in in-patient and community settings is grossly understudied, with insufficient literature on the topic. Therefore, the present study focused on nurses who work in both settings within mental health services in Malta. This study was the first to examine and compare the well-being encountered by nurses working in in-patient and community mental health settings in Malta, and also, aimed to address this topic on an international level.

5.2 PARTICIPANTS' DEMOGRAPHICS: ANALYSING KEY CHARACTERISTICS

In this section, the demographic characteristics of the participants will be explored, drawing comparisons with the demographic characteristics of participants in previous studies, referenced in the 'Literature Review' (Chapter 2). Such a comparative analysis enables a critical evaluation of the present study's findings, taking into account any differences in demographic profiles between the current and previous literature.

Most participants in this study reportedly identified as female (60%), which reflects the current situation in the Maltese healthcare setting concerning the lack of male nurses. Similar gender discrepancies were discovered in studies undertaken elsewhere, including those conducted in Australia by Delgado et al. (2021) and Foster et al. (2020), Japan by Leka et al. (2012), Ireland by McTiernan & McDonald (2015), and the United Kingdom by Oates et al. (2017). This implies that, locally, gender is not a significant determinant in the use of Ryff's PWB in relation to nurses working in mental healthcare.

According to the MUMN, there are currently more General Nurses (nurses with a Diploma or a Degree in General Nursing) than MHNs, who work in mental health settings. It is worth noting that nurses with General Nursing credentials and those with a Degree in Mental Health Nursing fulfil the same tasks and obligations in these situations. To address this issue, a strong effort is being made to encourage general nurses to pursue further training in mental health nursing, which equips them with specific abilities in this field and allows them to give optimal care to service users. Against this context, the current study adds to the worldwide literature by evaluating participant answers based on the kind of nursing qualification held within the same environment.

65.5% of participants in the present study worked in an in-patient setting, whereas the other 34.5% worked in a community mental health setting. These results were compared to those reported in other studies, such as McTiernan & McDonald (2015), who found that 52% of participants worked in in-patient wards and 48% worked in community mental health settings; Delgado et al. (2021), discovered that 45.7% of participants worked in a hospital setting and 40.7% worked in community settings; and Foster et al. (2020) who uncovered that 44% of participants worked in a hospital setting and 41% worked in community settings. These findings shed light on the distribution of MHNs across various settings and can provide further insight into the problems and demands of nursing in each environment. The mental health community has been on the rise throughout the years, emphasising the importance of providing care to individuals whilst keeping them in the community. However, at present, there is still a higher percentage of nurses working in an in-patient setting.

The findings for the variable 'Years of Experience as a Nurse' established a higher distribution in the subgroup of >1-5 years (33.5%) and 51+ years (31%). When these findings were compared to those of other research, a fluctuation in the proportion of individuals with varying degrees of expertise was observed. Oates et al. (2017) had similar characteristics within this variable (0-5

Years: 25.6%, >21 Years: 28.7%). Meanwhile, Foster et al. (2020) and Delgado et al. (2021) had a larger subgroup with 0-5 years, whereas Foster et al.'s study had 38% and Delgado et al.'s study had <10 years' experience group consisted of 43.6%. Despite this, the current study included individuals with varying levels of experience in order to provide a broader viewpoint on the topic. Furthermore, incorporating people with differing degrees of expertise in mental health settings might aid in understanding the various views and ways to cope with mental health concerns.

In the context of this study, the SDT provided a framework for understanding how nurses perceived autonomy, competence, and relatedness to their colleagues, as well as how patients impact their overall well-being (Deci & Olafsen, 2017). This study utilised SDT to evaluate the relationships between autonomy, relatedness, competence and well-being, as well as how organisational support, role clarity, and professional development opportunities may influence these factors. Therefore, using SDT as a theoretical lens enhanced the understanding of the complex interplay between various factors that influence nurses' well-being in in-patient and community mental health settings. Given the compatibility of the SDT framework, together with the current study, this theoretical approach has been adopted and consequently applied to each finding in order to further understand the results obtained.

5.3 AN OVERVIEW ON NURSES' WELL-BEING

The following section will compare the present study's findings to those obtained from previous studies which utilised Ryff's SPWB.

In the studies conducted by Foster et al. (2020), Delgado et al. (2021) and Ye-won & Bong-sil (2021), the PWB of nurses was relatively high. This was similar to this current research study in which the participants' overall well-being was moderately high. Foster et al. (2020) elaborated on this, arguing that nurses' positive PWB has been consistent with other studies.

The highest Mean Score in Delgado et al.'s study (2021) was for 'Personal Growth', whereas the lowest mean score for the subscales was that of 'Autonomy', demonstrating that participants' feelings of progress, growth, and attaining their own potential were greater than their capacity to engage in self-evaluation, make decisions based on their own judgements, and self-determination. Meanwhile, Ye-Won and Bong-sil (2021) argue that 'Self-Acceptance' and 'Environmental Mastery' had the highest scores when determining factors that impact PWB. Contrary to Delgado

et al.'s (2021) study, in the present study, the highest mean score was for the subscale of 'Autonomy' and the lowest mean score was for the 'Purpose in Life' subscale. This indicates that participants' feelings to engage in self-evaluation, make decisions based on their own judgements, and self-determination was higher than experiencing feelings of having a sense of meaning in life, having various goals and aims, having a sense of direction and seeing the purpose of past life. Nurses might have scored lower on the purpose of life due to the emotionally demanding nature of the profession. This is reflected by the fact that nurses in Malta often work long shifts, typically lasting approximately twelve hours.

These findings could be attributed to several factors. For instance, Rouhi-Balasi (2020) elaborated on one of these factors by stating that working in a mental health setting often requires nurses to take certain independent decisions and exercise autonomy, improving their sense of control and self-determination. Loukzadeh & Bafrooi (2013) corroborated this by stating that long hours might impact their sense of purpose in life, which could also be hindered due to high workload, limited resources, and personal fulfilment. Furthermore, it was discussed how the focus on addressing the mental health needs of patients may lead to a greater emphasis on immediate patient care rather than personal fulfilment and long-term life goals.

Finally, Ye-Won and Bong-sil (2021) claimed that education had a significant effect, on the factors impacting PWB. Comparably, the present study utilised three subscales which showed statistical significance on the 'Education' demographic variable. This suggests that the 'Education' variable impacted the nurses' overall well-being the most; therefore the hypothesis that education impacts the well-being of nurses was accepted.

The following sections will further elaborate on the subscales of Ryff's PWB (Ryff, 2014). Each subscale will be assessed and compared with the demographic variables.

5.3.1 AUTONOMY SUBSCALE

MacDonald (2002) elaborated on how nurses who possess autonomy would therefore have more control over their practice and a higher freedom to exercise their clinical judgment. Thompson et al. (2012) added how the extent and nature of the nurses' autonomy are mainly influenced by the work environment and their perceptions of their own autonomy. Rao et al. (2017) emphasised how being autonomous in the nursing profession is indeed regarded as vital, and carries with it several advantages. In fact, according to Frank (2012), when nurses feel autonomous, they are

better suited to provide person-centred care which is tailored to the individual's needs. By providing individualised care, patient outcomes are often improved and the recovery time is shortened. Moreover, Rouhi-Balasi (2020) argued that autonomy also enhances collaboration between the multidisciplinary team, as it encourages nurses to take certain decisions independently whilst also improving communication and collaboration. In turn, this allows nurses to develop their clinical and leadership skills which helps them advance their careers. Lastly, Iliopoulou et al. (2010) elaborated that since autonomy empowers nurses to take certain independent decisions aligned with their professional values, it also motivates nurses to perform better in their work which, in turn, also increases their job satisfaction.

The results of the present study demonstrated that nurses working within Maltese mental health services felt autonomous. In relation to the 'Autonomy' subscale, the current study received the highest rating out of the six subscales. This indicates that participants may have felt that they could take certain decisions independently and were not influenced by external perceptions. Since the nursing profession in mental health involves a great degree of independent decision-making and responsibility, nurses in this field may have had more opportunities to exercise autonomy in their daily practice. Moreover, nurses in the mental health field often formulate care plans and take certain treatment decisions independently, which requires them to adapt quickly to changing situations by making critical judgments which can foster a sense of autonomy. In fact, Thompson et al. (2012) expand on this point, noting that nurses' contribution to implementing their own individualised care plan might have occurred due to a supportive and collaborative environment which motivates nurses to empower their service users to be more autonomous, whilst also reflecting on their own sense of autonomy.

A statistically significant difference was observed in the 'Grade' variable on the 'Autonomy' subscale, between 'Staff Nurses' and 'Senior Staff Nurses', and 'Senior Staff Nurses' and 'Registered Mental Health Nurses'. Both 'Staff Nurses' and 'Registered Mental Health Nurses' felt more autonomous when compared to 'Senior Staff Nurses'.

When compared to Senior Staff Nurses (SSN), Staff Nurses (SN) who participated in this study had a higher score on the 'Autonomy' subscale. SNs may be able to focus more on direct patient care, allowing them to take more autonomous decisions within their area of expertise. Moreover, the SN grade typically indicates that nurses belonging to this subgroup are relatively newer recruits, thus they might have had greater training in areas such as critical thinking and decision-making as

part of their nursing Degree or Diploma programme of studies. This may make them more inclined to engage in ongoing professional development and stay updated with the latest research which may contribute to their ability to work autonomously. Weston (2010) opines that nurses who tend to focus on direct patient care are more capable of making choices autonomously within their area of practice. Furthermore, Ponto (2011) commented on nurses that have received greater training in areas such as critical thinking, decision-making, and the need for reflective practice as part of their nursing programme of studies. Consequently, they may be more open to trying new things and taking on greater responsibilities. In fact, Widarsson et al. (2020), elaborated on how this may make them more inclined to engage in ongoing professional development and keep up to date with their professional practice, which may contribute to their capacity to operate more autonomously.

The findings of this research study, particularly with respect to Registered Mental Health Nurses (RMNs) scoring more than SSNs on the 'Autonomy' subscale, may also be attributed to RMNs receiving more specialised training to be able to provide for persons with mental health disorders. This may enhance their overall quality of care by delivering specific treatment approaches due to having a broader knowledge of the subject. Therefore, they may be more independent than their SSNs' colleagues when taking certain decisions related to patient care. Meanwhile, this may also motivate RMNs to actively participate in certain continuous professional development activities which may support them to keep up-to-date with the latest knowledge and development in practice, potentially increasing their capacity to operate more independently. The present study's results align with the findings obtained by Tummers et al (2001), which indicated that RMNs may feel more fully trained than SSNs working in a variety of mental health settings such as hospitals, clinics, or even community mental health teams. Additionally, Drury et al. (2005) explained that RMNs may give more personalised care and attention to their mental health patients in order to suit their requirements. RMNs frequently use a variety of treatment approaches, such as therapy and medication management which they learned in their Degree in Mental Health Nursing. Consequently, McKeown & White (2015) state how RMNs may find it easier to take certain choices about the best course of treatment for their patients. Ramalisa et al., (2018) elaborated on how MHNs indeed are more likely to participate in continuous professional development activities such as courses and training, which may contribute to their autonomy.

SSNs may have more experience and expertise than RMNs and SNs, however, this typically means that they have more responsibility, which might limit their feelings of autonomy. Additional

pressures on SSNs in a managerial role, in order to meet their superiors' expectations and stick to established norms, might hinder their capacity to work independently. SSNs may be responsible for supervising their colleagues' work and ensuring adherence to protocols, which may also impact their capacity to operate autonomously. As a result, they may be less inclined to take risks or make autonomous judgements, in order to avoid any possible hazards and/or implications. SSNs may also have additional administrative tasks, including staffing schedules, limiting their capacity to work independently. It should be noted that SSNs may have been practising as nurses for a longer time than RMNs and SNs; therefore, they could be more set in their ways and in turn, they might be less likely to try new approaches or take risks, especially as their training could have been more focused on the medical approach, experiencing less training on autonomy and critical thinking.

This finding aligns with Oshodi et al. study (2019) which provides insights into the factors that hinder nurses' autonomy. As stated by Oshodi et al. (2019), SSNs may feel additional pressure to meet their superiors' expectations and stick to established norms. Moreover, Rice (2022) discusses how SSNs may be responsible in some healthcare institutions for supervising the work of other nurses and ensuring that protocols and procedures are followed, subsequently, they may need to conform to organisational policies above their own decision-making, which may lead to burnout. Furthermore, Rice (2022) implies that SSNs may be more conscious of the possible hazards and implications of particular actions, and as a result, they may be more careful and seek assistance from their superiors, rather than take decisions autonomously. Griffiths et al. (2022) explained how additional administrative tasks limit the capacity to focus on patient care and work independently. Additionally, Drury et al. (2009) assume that SSNs may have been practising as nurses for a longer time than RMNs and therefore, their autonomy could be hindered by being more set in their ways and being less likely to try new approaches or take risks.

The finding that SNs and RMNs felt more autonomous when compared to SSNs aligns with the principles of SDT. SDT proposes that individuals have basic psychological needs, including autonomy (Deci, & Ryan, 1980). SNs and RMNs may have more direct patient care responsibilities and decision-making authority within their scope of practice, allowing them greater autonomy and the ability to fulfil their need for autonomy. In contrast, SSNs, who oftentimes have more administrative or managerial responsibilities and greater accountability, may experience more constraints on their decision-making, potentially limiting their perceived autonomy. The hierarchical structures within healthcare settings can also play a role, as SSNs may experience more external control and supervision.

Overall, this finding highlights the importance of considering autonomy as a crucial factor in nurses' well-being and job satisfaction, as outlined by SDT (Deci, & Ryan, 1980). This, therefore, implies that nurses who perceive themselves as more autonomous may experience higher levels of motivation, job engagement, and overall well-being. Understanding the factors which contribute to differences in perceived autonomy among nursing grades can provide valuable insights for healthcare organisations to create supportive work environments that enhance nurses' autonomy and, ultimately, promote their well-being.

No other statistically significant differences were observed when the 'Autonomy' subscale was compared with other grades. Moreover, no other statistical significances were observed with 'Age', 'Nationality', 'Education', 'Years of Experience as a Nurse', 'Working Shift', 'Working Hours' and 'Working Place' variables. Therefore, the aforementioned variables did not impact the nurses' autonomy.

5.3.2 ENVIRONMENTAL MASTERY SUBSCALE

Environmental competence is critical in the nursing profession for providing good quality patient care (Pahlevani et al., 2015). Loukzadeh & Bafrooi (2013) emphasised that developing environmental mastery skills is a continuous activity that can help nurses' ongoing professional growth and increase job satisfaction. In general, environmental mastery is a crucial component of nursing practice that may lead to improved patient care, enhanced work satisfaction, and general well-being for nurses.

The results of the present study determined that overall, nurses working within Maltese mental health services had a good sense of Environmental Mastery. This indicates that such nurses felt able to effectively manage and shape their external environment in ways that met their needs and goals. This scoring could be attributed to several factors; such as a supportive work environment characterised by effective leadership skills, supportive colleagues and multidisciplinary approaches to patient care promotes a sense of control among nurses. Additionally, access to regular training and professional development opportunities also empowers nurses to navigate their work responsibilities effectively. Cultural factors, such as a strong sense of community and social support, also play a role in fostering a positive work environment. Pahlevani et al. (2015) validated this by stating that nurses with a higher degree of environmental mastery are better able to manage their job demands and adapt to unexpected occurrences or changes in their environment. In this

case, being a mental health setting, it can often be an unpredictable environment. Nurses can successfully prioritise activities, handle stress in a healthy manner, and communicate effectively with other members of the healthcare team whilst also creating a positive work culture.

A statistically significant difference was observed in the 'Education' variable on the 'Environmental Mastery' subscale. A statistical difference occurred between 'Degree in General Nursing' and 'Degree in Mental Health Nursing'. Another statistical difference occurred between 'Master's Degree' and 'Degree in General Nursing', and 'Master's Degree' and 'Degree in Mental Health Nursing'. Participants with a 'Master's Degree' had a better sense of 'Environmental Mastery' when compared to those with a 'Degree in General Nursing' and a 'Degree in Mental Health Nursing'. Furthermore, participants with a 'Degree in Mental Health Nursing' felt more capable of managing and shaping their external environment to fulfil their needs and goals.

Pursuing a Master's Degree demands time and commitment, and may suggest a higher level of dedication to continued professional growth. Participants who obtained a Master's Degree may have scored higher on the 'Environmental Mastery' subscale as this niche of nurses may be more driven to keep learning and developing their abilities, which can contribute to a better feeling of environmental mastery. Additionally, these participants might have more specialised knowledge and training in mental health and psychiatric care, as the programme of studies frequently underlines the value of evidence-based practice, which can assist nurses in developing a more methodical and empirically-based approach to managing their work environment. This can also be attributed to their enhanced knowledge and training, as they may have a broader perspective on mental health nursing and the healthcare system as a whole which may allow them to view the larger picture and grasp how various components of the healthcare environment are interrelated. In turn, this may help them manage their work environment more efficiently.

Meyer & Shatto (2018) contributed to this by highlighting how Master's Degree courses tend to emphasise the value of leadership and management abilities; effective time management, prioritising, and communication, which are critical abilities for managing a complicated healthcare environment. Watson & Wells (1987) discussed how nurses with a Master's Degree may have more specialised knowledge which allows them to better manage the unique demands and challenges of the mental health setting, contributing to a greater sense of environmental mastery. Drennan (2010) also commented on how nurses who are provided with the skills and resources, take certain informed decisions and manage their workload more efficiently, which may lead to a higher feeling

of environmental mastery. Due to this, Clark & Morris (2015) suggested that nurses with a Master's Degree may feel more confident and self-efficacious in their positions, which can lead to a higher feeling of environmental mastery.

Furthermore, the present study observed that nurses working within the local mental health sector holding a Degree in Mental Health Nursing had a stronger feeling of Environmental Mastery when compared to nurses with a Degree in General Nursing. Similarly, this may be attributed to the more specialised training received by mental health nursing students in the field of mental health. Being specialised and trained in mental health may have made RMNs feel as if they are more prepared to deal with the particular demands and challenges which arise from such settings. Additionally, this is attributed to how RMNs may have better knowledge of the needs of individuals suffering from mental illnesses, which can help them in working with patients more effectively. RMNs' placements tend to occur within mental health services, which is not the case for nurses with a General Nursing Degree. Therefore, RMNs may also be more likely to have a greater awareness of the mental health system and how it works.

This is further corroborated by Ye-won (2021) who reports that nurses who have more specialised knowledge and training in mental health are able to deal with the particular challenges posed by this setting, which may lead to a higher feeling of environmental mastery. Adding to this, Hanna & Mona (2014), elaborated how having better knowledge of the needs and experiences of individuals suffering from mental illnesses may help nurses to provide more empathetic care, leading to a stronger sense of environmental mastery. Jones et al. (2015) argue that RMNs may have a better understanding of the mental health system which can help individuals traverse the system more efficiently, while also gaining the skills and knowledge required to properly manage the environment. Lastly, Loukzadeh & Bafrooi (2013) stated that exposure to a variety of mental health issues, as well as experience working with multidisciplinary teams and managing complicated patient situations, may also influence their sense of environmental mastery.

The findings of the present study found that nurses with a Master's Degree reported feeling more in control and having a better sense of environmental mastery compared to those with a Degree in General Nursing or a Degree in Mental Health Nursing. Additionally, nurses with a Degree in Mental Health Nursing had a better sense of environmental mastery than those with a Degree in General Nursing.

Both findings align with the principles of SDT which places a strong emphasis on how people's psychological demands for autonomy, competence, and relatedness shape their motivation and state of well-being (Deci, & Ryan, 1980). The need for competence can be linked to the higher sense of control reported by nurses with a Master's Degree and nurses with a Degree in Mental Health Nursing because these nurses may perceive themselves as more competent and effective in their professional roles as a result of their advanced education and specialised knowledge obtained through their degrees. These nurses can exercise more influence over their working environment and feel more in charge of their surroundings because of the enhanced autonomy and decision-making ability that frequently come with a Master's Degree. Finally, the specialised training may encourage a more profound sense of relatedness with colleagues and clients in the mental health sector, creating a nurturing work culture and collaborative setting that improves their awareness of the environment and fosters a sense of mastery. According to the findings' explanation within the SDT framework, educational achievement can impact nurses' understanding of mastery and well-being.

There were no significant differences found when comparing the 'Environmental Mastery' subscale with different levels of education. Similarly, 'Age', 'Nationality', 'Grade', 'Years of Experience as a Nurse', 'Working Shift', 'Working Hours', and 'Working Place' variables did not show any statistically significant impact on nurses' sense of environmental mastery. These variables did not influence the nurses' perception of control and competence in their work environment.

5.3.3 PERSONAL GROWTH SUBSCALE

Vishnevsky (2015), stated that personal development in the nursing profession can be fostered through ongoing professional development, reflective practice, and a commitment to lifelong learning. By consistently pursuing new experiences and possibilities for growth, nurses can boost their sense of personal progress and contribute to their overall PWB. Vishnevsky (2015), went on to explain how nurses who have a feeling of personal progress would be more likely to take chances in order to attain their objectives and have a greater purpose in life. Furthermore, in the nursing profession, personal growth is crucial for nurses to maintain their PWB, which in turn adds to their capacity to offer high-quality care to their patients. Personal development can help nurses feel more fulfilled at work, boost their confidence and self-efficacy, and improve their resilience to stress and burnout (Taubman-Ben-Ari & Weintroub, 2008). Furthermore, the researchers state that nurses who prioritise personal development are more motivated and engaged in their work, resulting in higher job satisfaction and overall well-being.

The results of the current study demonstrate that nurses working within Maltese Mental Health Services had a fair sense of personal growth. This indicates that locally, nurses felt a desire for self-improvement and a sense of continued development, similar to Delgado et al. (2021) whose participants scored the most in this subscale. The nurses' work dynamics, as well as challenges faced whilst working in the mental health sector, may have exposed them to diverse experiences that foster personal growth. Furthermore, access to professional development, working as a team, and experiencing a supportive work environment may also contribute to personal growth. White & Grason (2019) elaborated on how nurses may broaden their knowledge, skills, and talents by constantly pursuing new chances for growth and development, whilst working in a collaborative environment, which may also enhance their confidence.

In relation to demographic variables, a significant difference was observed in the 'Age' and 'Nationality' variables on the 'Personal Growth' subscale. A statistical difference occurred between nurses in the '51+ Years' subgroup and '21-30 Years' subgroup, '31-40 Years' subgroup and '41-50 Years' Subgroup', and '41-50 Years' and 51+ Years'. The age group '51+ Years' had a better sense of personal growth when compared to the '21-30 Years' and '41-50 Years' subgroups. Moreover, '31-40 Years' subgroup also had a better sense of personal growth when compared to the '41-50 Years' subgroup which will be discussed further later on. The 'Nationality' variable showed a statistical difference between the 'European' and 'Non-European' subgroups, in which the 'Non-European' subgroup had a better sense of personal growth when compared to 'Europeans' on the 'Personal Growth' subscale.

According to the results obtained in this research study, nurses aged 51 years and over had a greater feeling of personal improvement than those aged 21-30 years and 41-50 years in the mental health environment. Older nurses have more experience in the field, which may contribute to a sense of personal development and growth. Additionally, older nurses may have had more opportunities for continuing education and professional development throughout their careers, which can enhance their sense of progress and learning, gaining a greater understanding of their own morals, virtues, and weaknesses, which could help them to establish a stronger sense of purpose and direction in their work. They may have learnt to welcome change and view hurdles as opportunities for growth and development. Overall, these considerations may assist to explain why older nurses in the mental health context report a stronger feeling of personal progress than younger nurses.

Similarly, Fackler (2019), corroborated this by stating that assuming that elder nurses have been in the profession for quite a while, with more years of experience, elder nurses may have gained a better understanding of their role in the healthcare system, learning from their own mistakes, leading to a stronger feeling of purpose, self-awareness, self-reflection, and a deeper meaning of their work. Finally, Ryan et al. (2017) discuss how older nurses may have a more optimistic attitude toward life in general, which may translate to a better feeling of personal improvement.

Nurses between the ages of 31 and 40 years of age appear to be more open to new experiences and changes in the current study. Likewise, when comparing these findings to Pool et al. (2015), it is better understood how this age group may be more open to new perspectives and ways of thinking, which may lead to personal growth and development. This does not appear to be the case with nurses in the 41-50 age group, who appear to be less receptive to change, which might restrict their prospects for personal growth. Nurses between the ages of 31 and 40 may be looking for new challenges and possibilities for advancement, both professionally and on a personal level. Meanwhile, nurses in the 41-50 age range may be more established in their jobs and less willing to take on new challenges. Furthermore, the younger age group may have more access to resources and training which can contribute to personal improvement. Pool et al. (2015) elaborate on how younger nurses might be more willing to take on new tasks or pursue further education or training, which can contribute to their feeling of personal advancement. Van der Heijden et al. (2020) stated that nurses in the 41-50 age range typically have fewer prospects for job advancement or work in less supportive situations, limiting their opportunities for personal growth. Duffield et al., (2015) explained that the younger age group may have more access to resources, as well as chances for training and job advancement, which can enhance their feelings of personal progress and their feelings of personal improvement.

Results from the present study also showed that non-European nurses may have faced additional challenges to work in the nursing profession in Malta. Such challenges included language barriers, different training, and/or cultural differences. Non-European nurses are more likely to have experienced cultural differences and challenges in their personal and professional lives, which may foster a sense of personal growth as they learn to adapt to the new way of living. European nurses, on the other hand, may have met fewer cultural variations and challenges, perhaps limiting their opportunities for personal development. This was also explored by Allan & Westwood in 2016 who argue that non-European nurses' experiences can foster self-awareness, adaptability, and flexibility, which are all important aspects of personal growth. Aroral & Gulia (2020) explained

how overcoming such obstacles can provide a sense of accomplishment as well as personal progress in non-European nurses which may, in turn, have also enhanced their feeling of purpose and drive in their job, motivating them to have a better sense of personal growth. Meanwhile, European nurses may have faced fewer obstacles, limiting their prospects for personal growth. European nurses may be more inclined to work in their own nation or area, limiting their feeling of purpose and drive (Allan & Westwood, 2016).

The finding that nurses over the age of 51 reported more personal progress than those in the younger age groups of 21–30 and 41–50 years is aligned with the SDT. Due to their increased decision-making power and flexibility to engage in activities that promote personal growth, older nurses may feel more in control of their lives and may foster personal growth. Additionally, because they have mastered their responsibilities over time, their broad professional experience leads to a higher sense of competence. Their sense of relatedness is further enhanced by the opportunity for deeper connections and relationships to form during the course of their careers, which offers support and growth possibilities. These elements contribute to the older nurses' higher sense of personal growth, underscoring the significance of assisting nurses of various age groups in their professional development and fostering an environment that supports autonomy, competence, and relatedness, as recommended by SDT.

Nurses in the 31–40 age range may be at a point where these individuals strive for increased autonomy and self-direction, benefiting from the experience and expertise they have so far acquired, according to SDT, which also explains why they reported a better sense of personal growth than nurses in the 41–50 age group. They are able to partake in activities and encounters that foster personal development resulting from their feelings of autonomy. Additionally, nurses may have probably gained sufficient experience by the time they are in the 31–40 age range to feel more confident in their professional capacities, which contributes to a higher feeling of personal development. Additionally, their feelings of relatedness are enhanced by opportunities for deeper connections and relationships to form during this period, which offers the opportunity for support and growth.

The theoretical framework also aligns with the finding that nurses from non-European countries felt their personal growth had advanced more than nurses coming from European countries (Deci, & Ryan, 1980). The SDT suggests that non-European nurses may have more flexibility to make decisions and pursue personal and professional objectives that advance their personal

development because of differences in culture and workplace dynamics. Additionally, non-European nurses may regard themselves as more competent due to their varied cultural backgrounds and distinctive educational experiences, which will promote personal development. Non-European nurses may also have difficulties and a need for adaptation, which may lead to a stronger desire for relatedness and the development of connections and support networks that aid in personal development.

There were no significant differences found when comparing the 'Personal Growth' subscale with different grades or other variables such as 'Education', 'Years of Experience as a Nurse', 'Working Shift', 'Working Hours', and 'Working Place'. This indicates that these variables did not have an impact on the nurses' sense of personal growth.

5.3.4 POSITIVE RELATIONS WITH OTHERS SUBSCALE

Amongst the many essential elements in nursing, establishing several positive relationships remains one of the most prevalent. This is accompanied together with collaboration and teamwork. Indeed, combining these three factors will result further effective communication, coordination, and mutual support - promoting a strong bond with patients and their families in the meantime. Indeed, positive relations enable nurses to provide emotional support during difficult periods, aiding patients in coping with illness and enhancing their overall well-being. Additionally, positive relationships among colleagues foster a positive work environment, reducing stress and burnout while promoting professional development (Krueger et al., 2017).

The results of the current study demonstrate that nurses working within Maltese mental health services felt a good sense of positive relations with others. This indicates that local nurses may have felt mutually supported, experienced caring relationships, felt connected to others, and had a sense of belonging. Nurses are constantly engaging with patients, families, and other healthcare workers, which is why having positive relationships with others is very crucial. Building and sustaining great connections with others may result in better patient outcomes, more work satisfaction, and lower burnout. This can be attributed to frequent interactions with patients and colleagues, a supportive and collaborative work environment, the close-knit nature of Maltese society emphasising social connections, patient-centred care approaches promoting empathy, and the availability of team-building activities and communication training. These elements contribute to the development of positive relationships among the nurses. Kourkouta & Papathanasiou (2014) elaborated on how nurses who can build trust and rapport with patients and their families

are more likely to have effective therapeutic partnerships and deliver better care. Positive interactions with colleagues may also assist to build a supportive work environment and minimise stress and burnout. As a result, nurses who score high on Ryff's 'Positive Relations with Others' subscale component, are more likely to feel work satisfaction, higher quality patient care, and enhanced overall well-being (Bramhall, 2014).

No statistical significance was observed with regard to the demographic variables. Therefore, SDT's principles were utilised to attempt to explain as to why no significant variations in the subscale measuring 'Positive Relations with Others' were observed. The absence of statistically significant results show how this demand for relatedness may be widely satisfied among nurses, regardless of their demographic traits. Overshadowing possible variances based on demographics emphasises the significance of interpersonal dynamics and work environment aspects that may impact good relationships with people in the nursing profession (Deci, & Ryan, 1980).

5.3.5 PURPOSE IN LIFE SUBSCALE

A feeling of purpose in life may help nurses both professionally and personally. A strong sense of purpose can motivate nurses to deliver high-quality care and enhance patient outcomes, and make a difference in people's lives. This was further discussed by Loukzadeh & Bafrooi (2013) who claimed that nurses who have a sense of purpose are more prone to pursue continuing education, participate in research, and seek positions of leadership. Overall, a feeling of purpose in life is a crucial part of PWB that may help nurses both personally and professionally.

Results from the current study demonstrate that nurses working within Maltese Mental Health Services somewhat struggle to have a sense of Personal Growth. This indicates that local nurses find it hard to cope with the stress and demands of the job. Loukzadeh & Bafrooi (2013) argued that having a sense of personal growth may help nurses cope with job stress and expectations by providing a sense of purpose and fulfilment. A strong sense of purpose might even help nurses stay happy at work and avoid burnout. Furthermore, Pfund et al. (2020) stated that the nature of the nurses' work, which consists of providing care to individuals with mental health challenges, instils a strong sense of purpose. In fact, person-centred approaches and witnessing patients' progress may also contribute to their sense of meaning and purpose. A supportive work environment, emphasising teamwork and recognising nurses' contributions, further nurtures their sense of purpose (Pfund et al., 2020).

In relation to demographic variables, a significant difference was observed in the 'Education' variable on the 'Self-Acceptance' subscale. A statistical difference occurred between nurses with a 'Diploma in Nursing' and a 'Degree in General Nursing', a 'Diploma in Nursing' and a 'Degree in Mental Health Nursing', a 'Degree in General Nursing' and a 'Master's Degree', and a 'Degree in Mental Health Nursing' and a 'Master's Degree'.

Results show that participants with a Diploma in Nursing have a stronger feeling of purpose in life than those with a Mental Health Nursing Degree, in which a mental health environment is the nature of their training and education. Nurses with a General Nursing Diploma may have a more thorough and diversified education that covers a broader variety of medical and nursing issues, whereas nurses with a Mental Health Nursing Degree have a more specialised concentration on mental health and psychiatric treatment. Another element to examine is the influence of work satisfaction on life purpose. Nurses with a Diploma in General Nursing may have more career prospects or feel more fulfilled at work, which may lead to a higher sense of purpose and meaning in their life. Evans & Kelly (2004) explored different aspects of how education might impact nurses' sense of purpose in life. They explain how general nurses may feel more secure and fulfilled in their capacity to care for a larger range of patients with varying health problems, which may lead to a stronger sense of purpose in life, which corroborates the findings gathered from the present study.

There are several reasons why nurses with a Diploma in General Nursing have a stronger sense of purpose in life than those with a Degree in General Nursing working in mental health. Diploma certificate holders may have selected nursing as a career later in life, after gaining more life experience and a deeper understanding of their purpose and beliefs. It is also conceivable that the discrepancy is attributable to differences in personality or other characteristics unrelated to educational level. The explanation offered by Montgomer et al., (2009) aligns with these findings, claiming that Diploma programmes frequently emphasise hands-on experience and practical training, which may lead to a better sense of fulfilment and purpose in one's employment.

Nurses with a Master's Degree may have a greater understanding of the broader context of mental health and the healthcare system than those with a Degree in General Nursing. This may help nurses with a Master's Degree to feel more connected, boosting their competence and confidence in their job with patients. Moreover, nurses with a Master's Degree may have greater opportunities for professional development and advancement. Additionally, when it came to mental health,

individuals with a Master's Degree in nursing felt more purposeful in life than those with a Degree in Psychiatric Nursing; nursing professionals with a Master's Degree may have had more exposure to various nursing specialties and the possibility to develop a broader perspective on nursing and its impact on patients and society. Nurses with a Mental Health Nursing Degree, on the other hand, could be more focused on the care of mental health illnesses and may not have had the same level of exposure to other fields of nursing.

Pfund et al. (2020) explain how such opportunities can provide them with a sense of purpose and direction in their careers, providing them with a deeper understanding of their work and a greater sense of purpose and fulfilment in the mental health setting, which might explain why nurses with a Master's Degree may have a higher sense of purpose in life than those with a General Nursing Degree, particularly in the mental health field. Additionally, according to Taubman-Beri-Ari & Weintroub (2008), nurses with a Master's Degree may have had more opportunities for introspection and self-reflection as part of their further education, which may have influenced them to feel more purposeful.

According to the SDT framework, the satisfaction of psychological demands for autonomy, competence, and relatedness may be used to explain why nurses with a Diploma reported a stronger feeling of purpose in life than those with a Degree in General Nursing or Mental Health Nursing (Deci, & Ryan, 1980). As a result of their program's potential to give them applicable skills and first-hand patient care experiences, nursing students who obtain a Diploma may feel more in control of their professional life and more in line with their ideals. Additionally, social interactions and an encouraging learning environment seen in Diploma programs may promote a sense of relatedness, offering a sense of support and belonging that helps people feel more purposeful in their lives. Furthermore, SDT hypothesises that the reason Master's-educated nurses reported a higher sense of autonomy than those with Degree in General Nursing or Mental Health Nursing is that their advanced education and specialisation give them more power in decision-making and opportunities for fulfilling work that is in line with their values. Their perceived competence is increased by the acquisition of advanced knowledge and abilities obtained from their Master's Degree, which enables them to have a greater effect on patient care and advanced nursing practice. Additionally, Master's Degree programs promote a sense of relatedness and belonging through collaborative learning settings and networking opportunities, offering support and validation that help to strengthen a sense of purpose in life.

No significant differences were found when comparing the 'Purpose in Life' subscale with different educational levels or other variables such as 'Grade', 'Age', 'Nationality', 'Years of Experience as a Nurse', 'Working Shift', 'Working Hours', and 'Working Place'. These variables did not have an impact on the 'Purpose in Life' subscale.

5.3.6 SELF-ACCEPTANCE SUBSCALE

Self-acceptance is a vital component of personal and professional development in the nursing profession since it may help nurses deal with the everyday strains and difficulties of work. Losa-Iglesias (2017) elaborated on how nurses who score high on self-acceptance are inclined to be satisfied at work, have a better work-life balance, and be happier overall. Moreover, the author further explained how self-acceptance is essential in the nursing profession as nurses with a good attitude towards themselves may be better prepared to deal with the strains and challenges of the work and can help them to uphold a good attitude and manage challenging conditions. MacInnes (2006) states that self-acceptance is also necessary for personal and professional development. Nurses who embrace themselves are more likely to seek learning and development opportunities, which may help them improve in their professions and provide better care to their patients.

The results of the current study demonstrate that nurses working within Maltese Mental Health Services somewhat had a sense of self-acceptance. This indicates that local nurses felt that they had a positive attitude towards themselves and were better equipped to handle the stresses and challenges of the job. Their work in the field requires self-awareness and reflection, which may lead to a strong sense of self-acceptance. The supportive work environment, emphasising leadership, teamwork, and individual well-being, may contribute to their self-acceptance. The nature of their work, focused on promoting patients' well-being and witnessing their progress, fosters a sense of purpose and self-acceptance. Maheshwari & Gill (2015) discussed how self-acceptance is essential for developing healthy interactions with patients and colleagues, as nurses who accept themselves are more likely to be empathetic and understanding towards others, which can lead to better communication and more effective care.

In relation to demographic variables, a significant difference was observed in the 'Education' variable on the 'Self-Acceptance' subscale. A statistical difference occurred between nurses with a 'Diploma in Nursing' and a 'Degree in Mental Health Nursing', and a 'Degree in General Nursing' and a 'Degree in Mental Health Nursing'. The groups with a 'Diploma in Nursing' and a 'Degree

in General Nursing' had a better sense of self-acceptance when compared to those with a 'Degree in Mental Health Nursing'.

There may be several reasons why Diploma and Degree General Nurses in psychiatric hospitals have higher self-acceptance than RMNs. General nurses may have had more in-depth training in working with patients with varying health conditions, which adds to their sense of self-acceptance. Additionally, general nurses may have had more opportunities for work advancement and professional growth, which can increase their self-esteem and confidence. Therefore, general nurses may obtain further training and help in these areas because self-care and mental health wellness are usually incorporated in general nursing education and continuing education courses. Since it is not the general nurses' speciality to work in a psychiatric setting, they may be more conscious that working in a mental health setting is not their specialisation, accepting their position and their mistakes more easily. RMNs may believe that their work is not recognised or regarded as highly as other nursing specialities due to stigma, which in turn, may negatively impact their self-acceptance. MacInnes (2006) highlights how due to their versatile training, general nurses may have felt more at ease with the degree of responsibility they have in caring for patients, which may lead to a higher feeling of self-acceptance. Surgenor et al. (2005) discuss how general nurses are usually exposed to a larger variety of patients and settings, which might help them develop self-awareness and acceptance. Meanwhile, Hayman-White et al. (2007) elaborate on how education in psychiatric nursing may be more focused on the technical components of mental health care rather than the human and emotional parts of the profession; so they accept their flaws and mistakes more readily and may be willing to learn new things. Finally, Rushworth & Happell (2000) explain how, in their study, it was noted that mental health patients are frequently stigmatised and discriminated against, which may have an influence on psychiatric nurses' self-acceptance.

The findings showing General Nursing Degree holders and General Nursing Diploma holders reported higher levels of self-acceptance than those with a Degree in Mental Health Nursing to support the principles of SDT. A larger range of experiences and possibilities for autonomy in practice may be available to nurses with a General Nursing Degree or Diploma, enabling them to express themselves and make decisions that are in line with their actual selves. Since they were exposed to more situations and afterwards may have greater confidence in their skills and professional capabilities, the competence acquired from their education and training in general nursing may help them to feel more positive about themselves. A sense of relatedness may also be

fostered through the many social networks and relationships formed during their education and practice, creating a nurturing atmosphere that encourages self-acceptance (Deci, & Ryan, 1980).

No significant differences were found when comparing the 'Self-Acceptance' subscale with different educational levels or other variables such as 'Grade', 'Age', 'Nationality', 'Years of Experience as a Nurse', 'Working Shift', 'Working Hours', and 'Working Place'. These variables did not affect the nurses' sense of self-acceptance.

5.4 CONCLUSION

The present study made use of Ryff's SPWB questionnaire to explore the well-being of nurses working in in-patient and community mental health settings in Malta. The study revealed that participants somewhat agree to have overall good well-being. 'Age', 'Grade', 'Education', and 'Nationality' were the four demographic variables which generated statistical differences, with 'Education' being the most prevalent variable with three statistical differences, thus the hypothesis that education impacts the well-being of nurses was accepted. The rest of the variables did not have any impact on any of the subscales that were examined. Hence, the hypothesis that nurses working regular shifts experience lower-level well-being was rejected.

'Environmental Mastery', 'Purpose in Life', and 'Self-Acceptance' produced a significance against the 'Education' variable. Meanwhile, the subscale 'Autonomy' produced a significance with the 'Grade' variable. The subscale of 'Personal Growth' produced two significant differences when compared to the 'Age' and 'Nationality' variables. Meanwhile, 'Positive Relations With Others' did not show any significance with the demographic characteristics. No statistical differences were identified between nurses working in in-patient and those working in community mental health settings. Therefore the hypothesis that nurses working in the community mental health setting experience better well-being than those working in an in-patient mental health setting was rejected.

The final chapter will present a conclusion to this research study whilst also outlining the strengths and limitations of this research, as well as provide details with regard to recommendations for further research, education, and practice for improvement.

Chapter Six

RECOMMENDATIONS & CONCLUSION

6.0 INTRODUCTION

The following chapter summarises the findings of this research. A discussion will then follow on the study's strengths and weaknesses. Lastly, a list of educational, research and practice recommendations were submitted.

6.1 SUMMARY OF THE STUDY

This study analysed the well-being of nurses who work in an in-patient or a community mental health setting in Malta. Whilst conducting the literature review, it was noted that the local forum appears to be short of literature about this subject. As a guiding theoretical framework to tackle this research gap, the current study adopted the SDT which assumes a connection between personality, human motivation, and optimal performance and proposes that human behaviour is shaped by two distinct types of motivation. Moreover, it seeks to explain how these motivations influence an individual's actions (Deci, & Ryan, 2012).

To address this, a quantitative cross-sectional method was chosen. Ryff's SPWB-42 (Ryff, 2014) was utilised as a validated questionnaire in order to collect the data. In addition to the questionnaire, 'Age', 'Gender', 'Nationality', 'Education', 'Grade', 'Years of Experience as a Nurse', 'Working Place', 'Working Shift' and 'Working Hours' were added as socio-demographic variables. These demographic variables were indeed included to investigate whether they influence the six main domains of Ryff's SPWB.

Together with the questionnaire, an information letter was attached for each participant to emphasise the purpose of the study. Two intermediaries were appointed to assist with the distribution and collection of the surveys, which were then handed back to the researcher in a sealed envelope. This enabled the researcher to refrain from making any direct contact with the participants in order to prevent bias and protect anonymity.

Once data was collected, it was then inputted and consequently analysed through the SPSS. Non-parametric tests were used for the data analysis; namely the Mann-Whitney U Test and the Kruskal-Wallis H Test. Additionally, comparisons between the different groups were also performed to analyse whether any of the demographic variables had an impact on the different scales of Ryff's PWB.

All nurses employed in a mental health in-patient setting (N=292) and community mental health settings (N=76) were invited to participate in the study. The sample size consisted of 197 nurses, resulting in a response rate of 53.5%. The majority of the findings show that most participants were female (63.5%), and working in an in-patient setting (65.5%). The majority worked on a full-time basis (99.5%) with regular shifts (59.9%). The most popular age range was that of 21-30 years (29.4%) and held a Senior Staff Nurse position (38.1%). Most of the participants had a Degree in Mental Health Nursing (32%) and had 0-5 years of experience as a nurse (33.5%). 89.3% of the participants were of Maltese nationality, thus making it the most dominant nationality.

Results showed that the 'Grade' variable revealed a statistical significance on the 'Autonomy' subscale. To further analyse the variable, an in-between group analysis was performed by Mann-Whitney U Test which exposed a statistical significance between SNs and SSNs, as well as SSNs and RMNs. According to Ryff (2014), this demonstrates that participants with this grade exhibit a higher degree of self-determination and autonomy. They are capable of resisting external social influences that may dictate their thoughts and actions, regulating their behaviour based on internal motivations, and are more proficient at assessing themselves according to personal standards.

The 'Education' variable reported a statistically significant difference on the 'Environmental Mastery' subscale. This was further investigated by comparing the in-between groups of the variable. This indicated that participants with a Master's Degree showed statistical significance when compared to participants with a Degree in General Nursing and a Degree in Mental Health Nursing. Moreover, a statistically significant difference between participants with a Degree in General Nursing and a Degree in Mental Health Nursing on the 'Environmental Mastery' subscale could be observed. These subgroups were found to be more inclined to acknowledge a sense of mastery and competence in managing their environment. Additionally, they demonstrated a higher capability to control a diverse range of external activities and effectively capitalise on available opportunities. Furthermore, these individuals exhibited a notable ability to select and create contexts which aligned with their personal needs and values (Ryff, 2014).

Results highlighted a statistical significance between the 'Personal Growth' subscale and the 'Age' variable. This was further tested when a statistically significant difference was noted between the '51 Years' age group and the '21-30 Years' and the '41-50 Years' age groups on the 'Personal Growth' subscale. Moreover, a statistical significance between the 'Personal Growth' subscale and

the 'Nationality' variable was found, where a statistically significant difference was noted between the 'European' and 'Non-European' subgroups. These findings suggest that the aforementioned groups have a strong perception of personal growth and continuous development. They exhibit openness to new experiences and possess a deep awareness of their own potential. Furthermore, they recognise and embrace positive changes in themselves and their behaviour over time, actively striving to align their actions with increased self-knowledge and effectiveness (Ryff, 2014).

Results indicate that the 'Education' variable also showed a statistically significant difference on the 'Purpose in Life Scale'. Those with a 'Diploma in Nursing' statistically differed from those with a 'Degree in General Nursing' and 'Degree in Mental Health Nursing'. Additionally, a 'Degree in General Nursing' differed from a 'Master's Degree', whilst a 'Degree in Mental Health Nursing' also differed from 'Master's Degree' on the 'Purpose of Life' subscale. In 2014, Ryff commented that participants who exhibit variations in this particular subscale tend to experience a sense of purpose and direction in life. They are more likely to perceive deeper meaning in both their present and past experiences. Additionally, they hold strong beliefs regarding the purpose and objectives of their life (Ryff, 2014).

Finally, the results demonstrate a statistical significance between the 'Education' variable and the 'Self-Acceptance' subscale. A statistically significant difference was found between the in-between groups of the 'Education' variable, namely between participants holding a Degree in Mental Health Nursing to those with either a Diploma in Nursing or a Degree in General Nursing. Nurses who demonstrated a statistical distinction in this regard typically exhibit a positive self-attitude. They are inclined to acknowledge and embrace various aspects of their own identity, encompassing both positive and negative qualities. Furthermore, they hold a positive outlook on their past life experiences (Ryff, 2014).

These findings aided to provide the groundwork for recommendations which will be discussed in the following section with regard to research, educational, managerial and clinical practice. No statistically significant differences were observed between the demographic variables and the 'Positive Relations with Others' subscale.

6.2 STRENGTHS OF THE STUDY

One of the principal strengths of this study is that it is the first study to analyse the well-being of nurses who work in a psychiatric setting whilst also utilising the socio-demographic variables with Ryff's SPWB. It is also the first study to analyse the well-being of nurses who work in a psychiatric setting in the Maltese health sector. A strength of this study is that it has delivered an insight into this aspect through a local perspective.

The Mental Health Services include both the mental health community services and the only psychiatric hospital available in Malta, MCH. Since no other governmental state services and/or hospitals operate in Malta, the researcher could invite all state nurses working in the mental health sector; therefore, this strengthens the representation and generalisability of the results (Wang & Cheng, 2020).

This study utilised a validated research instrument, including a socio-demographic section to allow for deeper analysis, further enhancing the strength of the research. Vostanis (2006) suggests that by utilising such a research tool, the results are validated and reliable, and the consistency of the results is improved. By using self-administered questionnaires, a large number of participants could participate in a short period (Watson, 2015).

The use of intermediaries to distribute and collect the questionnaires ensured that no direct contact took place between the researcher and participants; this reduced bias and increased anonymity in the study. Furthermore, ethical considerations were enforced. This made sure that participation occurred solely of the participant's free will. Consequently, this ensured anonymity, and so, participants were able to mark their answers without feeling judged or discriminated (Queirós et al., 2017).

Lastly, the researcher developed a better understanding of nurses' well-being in the mental health sector, in terms of 'Age', 'Gender', 'Nationality', 'Education', 'Grade', 'Years of Experience as a Nurse', 'Working Place', 'Working Shift' and 'Working Hours'.

6.3 LIMITATIONS OF THE STUDY

Although several attempts were made to minimise and balance any shortcomings, since a quantitative methodology has been used, certain disadvantages were inevitable. For a deeper understanding, a mixed-method approach would have been ideal to investigate the well-being of nurses that work in the mental health sector. Watson (2015) claims that this would have aided in understanding as to what led participants to score a higher or a lower rating during the questionnaires' subscales.

The use of questionnaires inherently holds certain disadvantages. Self-reported questionnaires could have resulted in response bias where participants would have chosen the most socially acceptable answer rather than what they felt. This often occurs as participants tend to misinterpret what they feel in order to conform to social norms (Vostanis, 2006).

Another limitation of this study was due to the time it was held, which occurred during the COVID-19 pandemic. As a result, the mental health services and the public health authority obliged certain restrictions to protect employees and service users. Whilst most of these measures were eased during the study, the mental health working practice has greatly changed, which might have impacted the well-being of nurses due to the stress that arose because of the pandemic (Birditt, 2021).

Moreover, Stubbs et al. (2021) discuss how the pandemic might have increased certain pressures on nurses which might have impacted their overall participation. This could have also affected participation in this study as nurses' workload is high, resulting in a lower response rate. Nurses who were experiencing stress and burnout could have refrained from filling in the survey, which in turn resulted in a lower response rate.

Due to the limited timeframe, nurses employed in Gozo's mental health sector and/or in non-governmental mental health entities could not be included in this study. Having their input could have impacted the results of this research study due to their smaller population and more intimate setting.

After analysing the findings, different recommendations were collated for future research, educational, management and clinical practice.

6.4 RECOMMENDATIONS

Following the data analysis of this study, a set of recommendations were identified by the research. These are further discussed in the following sections.

6.4.1 RECOMMENDATIONS FOR FUTURE RESEARCH

The findings of the study raised certain issues about future research. Thus, the researcher believes that future research should focus on:

- Incorporating other mental health professionals in the study as their input might have exposed certain differences and commonalities between the professions with regard to their well-being whilst working in the Mental Health Sector (López et al., 2015). Furthermore, Ryff's SPWB could have been used on other potential participants to gather a more holistic view of the mental health sector's employees' well-being whilst maintaining the same scale for uniform results (Schreurs et al., 2022).
- Future research should also consider focusing on qualitative research for a more in-depth analysis of the nurses' well-being in mental health care, including non-governmental organisations and Gozo's mental health services. This could focus on what impacts their well-being and how nurses cope and deal with certain stressors. A mixed methods approach would also be a suitable research design for further research on this study where quantitative and qualitative approaches could be integrated (McCusker & Gunaydin, 2015).
- Lastly, a longitudinal study can further explore how the nurses' well-being in the mental health sector changes over time whilst also analysing how this impacts the quality of care delivered by nurses (Brannen, 2005).

6.4.2 RECOMMENDATIONS FOR EDUCATION & CLINICAL PRACTICE

The findings of the study raised certain issues with regard to future research. Thus, the researcher believes that education and clinical practice should focus on:

- As noted in this study, undergraduate students and nurses should be exposed to a better understanding of how to deal with stress and burnout, and how to cope better to contain their mental health and well-being, according to the place of work, to acquire certain soft skills. This would aid nurses to acquire a better sense of environmental mastery (Velimirović, 2017).

- All nurses should be encouraged to perform reflective practice to pinpoint their weaknesses and strengths, and utilise them accordingly (Bégat & Severinsson, 2006). This would aid participants to acquire a better sense of autonomy and personal growth, by reflecting on their clinical practice and learning through their mistakes.
- Nurses should constantly be further trained in programmes such as mental health first aid and de-escalation techniques to enhance their skills and gain a better insight into what their role as a nurse is, whilst also gathering certain leadership skills (Tyler & Ellison, 1994). Nurses would benefit from this as during this research study, it was observed that nurses who were further trained in their profession had a better sense of environmental mastery.

6.4.3 RECOMMENDATIONS FOR MANAGEMENT & POLICIES

The findings of the study raised certain issues about future research. Thus, the researcher believes that management and policies should focus on:

- The possibility of initiating clinical supervision with nurses working in the mental health sector might avoid/limit certain managerial stressors and conflicts, as well as know how to deal with certain problems at work which might impact the nurses' well-being (Koivu et al., 2012). This is important especially whilst working in a mental health setting where this study observed that nurses with a Mental Health Nursing Degree struggled to accept themselves when compared to nurses who followed other courses which are exposed to clinical settings.
- Nurses with a lower level of education should be provided with further training and support to be able to gather further knowledge about their professional role as a nurse working in psychiatry (Kay & Russette, 2000), and be able to improve their sense of personal growth, autonomy and self-acceptance.
- It is recommended that the introduction of an environmental mastery policy and a cultural sensitivity policy should take place (Ruddock & Turner, 2007) in order to address the importance of environmental mastery and cultural sensitivity in the nursing profession regarding nurses' well-being (Palma et al., 2022).

6.5 CONCLUSION

This research has revealed that the well-being of nurses is impacted by several socio-demographics, with 'Education' being the most prevalent, showing a statistical significance in the 'Environmental

Mastery', 'Purpose in Life' and 'Self-Acceptance' subscales. Whilst no significant differences were noted between in-patient and community mental health nurses, it was also established that 'Grade', 'Age' and 'Nationality' also have a statistical significance when tested against Ryff's SPWB.

In this chapter, a series of recommendations were then explored in order to improve nurses' well-being, both in in-patient and community mental health, for future research, educational and clinical practice, and management and policy aspects. This research will hopefully shed some light on the importance of health professionals' well-being, especially on nurses who are in the workforce of mental health care, and its correlation with the quality of care for their service users as discussed by Richards et al. in 2010.

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APPENDICES

APPENDIX A: RESEARCH INSTRUMENT

Nurses' Well-Being In In-Patient & Community Mental Health Care: A Comparative Study

Section A: Demographic Questions

Please answer the following by ticking the appropriate box. By filling in and submitting this questionnaire you are denoting consent.

Age:

- | | | |
|--------------------------------------|--------------------------------------|--------------------------------------|
| ☐ 18-20 Years | ☐ 21-30 Years | ☐ 31-40 Years |
| ☐ 41-50 Years | ☐ 51+ Years | |

Gender:

- | | | |
|-------------------------------|---------------------------------|--------------------------------|
| ☐ Male | ☐ Female | ☐ Other |
|-------------------------------|---------------------------------|--------------------------------|

Nationality:

- | | | |
|----------------------------------|---------------------------------------|-----------------------------------|
| ☐ Maltese | ☐ Non-European | ☐ European |
|----------------------------------|---------------------------------------|-----------------------------------|

Education:

- | | |
|--|--|
| ☐ Diploma in Nursing | ☐ Degree in General Nursing |
| ☐ Degree in Mental Health Nursing | ☐ Master's |
| ☐ Doctorate | |

Grade:

- | | | |
|---|--|---|
| ☐ Enrolled Nurse | ☐ Staff Nurse | ☐ Senior Staff Nurse |
| ☐ Registered Mental Health Nurse | ☐ Deputy Charge Nurse | ☐ Charge Nurse |

Years Of Experience As A Nurse:

- | | | |
|--------------------------------------|-------------------------------------|--------------------------------------|
| ☐ 0-5 Years | ☐ 6-10 Years | ☐ 11-15 Years |
| ☐ 16-20 Years | ☐ 21+ Years | |

Working Place:

- | | |
|--|---|
| ☐ In-Patient Care | ☐ Community Care |
|--|---|

Working Shift:

- | | | |
|--|---|---|
| ☐ Regular Shift | ☐ Night Shift Only | ☐ Day Shift Only |
|--|---|---|

Working Hours:

- | | | |
|------------------------------------|------------------------------------|--|
| ☐ Full-Time | ☐ Part-Time | ☐ Reduced Hours |
|------------------------------------|------------------------------------|--|

Section B: Ryff's Scale of Psychological Well-Being (PWB)

The following set of questions deals with how you feel about yourself and your life. Please remember that there are no right or wrong answers.

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
1. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.	1	2	3	4	5	6
2. In general, I feel I am in charge of the situation in which I live.	1	2	3	4	5	6
3. I am not interested in activities that will expand my horizons.	1	2	3	4	5	6
4. Most people see me as loving and affectionate.	1	2	3	4	5	6
5. I live life one day at a time and don't really think about the future.	1	2	3	4	5	6
6. When I look at the story of my life, I am pleased with how things have turned out.	1	2	3	4	5	6
7. My decisions are not usually influenced by what everyone else is doing.	1	2	3	4	5	6
8. The demands of everyday life often get me down.	1	2	3	4	5	6
9. I think it is important to have new experiences that challenge how you think about yourself and the world.	1	2	3	4	5	6
10. Maintaining close relationships has been difficult and frustrating for me.	1	2	3	4	5	6
11. I have a sense of direction and purpose in life.	1	2	3	4	5	6
12. In general, I feel confident and positive about myself.	1	2	3	4	5	6
13. I tend to worry about what other people think of me.	1	2	3	4	5	6
14. I do not fit very well with the people and the community around me.	1	2	3	4	5	6
15. When I think about it, I haven't really improved much as a person over the years.	1	2	3	4	5	6
16. I often feel lonely because I have few close friends with whom to share my concerns.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
17. My daily activities often seem trivial and unimportant to me.	1	2	3	4	5	6
18. I feel like many of the people I know have gotten more out of life than I have.	1	2	3	4	5	6
19. I tend to be influenced by people with strong opinions.	1	2	3	4	5	6
20. I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
21. I have a sense that I have developed a lot as a person over time.	1	2	3	4	5	6
22. I enjoy personal and mutual conversations with family members or friends.	1	2	3	4	5	6
23. I don't have a good sense of what it is I'm trying to accomplish in life.	1	2	3	4	5	6
24. I like most aspects of my personality.	1	2	3	4	5	6
25. I have confidence in my opinions, even if they are contrary to the general consensus.	1	2	3	4	5	6
26. I often feel overwhelmed by my responsibilities.	1	2	3	4	5	6
27. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	1	2	3	4	5	6
28. People would describe me as a giving person, willing to share my time with others.	1	2	3	4	5	6
29. I enjoy making plans for the future and working to make them a reality.	1	2	3	4	5	6
30. In many ways, I feel disappointed about my achievements in life.	1	2	3	4	5	6
31. It's difficult for me to voice my own opinions on controversial matters.	1	2	3	4	5	6
32. I have difficulty arranging my life in a way that is satisfying to me.	1	2	3	4	5	6
33. For me, life has been a continuous process of learning, changing, and growth.	1	2	3	4	5	6
34. I have not experienced many warm and trusting relationships with others.	1	2	3	4	5	6

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
35. Some people wander aimlessly through life, but I am not one of them.	1	2	3	4	5	6
36. My attitude about myself is probably not as positive as most people feel about themselves.	1	2	3	4	5	6
37. I judge myself by what I think is important, not by the values of what others think is important.	1	2	3	4	5	6
38. I have been able to build a home and a lifestyle for myself that is much to my liking.	1	2	3	4	5	6
39. I gave up trying to make big improvements or changes in my life a long time ago.	1	2	3	4	5	6
40. I know that I can trust my friends, and they know they can trust me.	1	2	3	4	5	6
41. I sometimes feel as if I've done all there is to do in life.	1	2	3	4	5	6
42. When I compare myself to friends and acquaintances, it makes me feel good about who I am.	1	2	3	4	5	6

APPENDIX B: PERMISSION TO USE RESEARCH INSTRUMENT



Kirstie Brincat <kirstie.brincat.16@um.edu.mt>
to cryff, Paulann ▾

9 May 2022, 10:49 ☆ ↶ ⋮

Dear Prof Ryff,

My name is Kirstie Brincat and I am currently reading for a Master of Science in Mental Health Studies at the University of Malta.

As part of my course requirements I will be conducting a research study entitled 'Nurses' Well-Being in In-Patient and Community Mental Health Care: A Comparative Study'. The aim of this study is to investigate the current state, occurrence and factors influencing the well-being of nurses working within a psychiatric in-patient setting and those working within a community setting.

Whilst carrying out a preliminary literature search, I came across your work, namely the validation of the revised 'The Ryff Scales of Psychological Well-Being'. This psychometric tool fits the aim of my study and would be grateful if you can grant me permission to use your tool in my work. I would also greatly appreciate a copy of the tool's coding and/or scoring documentation relevant to the tool. If you grant me permission, I would appreciate such in writing so that I can submit your approval as part of my proposal for ethical review.

I thank you in advance for considering my request.

Kind Regards,

Kirstie Brincat

BSc (Hons) in Nursing

MSc (Melit) in Mental Health Studies Student



THERESA M BERRIE <berrie@wisc.edu>

to me ▾

📧 10 May 2022, 15:28 ☆ ↩ ⋮

Greetings,

Thanks for your interest in the well-being scales.
I am responding to your request on behalf of Carol Ryff.
She has asked me to send you the following:

You have her permission to use the scales for research or other non-commercial purposes.

They are attached in the following files:

"Ryff PWB Scales" includes:

- psychometric properties
- scoring instructions
- how to use different lengths of the scales
(see note about the 18-item scale, which is not recommended)

"Ryff PWB Reference Lists" includes:

- a list of the main publications about the scales
- a list of published studies using the scales

There is no charge to use the scales and no need to send us the results of your study.

We do ask that you please send us copies
of any journal articles you may publish using the scales to:
berrie@wisc.edu and cryff@wisc.edu.

Best wishes for your research,

--

APPENDIX C: PARTICIPANTS' INFORMATION SHEET

Dear Participant,

My name is Kirstie Brincat and I am currently reading for a Master of Science in Mental Health Studies at the University of Malta. As part of my course requirements, I am conducting a research study entitled, “Nurses’ Well-Being in In-Patient and Community Mental Health Care: A Comparative Study”. The aim of this study is to investigate the level of well-being of nurses working in an in-patient and community care. Your participation in this study would help us gain a better understanding about the nurses’ well-being. Furthermore, all data collected from this research shall be used solely for the purpose of this study.

You are being invited to participate in a study which will investigate the level of well-being in nurses working in in-patient and community mental health care.

You are not obliged to participate in this study or to answer all the questions and you may withdraw from the study at any time without giving a reason. Furthermore, withdrawal from the study will not have any negative repercussions on you and any data collected will be erased. Data will be stored anonymously. I can assure you that confidentiality will be maintained throughout the study and that your identity and personal information will not be revealed in any publications, reports or presentations arising from this research.

The data necessary to this research will be accessed by the researcher, and the anonymised data will be only viewed by myself, the supervisors and the examiners. The data files will be stored on the researcher’s personal computer that is password protected and in an encrypted format. Any material in hard-copy form will be placed in a locked cupboard.

Participation in this study is completely voluntary and you are free to accept or refuse to take part without giving a reason. A copy of the information sheet is provided for future reference. As a participant, you have the right, under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, to access, rectify and where applicable ask for the data concerning you to be erased. Once the study is completed and the results are published, the anonymous data will be retained in an anonymous form.

If you accept to participate in this study, kindly complete the accompanying self-report questionnaire. This questionnaire should take approximately 15 minutes to complete. It is important that all questions are answered, as incomplete questionnaires will not be included in the study. By completing the questionnaire, you are giving consent to participate in the study. The questionnaire will be distributed and collected by Mr. Kevin Gafa and/or Ms. Josephine Cassar, who will act as an intermediary for this study. Once completed, the questionnaires will be returned to the intermediary in a sealed envelope that is then opened by the researcher.

Although there is no immediate benefit from this study, your participation will help provide an understanding and comparing the well-being of nurses working in in-patient and community mental health care. This study has been approved by the Research Ethics Committee of the Faculty of Health Sciences at the University of Malta.

Thank you for your time and consideration. Should you have any questions or concerns do not hesitate to contact me on 99375818 or by e-mail Kirstie.brincat.16@um.edu.mt or my supervisor Dr. Paulann Grech on 23401180 or Paulann.grech@um.edu.mt.

Yours Sincerely,



Kirstie Brincat
Researcher



Dr. Paulann Grech
Research Supervisor

APPENDIX D: FREC'S APPROVAL

The status of your REDP form (FHS-2022-00136) has been updated to Approved    



form.urec@um.edu.mt

to me ▾

Mon, 11 Jul 2022, 12:21



Dear Kirstie Brincat,

Please note that the status of your REDP form (FHS-2022-00136) has been set to *Approved*.

You can keep track of your applications by visiting: <https://www.um.edu.mt/research/ethics/redp-form/frontEnd/>.

*****This email has been automatically generated by URECA. Please do not reply. If you wish to communicate with your F/REC please use the respective email address.*****

APPENDIX E: MCH'S ADMINISTRATION APPROVAL

**Dr. Stephanie Xuereb,
Chief Executive Officer,
Mount Carmel Hospital**

Dear Dr. Xuereb,

My name is Kirstie Brincat, a Staff Nurse currently reading for a Master of Science in Mental Health Studies at the University of Malta under the supervision of Dr Paulann Grech. As part of the course requirements I am conducting a research study entitled, "Nurses Well-Being in In-Patient and Community Mental Health Care: A Comparative Study". The benefits of this research are to investigate the well-being of nurses' working in an in-patient and community care endure.

To be able to conduct this research, I would like to distribute the "Ryff's Scales of Psychological Well-Being" (Ryff PWB Scales) questionnaire (copy attached) to all nurses working within the mental health field. I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer. Participants have the right, under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, to access, rectify and where applicable ask for the data concerning them to be erased. Once the study is completed and the results are published, the data will be retained in anonymous form. Any personal details will be destroyed.

Distribution and collection of the completed questionnaires will be carried out by an intermediary, namely Mr. Kevin Gafa (Senior Practice Nurse) and Ms. Josephine Cassar (Senior Nursing Manager) for which they have already consented in writing. The questionnaire takes approximately 15 minutes to complete. In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from mentors currently providing their services in hospital.

I would be grateful if you would support this research. For further information, do not hesitate to contact either myself on kirstie.brincat.16@um.edu.mt or 99375818 or my supervisor Dr. Paulann Grech, Senior Lecturer, Department of Mental Health, Faculty of Health Science, University of Malta on paulann.grech@um.edu.mt or 23401180.

I wish to thank you for your help.

Yours Respectfully,
Kirstie Brincat
Masters in Mental Health Studies
University of Malta

If you accept to assist in this study, kindly sign the declaration below:

After reading the above, I, Dr. Stephanie Xuereb, give my consent to assist in this study.

Signature: 

DR. STEPHANIE XUERE
CHIEF EXECUTIVE OFFICER
MENTAL HEALTH SERVICES

30 / 5 / 2022 -

Mr. Oswald Balzan
Data Protection Officer,
Mount Carmel Hospital

Dear Mr. Balzan,

My name is Kirstie Brincat, a Staff Nurse currently reading for a Master of Science in Mental Health Studies at the University of Malta under the supervision of Dr Paulann Grech. As part of the course requirements I am conducting a research study entitled, "Nurses Well-Being in In-Patient and Community Mental Health Care: A Comparative Study". The benefits of this research are to investigate the well-being of nurses' working in an in-patient and community care endure.

To be able to conduct this research, I would like to distribute the "Ryff's Scales of Psychological Well-Being" (Ryff PWB Scales) questionnaire (copy attached) to all nurses working within the mental health field. I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer. Participants have the right, under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, to access, rectify and where applicable ask for the data concerning them to be erased. Once the study is completed and the results are published, the data will be retained in anonymous form. Any personal details will be destroyed.

Distribution and collection of the completed questionnaires will be carried out by an intermediary, namely Mr. Kevin Gafa (Senior Practice Nurse) and Ms. Josephine Cassar (Senior Nursing Manager) for which they have already consented in writing. The questionnaire takes approximately 15 minutes to complete. In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from mentors currently providing their services in hospital.

I would be grateful if you would support this research. For further information, do not hesitate to contact either myself on kirstie.brincat.16@um.edu.mt or 99375818 or my supervisor Dr. Paulann Grech, Senior Lecturer, Department of Mental Health, Faculty of Health Science, University of Malta on paulann.grech@um.edu.mt or 23401180.

I wish to thank you for your help.

Yours Respectfully,
Kirstie Brincat
Masters in Mental Health Studies
University of Malta

If you accept to assist in this study, kindly sign the declaration below:

After reading the above, I, Mr. Oswald Balzan, give my consent to assist in this study.

Signature: _____



Balzan Oswald at Health-Mental Health Services

to me ▾

Wed, 25 May, 10:03 (5 days ago)



Dear Ms.Brincat,

Permission granted to collect data from nurses currently providing their services within the mental health services.

Make sure that you fill a consent form by every participant and keep it safe.

APPROVED

Oswald Balzan

Principal

Mount Carmel Hospital

Health-Mental Health Services

☎ +356 23304014 ✉ oswald.balzan@gov.mt

<https://health.gov.mt> | www.publicservice.gov.mt | fb.com/servizzpubbliku



MINISTRY FOR HEALTH

MOUNT CARMEL HOSPITAL, TRIQ NOTABILE,

ATTARD, MALTA

Kindly consider your environmental responsibility before printing this e-mail

Dr. Victoria Sultana
Director Of Nursing,
Mount Carmel Hospital

Dear Dr. Sultana,

My name is Kirstie Brincat, a Staff Nurse currently reading for a Master of Science in Mental Health Studies at the University of Malta under the supervision of Dr Paulann Grech. As part of the course requirements I am conducting a research study entitled, "Nurses Well-Being in In-Patient and Community Mental Health Care: A Comparative Study". The benefits of this research are to investigate the well-being of nurses' working in an in-patient and community care endure.

To be able to conduct this research, I would like to distribute the "Ryff's Scales of Psychological Well-Being" (Ryff PWB Scales) questionnaire (copy attached) to all nurses working within the mental health field. I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer. Participants have the right, under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, to access, rectify and where applicable ask for the data concerning them to be erased. Once the study is completed and the results are published, the data will be retained in anonymous form. Any personal details will be destroyed.

Distribution and collection of the completed questionnaires will be carried out by an intermediary, namely Mr. Kevin Gafa (Senior Practice Nurse) and Ms. Josephine Cassar (Senior Nursing Manager) for which they have already consented in writing. The questionnaire takes approximately 15 minutes to complete. In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from mentors currently providing their services in hospital.

I would be grateful if you would support this research. For further information, do not hesitate to contact either myself on kirstie.brincat.16@um.edu.mt or 99375818 or my supervisor Dr. Paulann Grech, Senior Lecturer, Department of Mental Health, Faculty of Health Science, University of Malta on paulann.grech@um.edu.mt or 23401180.

I wish to thank you for your help.

Yours Respectfully,
Kirstie Brincat
Masters in Mental Health Studies
University of Malta

If you accept to assist in this study, kindly sign the declaration below:

After reading the above, I, Dr. Victoria Sultana, give my consent to assist in this study.

Signature: _____



Sultana Victoria at Health-Mental Health Services

to me, Paulann ▼

Study approved subject to UREC clearance.

Sent from my iPhone

Wed, 25 May, 10:48 (5 days ago)



On 16 May 2022, at 10:29, Kirstie Brincat <kirstie.brincat.16@um.edu.mt> wrote:

APPENDIX F: APPROVAL FROM INTERMEDIARIES

Mr. Kevin Gafa
Senior Practice Nurse
Mount Carmel Hospital

Dear Mr. Gafa,

My name is Kirstie Brincat, a Staff Nurse currently reading for a Master of Science in Mental Health Studies at the University of Malta under the supervision of Dr Paulann Grech. As part of the course requirements I am conducting a research study entitled, "Nurses' Well-Being in In-Patient and Community Mental Health Care: A Comparative Study". The benefits of this research are to investigate the well-being of nurses working in an in-patient and community care endure.

In order to safeguarding anonymity and confidentiality, I would like to ask if you would be willing to act as an intermediary and distribute and collect the questionnaire (copy attached) in the envelope provided to all nurses working within the mental health field. I wish to assure you that participation is strictly voluntary and that no information capable of identifying potential participants will be requested. Confidentiality and anonymity is therefore guaranteed. Potential respondents are free to decline participation in the study and no pressure is to be made on participants to fill the questionnaire. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. The questionnaire takes approximately 15 minutes to complete. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

In order to apply and get approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, agreeing to act as an intermediary and assist in the study by distributing and collecting the questionnaires provided, in conjunction with an information letter that is to be kept by the participants. Completed questionnaires are to be returned in the appropriate labelled and sealed box placed in your office.

If you accept to assist in this research, please fill in the required details in the consent section below. For further information, do not hesitate to contact either myself on kirstie.brincat.16@um.edu.mt or 99375818 or my supervisor Dr. Paulann Grech, Senior Lecturer, Department of Mental Health, Faculty of Health Science, University of Malta on paulann.grech@um.edu.mt or 23401180.

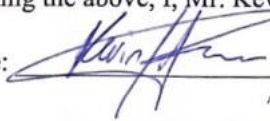
I wish to thank you for your help.

Yours Respectfully,
Kirstie Brincat
Masters in Mental Health Studies
University of Malta

If you accept to assist in this study, please sign the declaration below:

After reading the above, I, Mr. Kevin Gafa, give my consent to assist in this study.

Signature:



16/05/2022

Kevin Gafa'

Psychiatric Nurse / Senior Practice Nurse
Mental Health Services

Ms. Josephine Cassar
Senior Nursing Manager
Mount Carmel Hospital

Dear Ms. Cassar,

My name is Kirstie Brincat, a Staff Nurse currently reading for a Master of Science in Mental Health Studies at the University of Malta under the supervision of Dr Paulann Grech. As part of the course requirements I am conducting a research study entitled, "Nurses' Well-Being in In-Patient and Community Mental Health Care: A Comparative Study". The benefits of this research are to investigate the well-being of nurses working in an in-patient and community care endure.

In order to safeguarding anonymity and confidentiality, I would like to ask if you would be willing to act as an intermediary and distribute and collect the questionnaire (copy attached) in the envelope provided to all nurses working within the mental health field. I wish to assure you that participation is strictly voluntary and that no information capable of identifying potential participants will be requested. Confidentiality and anonymity is therefore guaranteed. Potential respondents are free to decline participation in the study and no pressure is to be made on participants to fill the questionnaire. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. The questionnaire takes approximately 15 minutes to complete. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

In order to apply and get approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, agreeing to act as an intermediary and assist in the study by distributing and collecting the questionnaires provided, in conjunction with an information letter that is to be kept by the participants. Completed questionnaires are to be returned in the appropriate labelled and sealed box placed in your office.

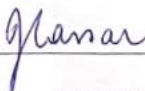
If you accept to assist in this research, please fill in the required details in the consent section below. For further information, do not hesitate to contact either myself on kirstie.brincat.16@um.edu.mt or 99375818 or my supervisor Dr Paulann Grech, Senior Lecturer, Department of Mental Health, Faculty of Health Science, University of Malta on paulann.grech@um.edu.mt or 23401180.

I wish to thank you for your help.

Yours respectfully,
Kirstie Brincat
Masters in Mental Health Studies
University of Malta

If you accept to assist in this study, please sign the declaration below:

After reading the above, I, Ms. Josephine Cassar, give my consent to assist in this study.

Signature: 
Josephine Cassar
Senior Nursing Manager
Community Mental Health

APPENDIX G: POST-HOC COMPUTATIONS

According to Section 4.5.1 Autonomy Subscale:

Autonomy – Grade	Mean Rank	U (Z)	Significance Level
Enrolled Nurses - Staff Nurses	38.25 - 39.60	208.500 (-0.142)	0.887
Enrolled Nurses - Senior Staff Nurses	52.50 – 40.08	156.000 (-1.253)	0.210
Enrolled Nurses - Registered Mental Health Nurses	15.50 – 14.87	66.000 (-0.163)	0.871
Enrolled Nurses - Charge Nurses	15.50 – 13.57	54.000 (-0.532)	0.595
Staff Nurses - Senior Staff Nurses	85.31 – 63.14	1885.500 (-3.181)	0.001
Staff Nurses - Registered Mental Health Nurses	48.21 – 47.35	813.000 (-0.132)	0.895
Staff Nurses - Charge Nurses	48.38 – 42.29	657.000 (-0.918)	0.359
Senior Staff Nurses - Registered Mental Health Nurses	46.46 – 59.41	634.500 (-1.924)	0.054
Senior Staff Nurses - Charge Nurses	46.65 – 55.10	649.000 (-1.236)	0.216
Registered Mental Health Nurses - Charge Nurses	23.72 – 21.17	213.500 (-0.663)	0.508

According to Section 4.5.2 Environmental Mastery Subscale:

Environmental Mastery – Education	Mean Rank	U (Z)	Significance Level
Diploma in Nursing – Degree in General Nursing	55.11 – 46.07	1023.500 (-1.567)	0.117
Diploma in Nursing – Degree in Mental Health Nursing	56.35- 56.62	1536.000 (-0.044)	0.965
Diploma in Nursing – Master’s	38.22 – 47.44	648.000 (-1.724)	0.085
Degree in General Nursing – Degree in Mental Health Nursing	50.42 – 63.23	1245.500 (-2.071)	0.038
Degree in General Nursing – Master’s	34.55 – 55.68	436.000 (-3.888)	<0.001
Degree in Mental Health Nursing – Master’s	44.65 – 57.06	797.00 (-2.084)	0.037

According to Section 4.5.3 Personal Growth Subscale:

Personal Growth – Age	Mean Rank	U (Z)	Significance Level
18-20 Years – 21-30 Years	23.38 – 32.06	83.500 (-0.940)	0.347
18-20 Years – 31-40 Years	17.63 – 28.29	60.500 (-1.317)	0.188
18-20 Years – 41-50 Years	21.88 – 25.82	77.500 (-0.526)	0.599
18-20 Years – 51+ Years	14.88 – 22.73	49.500 (-1.212)	0.226
21-30 Years – 31-40 Years	50.69 – 58.92	1229.000 (-1.373)	0.170
21-30 Years – 41-50 Years	54.47 – 50.02	1220.000 (-0.754)	0.451
21-30 Years – 51+ Years	41.63 – 59.96	703.500 (-3.164)	0.002
31-40 Years – 41-50 Years	54.02 – 42.50	874.000 (-2.042)	0.041
31-40 Years – 51+ Years	40.71 – 50.50	760.500 (1.789)	0.074
41-50 Years – 51+ Years	34.30 – 53.26	497.000 (-3.558)	<0.001
Personal Growth – Nationality	Mean Rank	U (Z)	Significance Level
Maltese – European	92.12 – 51.50	242.500 (-1.721)	0.085
Maltese – Non-European	94.31 – 120.59	1022.500 (-1.823)	0.068
European – Non-European	5.20 – 12.81	11.000 (-2.487)	0.013

According to Section 4.5.5 Purpose in Life:

Purpose in Life – Education	Mean Rank	U (Z)	Significance Level
Diploma in Nursing – Degree in General Nursing	58.33 – 42.98	866.000 (-2.656)	0.008
Diploma in Nursing – Degree in Mental Health Nursing	68.73 – 46.98	944.000 (-3.533)	<0.001
Diploma in Nursing – Master’s	42.63 – 41.09	802.000 (-0.288)	0.773
Degree in General Nursing – Degree in Mental Health Nursing	60.87 – 54.77	1434.500 (-0.988)	0.323
Degree in General Nursing – Master’s	36.31 – 53.03	526.000 (-3.081)	0.002
Degree in Mental Health Nursing – Master’s	40.94 – 63.93	563.500 (-3.863)	<0.001

According to Section 4.5.6 Self-Acceptance Subscale:

Self-Acceptance – Education	Mean Rank	U (Z)	Significance Level
Diploma in Nursing – Degree in General Nursing	52.20 – 45.98	1019.000 (-1.600)	0.110
Diploma in Nursing – Degree in Mental Health Nursing	67.72 – 47.77	993.500 (-3.253)	0.001
Diploma in Nursing – Master’s	45.29 – 37.26	672.000 (-1.500)	0.134
Degree in General Nursing – Degree in Mental Health Nursing	65.22 – 51.25	1213.000 (-2.272)	0.023
Degree in General Nursing – Master’s	44.25 – 41.13	803.500 (-0.576)	0.565
Degree in Mental Health Nursing – Master’s	46.18 – 54.22	893.500 (-1.361)	0.173