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Perceived Support as a Protective Factor for Psychological Resources, Health, and Work Functioning in New Nurses: A Cross-Sectional Descriptive Comparative Study

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ABSTRACT

Background: Support from a workplace referent (e.g., formal and/or informal mentor) is recognized as a key organizational resource, yet its effect on new nurses' psychological resources, occupational health, and occupational functioning remains unexplored at career start.

Aim: This study contrasts new nurses' work experiences based on their perception of having (or not) the support from a workplace referent during their professional integration. Specifically, we examine whether this perception is related to their personal psychological resources, occupational health, and occupational functioning.

Design: A cross-sectional descriptive comparative study was conducted.

Methods: This study relies on self-reported data from a convenient sample of 297 new nurses (≤ two years of experience), either with or without a workplace referent.

Results: In total, 222 reported referent support, compared to 75. *T*-tests (SPSS, version 29) showed significant differences: nurses with referent support reported greater fulfillment of autonomy and relatedness, higher vigor, and less emotional exhaustion than their counterparts. Also, they reported higher work engagement and less intention to quit the profession.

Conclusions: The support from a workplace referent is important at career start due to its association with the personal resources mobilized by nurses to adapt to their job. Autonomy and relatedness are linked to perceived support; competence and psychological resilience seem less context-dependent, potentially reflecting individual dispositions shaped by prior experience. These results open new avenues to better support nurses in their transition to practice.

Relevance for Practice: The results underscore the importance of the support of workplace referents in relation to the psychological resources of new nurses and to their integration into clinical practice. They offer recommendations for designing more intentional and structured organizational strategies for formal and informal peer support in early-career nursing practice.

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1 | Introduction

The nursing sector is currently experiencing a shortage of qualified personnel. This is partly due to the demanding nature of nursing work, the contextual conditions in which it unfolds, and the early experiences nurses encounter that may either facilitate or hinder their integration. In this context, there is an increasing need to critically examine the strategies and mechanisms that can be implemented at the organizational level to promote work environments centered on a culture of support for new nurses [1]. Such environments are essential to new nurses' health and professional functioning. From this perspective, increased attention is being directed toward the efforts required at career start to foster positive work experiences that are essential to new nurses' health and professional functioning. In this respect, about half of national nursing associations acknowledge that formal support measures are not effectively allocated to new nurses [2]. A recent report indicates that nurses feel that they are not adequately supported to face the daily challenges of their profession at career start due to a lack of structured and funded mechanisms to adequately support their entry into practice [3]. In fact, in the current global nursing context, in many places, although decision-makers are committed to increasing the number of newly graduates to address the nursing shortage, the financial support dedicated to their integration remains tenuous, with the result that in some healthcare institutions, new nurses no longer have access to a formal workplace referent, commonly referred to as a formal mentor, to support their integration and retention in the profession [2, 4]. In such a context, some new nurses turn to informal referents—a more experienced coworker or team member (e.g., informal mentor)—for support. Although this form of support can offer help, it remains variable and unstructured. It should also be noted that some new nurses experience their integration without benefiting from any support from work referents. It goes without saying that in such conditions, their psychological resources, their health, and their functioning can be undermined. Accordingly, support can be understood as an issue that calls for an integrated and strategic approach grounded in shared responsibility between individual and organizational levels.

The absence of assigned experienced referents for new nurses in many healthcare institutions and specific units of care reflects a broader lack of formalized transition and career integration programs, limiting access to structured support (see the systematic review by [4]). Yet, preceptorship and mentoring are valued by new nurses as a protective organizational resource against work-related stressors [5]. Structural reforms and austerity measures across healthcare systems in a lot of countries, like Canada, raise concerns about the availability of adequate support for new nurses, particularly given that their professional and personal needs are often addressed in an inconsistent manner [4]. While timely and appropriate work support is known to foster positive outcomes [5, 6], misaligned or insufficient support may have an adverse effect on new nurses' integration [5]. The lack of support at career start thus constitutes a psychosocial risk factor to which new nurses are often exposed, regardless of the national health context. Moreover, a recent meta-analysis [5] indicates that it remains unclear when the effects of perceived support are most pronounced. From this perspective, these effects may vary according to workplace-related factors. It is therefore essential to examining whether the presence of support from a workplace referent, regardless of its nature (formal and/or informal), can help protect new nurses from work-related challenges. More specifically, how does the presence (or absence) of support affect new nurses' psychological resources, health, and functioning at work?

Grounded in Self-Determination Theory (SDT) [7], this study emphasizes the need for a deeper understanding of work support at the outset of nurses' clinical practice. In this regard, it aims to examine the differences related to the benefit of the support of a workplace referent, to determine *whether* and *when* it significantly influences new nurses' adaptation.

SDT is an integrative sequential motivational framework that can explain how contextual resources of an environment, such as the workplace context, can influence the individual's adaptation [8] in terms of health and functioning. According to this theory and several studies (e.g., [6, 9]), the adaptation of nurses depends on the support they perceive that they receive for three basic psychological needs. These are autonomy (the freedom to act and choose), competence (feeling empowered to achieve things for a positive outcome), and relatedness at work (feeling connected and appreciated by others). Slemp et al. [10], in their meta-analysis, highlight that the unique contribution of perceived support to basic psychological needs should be examined individually, despite their strong intercorrelations. Doing so may help better understand the extent to which support is associated with adaptation through the specific satisfaction of each of the basic psychological needs [5]. Together, these so-called *personal* psychological resources—since they emanate from the individual—help explain why, when faced with the same constraints, new nurses do not all adapt in the same way. In other words, a causal dynamic emerges between the new nurse and the workplace context. Both the personal resources and those available in the work setting contribute to shaping the individual's health and functioning. In this regard, SDT specifies the importance of focusing on the worker's *subjective* assessment of the presence of support, rather than on its objective presence (or absence) [7]. Accordingly, the quality and dynamics of perceived support directly stem from the work-related factors within which it is provided, reflecting the theoretical foundation of SDT that subjective evaluation is what ultimately matters. Indeed, a workplace context that supports the satisfaction of basic psychological needs facilitates the internalization of lived experiences [7, 11]. According to SDT, several forms of motivational resources are at the origin of individuals' behavior [11]. Beyond the influence of external resources, SDT emphasizes a natural human propensity for psychological growth and development, which typically unfolds through the satisfaction of their basic psychological needs [12]. When workplace conditions are aligned with these needs, new nurses are more likely to adapt effectively. In other words, they have a natural tendency to seek out stimulating challenges and actively engage in overcoming them [13], thereby demonstrating a genuine capacity for adaptation. It seems thus important to examine the extent to which new nurses perceive themselves benefiting (or not) from the support of a workplace referent and how they adjust in such a context.

Workplace support is a good determinant of the satisfaction of employees' basic psychological needs [7, 8] but can also

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strengthen employee's other personal resources [14]. A psychological resource often put forward in nursing practice to help new nurses adapt to their new reality is psychological resilience. Operationalized as the ability to bounce back in the face of adversity, resilience allows new nurses to react to the stressors that punctuate their everyday professional experience. In an integrative review [15] on the professional integration of new nurses, the importance of professional development (i.e., successful practicum experiences and strong clinical and communication skills acquired during the training process), as well as the support from significant people, was identified as an important levers of resilience. Important here is to note that resilience constitutes a dynamic and adaptive personal resource that can change depending on new nurses' perceptions of their work context, influencing their emotions, cognitions, and behaviors. As such, it is an important antecedent of new nurses' adaptation, as it reflects their capacity to respond positively to targeted organizational intervention, such as workplace support. It remains essential to pay attention to new nurses' personal resources, particularly those that sustain them most effectively, which underscores the importance of considering multiple resources simultaneously and distinctly (e.g., autonomy, competence, relatedness, and resilience). In light of those findings, we propose the following hypothesis:

H1: Significant differences in personal psychological resources (autonomy, competence, relatedness, and resilience) will be observed between the group of new nurses who perceive themselves to be supported by a workplace referent and those who do not; nurses who feel supported are likely to perceive their personal psychological resources more positively.

Current knowledge supports the contribution of resources to the nursing work experience, which should in turn foster psychological health at work, and consequently, functioning at work. In other words, resources should function in ways that promote high levels of well-being while limiting ill-being; however, to optimize their effects, it is important to examine them in an integrated manner. The same logic applies to adaptive attitudes. In this line of reasoning, perceived support contributes to states of well-being at work and optimal functioning [7]. The state of knowledge converges with the idea that individuals who perceive themselves to be supported are found to be resourceful in managing the stress and pressures of everyday life, as well as the challenges they face. According to this idea, workplace support constitutes a lever for adaptation [9]; it allows new nurses to better face, mitigate, or tolerate the situations or challenges they face at work [16]. On the other hand, several research studies document the deleterious effects of the lack of perceived support at work. Among other things, its absence or insufficiency may contribute to psychological distress among new nurses [17] and be associated with high levels of stress at work [18], which can evolve into symptoms of distress and emotional exhaustion [19]. Lack of perceived support is also associated with maladaptive behaviors (e.g., errors and absenteeism) and turnover [20, 21]. Moreover, in its absence, new nurses are less likely to participate in learning and professional development opportunities, compromising their quality of care (i.e., provision of safe, effective, and patient-centered care) [2, 17, 22] and their emotional attachment to their job (i.e., affective commitment) [16]. Accordingly, we propose the following hypotheses:

H2: Significant differences in occupational health (vigor and emotional exhaustion) will be observed between the group of new nurses who perceive themselves to be supported by a referent at work and those who do not; nurses who feel supported are likely to report more vigor at work and less emotional exhaustion.

H3: Significant differences in occupational functioning (affective commitment and turnover intentions) will be observed between the group of new nurses who perceive themselves to be supported by a workplace referent and those who do not; nurses who feel supported are likely to report a higher level of affective commitment, as well as a lower level of occupational turnover intentions.

2 | Materials and Methods

2.1 | Study Design and Sample

The participants of this cross-sectional descriptive comparative study were French-Canadian newly graduated nurses (less than 2 years of experience) from the province of Quebec, Canada. All had completed nursing training, qualifying them at minimum as candidates to the nursing profession. Our sample comes from a larger study in the principal researcher's doctoral project, conducted over a 1-year period, during which recruitment calls were launched between August 2023 and September 2024. Out of a sample of 298 new nurses, 297 provided information regarding whether they have a workplace referent or not. Participants were recruited both online, using a list of members provided by their professional order in Quebec, and in person. Participants were invited to complete a self-administered questionnaire in French, provided in either online or paper format, with a completion time of approximately 20 min. All participants were provided with the same information and consent form, irrespective of the mode of recruitment (online or in person). Informed consent was obtained from all participants prior to granting access to the questionnaire. Their participation was voluntary and confidential: they were assigned a unique identifier to ensure confidentiality and anonymity. Specifically, in-person recruitment involved solicitation of new nurses in the principal researcher's university nursing program. Participants were assured that participation would not affect their academic performance or learning environment. Kits containing the information and consent form, questionnaire, and a return envelope were distributed. Participants returned their questionnaires in the envelope. Data from in-person participants were transcribed only after final grades were approved at the end of the semester. This study was approved by the Ethics Committee of the principal researcher's institution.

2.2 | Measures

The study questionnaire comprised sociodemographic factors (gender, age, etc.). It also included contextual resources (perceived support) and personal resources (perceived autonomy, competence, and relatedness at work, as well as personal resilience). In addition, the questionnaire captured adaptation factors, including health indicators (vigor and emotional exhaustion) and work functioning indicators (affective commitment and occupational turnover intention). Important here is to note that the validity and reliability of the

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French-Canadian versions of these measures were initially attested to in previous studies (FRQSC, 2014–2017; [23], CIHR, 2021–2025 [24]). The Cronbach's alpha values presented below reflect the data collected from our sample. The reliability of all measurement scales was assessed using Cronbach's alpha coefficient, with values of 0.70 or higher indicating satisfactory internal consistency [25]. For all continuous variables, higher scores reflect greater levels of each corresponding construct. All continuous variables were treated as such and analyzed based on their mean scores.

2.2.1 | Perceived Support From a Referent at Work

Two statements were used to measure the perception of support from a workplace referent, namely (1) Do you have a formal referent at work (i.e., a resource and trusted person participating in a mentoring program in your institution to whom you refer as needed for advice and support) and (2) Do you have at least one informal referent at work (i.e., a resource person to whom you refer for advice and support as needed). The answers to these two questions allowed us to determine, in a binary manner (yes/no), whether perceived support from a workplace referent was present at career start, regardless of whether this support was formal and/or informal.

2.2.2 | Personal Psychological Resources

2.2.2.1 | Basic Psychological Needs Satisfaction. The Psychological Need States at Work-Scale (PNSW-S [26]-12 items; $\alpha = 0.927$) was used to measure the satisfaction of basic psychological needs of autonomy (3 items; $\alpha = 0.871$; e.g., "I feel free to make choices with regard to the way I work") competence (3 items; $\alpha = 0.898$; e.g., "I feel I am capable") and relatedness (6 items; $\alpha = 0.942$; e.g., "I feel supported"). Each statement was rated on a seven-point scale ranging from 1 (strongly disagree) to 7 (strongly agree).

2.2.2.2 | Resilience. The Brief Resilient Coping Scale (BRCS [27]-4 items; $\alpha = 0.579$) was used to measure the tendency to cope with stress in an adaptive manner. Each statement was rated on a five-point scale ranging from 1 (does not describe me at all) to 5 (describes me very well). An example of an item is: "Regardless of what happens to me at work, I believe I can control my reaction".

2.2.3 | Occupational Health

2.2.3.1 | Vigor at Work. The Ultra-Short Measure for Work Engagement (UWES-3 [28]-3 items; $\alpha = 0.840$) derived from the Utrecht Work Engagement Scale (UWES-9 [29]) was used to assess high levels of energy at work. Each statement was rated on a seven-point scale ranging from 1 (never) to 7 (every day). An example of an item is: "At my work, I feel bursting with energy".

2.2.3.2 | Emotional Exhaustion. The short subscale ([30]-5 items; $\alpha = 0.907$) derived from the Maslach Burnout Inventory–General Survey (MBI-GS-22 [31]) was used to assess work-related feelings of emotional exhaustion. Each statement was rated on a seven-point scale ranging from 1 (never) to 7 (every day). An example of an item is: "I feel emotionally drained from my work".

2.2.4 | Occupational Functioning

2.2.4.1 | Affective Commitment. The affective component measure of the Occupational Commitment Scales ([32]-3 items; $\alpha = 0.898$) was used to assess the prediction of occupational activity. Each statement was rated on a seven-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). An example of an item is: "I feel emotionally attached to my occupation".

2.2.4.2 | Occupational Turnover Intentions. The French version ([33]-5 items; $\alpha = 0.909$) of an adapted scale from O'Driscoll & Beehr [34] was used to measure new nurses' occupational turnover intentions. Each statement was rated on a seven-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). An example of an item is: "I'm thinking about quitting my current care facility".

2.3 | Data Analysis

The results were analyzed using IBM SPSS Statistics software, version 29. Independent-samples *t*-tests were used to measure statistically significant differences in the two groups' means of participants based on whether they benefited (or not) from the support of a workplace referent. Specifically, MANCOVA was conducted to assess the effect of perceived support while controlling for contingency variables. Univariate ANOVAs were performed for each dependent variable, with Levene's test to check homogeneity of variance and Welch's correction applied when necessary. To control the Type I error rate, we applied the Holm correction for multiple comparisons. Effect sizes (Cohen's d) were reported alongside *p* values for all significant comparisons. Analyses were conducted using listwise deletion, such that only cases with complete data for the variables included in each test were retained (see Supporting Information for characteristics of both sample groups). The level of statistical significance has been set at $p < 0.05$.

3 | Results

3.1 | Participants Characteristics

On average, participants were 26.8 years old (SD = 7.8) and were female (90.5%). A first research group represented nearly a third of the participants (74.7%) and stated that they benefited from the support of a workplace referent. The second research group was made up of 25.3% of the participants and reported not having a workplace referent. The sociodemographic data of these groups are detailed in Table 1.

Some sociodemographic differences are observed between the research groups. The participants in the group without the support of a workplace referent tend to be older and to work on a full-time basis, while the group with the support of a workplace referent includes more part-time nurses and more nurses who report benefiting from the support of significant others outside the job.

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TABLE 1 | Sociodemographic characteristics of the two sample groups of participants.

	With a workplace referent ($n = 222$)		Without a workplace referent ($n = 75$)	
	Mean	**SD**	**Mean**	**SD**
Age	26.0 ($n = 215$)	7.1	29.1 ($n = 74$)	9.4
	n	**%**	***n***	**%**
Gender identity				
Women	203	91.4	66	88.0
Men	19	8.6	9	12.0
Work schedule				
Full time	67	30.2	33	44.0
Part-time	154	69.4	42	56.0

Note: Some missing data explains why the totals are less than 100%.

TABLE 2 | Levene's test for homogeneity of variance between the scores of the groups with and without the support of a workplace referent.

Variables		Homogeneity of variance	
		F	***p* value**
Personal psychological resources	Autonomy	6.416	0.012*
	Competence	1.570	0.211
	Relatedness	0.337	0.562
	Resilience	1.714	0.192
Occupational health	Vigor	3.386	0.050*
	Emotional exhaustion	2.862	0.092
Occupational functioning	Affective commitment	13.439	< 0.001*
	Turnover intentions	10.351	0.001*

*Levene's test is significant ($p < 0.05$), suggesting a violation of the equal variance assumption.

To attenuate concerns that the observed group differences were influenced by contingency variables, a MANCOVA was conducted, with age and work schedule included as covariates. The effect of support remained significant: Pillai's Trace = 0.081, $F(8, 230) = 2.547$, $p < 0.05$, indicating that the group differences were robust and independent of the covariates.

3.2 | ANOVA

One of the premises for the use of independent-samples *t*-tests is the need for equality of variances. The Levene test was therefore used to confirm the homogeneity of the variance. The results indicated significant differences in the variance of the groups with respect to some of the variables measured (see Table 2). Due to the violation of the variance homogeneity of some results, they had to be adapted to Welch's ANOVA analysis, which adjusts the degrees of freedom based on the variances of the compared groups.

3.3 | Independent-Samples *t*-Tests

T-Tests were conducted to assess whether there were significant differences in new nurses' personal psychological resources, occupational health, and occupational functioning, depending on whether or not they benefited from the support of a workplace referent. Average scores for each of the studied variables were obtained for both models of workplace support (see Table 3). Also, the effect size (Cohen's d) was measured in order to assess the magnitude of the difference between the two groups. Based on conventional criteria [35, 36], the observed effect sizes are large. These large effect sizes observed may be partly explained by the dichotomous grouping strategy (*i.e.*, with a workplace referent and without a workplace referent), as such dichotomous grouping may inflate Cohen's d estimates, adding to their interpretation with caution [37]. In addition, the results suggest an association between perceived support and the dependent variables, but they do not allow for conclusions regarding practical significance within the context of the present study [35].

3.3.1 | Personal Psychological Resources

The results indicate a significant difference for the need of autonomy (with support: $\mu = 4.13$; SD = 1.163; without support: $\mu = 3.55$; SD = 1.452; $t = -2.692$, df = 74.959, $p < 0.01$) and the need of relatedness (with support: $\mu = 4.26$; SD = 1.313; without support: $\mu = 3.72$; SD = 1.452; $t = -2.645$, df = 245, $p < 0.01$). However, no significant difference was found for the need for competence (with support: $\mu = 4.82$; SD = 1.007; without support: $\mu = 4.61$; SD = 1.144; $t = -1.376$, df = 245, $p = 0.170$), as well as for the personal resource of resilience (with support: $\mu = 3.70$; SD = 0.537; without support: $\mu = 3.57$; SD = 0.619; $t = -1.649$, df = 256, $p = 0.100$).

3.3.2 | Occupational Health

Average score of perceived vigor at work—an indicator of psychological well-being—is significantly higher among new nurses who report having the support of a workplace referent ($\mu = 4.36$;

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TABLE 3 | Summary of mean scores, standard deviations, and *t*-test results comparing the groups with and without the perceived support of a workplace referent.

Variables		With a workplace referent		Without a workplace referent		*t* test	*p* value (2-tailed)	Holm threshold	Cohen's d
		Mean	SD	Mean	SD				
Personal psychological resources	Autonomy	4.13	1.163	3.55	1.452	−2.692	0.009*	0.01	1.232
	Competence	4.82	1.007	4.61	1.144	−1.376	0.170	0.05	1.039
	Relatedness	4.26	1.313	3.72	1.452	−2.645	0.009	0.0125	1.345
	Resilience	3.70	0.537	3.57	0.619	−1.649	0.100	0.025	0.557
Occupational health	Vigor	4.36	1.022	3.81	1.263	−3.014	0.003*	0.00714	1.081
	Emotional exhaustion	3.81	1.315	4.51	1.508	3.422	< 0.001	0.00625	1.360
Occupational functioning	Affective commitment	5.25	1.110	4.65	1.594	−2.603	0.011*	0.0166	1.233
	Turnover intentions	1.80	1.255	2.42	1.506	2.803	0.006*	0.00833	1.315

*Levene's correction for unequal variances.

SD = 1.022) compared to those who do not ($\mu = 3.81$; SD = 1.263) ($t = -3.014$, df = 78.559, $p < 0.01$). For its part, the average score of perceived emotional exhaustion—an indicator of psychological ill-being—is significantly lower among new nurses who report having the support of a workplace referent ($\mu = 3.81$; SD = 1.315) compared to those who do not ($\mu = 4.51$; SD = 1.508), ($t = 3.422$, df = 251, $p < 0.001$).

3.3.3 | Occupational Functioning

Average score of perceived emotional commitment to the profession—a positive indicator of work functioning—is significantly higher among new nurses who report having the support of a workplace referent ($\mu = 5.25$; SD = 1.110), compared to those who do not ($\mu = 4.65$; SD = 1.594) ($t = -2.603$, df = 69.664, $p < 0.05$). As for turnover intentions—a negative indicator of work functioning—average score is significantly lower in new nurses who report having the support of a workplace referent ($\mu = 1.80$; SD = 1.255), compared to those who do not ($\mu = 2.42$; SD = 1.506), ($t = 2.803$, df = 76.750, $p < 0.010$).

3.4 | Post Hoc *t*-Tests Controlling the Familywise Error Rate

Post hoc *t*-tests were conducted for each dependent variable. After applying the Holm–Bonferroni correction, all significant effects remained significant (see Table 3).

4 | Discussion

Based on SDT, this study aims to describe and compare the career integration experiences of new nurses based on whether or not they perceived having the support from a workplace referent. In other words, we tested whether there were statistically significant differences between two research groups—with and without the perceived support of a workplace referent—on distinct personal resources and adaptation factors, namely, new nurses' psychological resources (autonomy, competence, and relatedness at work, as well as personal resilience at career start), occupational health (work vigor and emotional exhaustion), and occupational functioning (affective commitment and intent to leave the nursing profession). This was made to determine whether the perception of support from a workplace referent (formal and/or informal) at the onset of the nursing career can serve as a protective factor, reinforcing nurse's personal psychological resources, health status at work, and overall functioning in the profession. Most of the results of the present study point in this direction. Aside from the need for competence and resilience, significant differences emerged between the research groups, with those perceiving support reporting better autonomy and relatedness at work (partially supporting H1), along with better occupational health (supporting H2) and occupational functioning (supporting H3).

Therefore, although the perceived support from a workplace referent is largely recognized as beneficial in the context of professional integration, it is important to recognize that it does not necessarily guarantee quality support or an adequate response to the specific needs of new nurses. This distinction is essential for deepening the understanding of the actual impact of support at the beginning of a nursing career. It follows theoretical and practical implications.

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4.1 | Theoretical Implications

4.1.1 | Perceived Support From a Workplace Referent

In nursing employment, psychosocial risk factors point to work management, as well as to the social and organizational context. Nurses are the group of professionals most at risk of being exposed to many psychosocial factors in the workplace, which constitute challenges to their occupational health and functioning. Such psychosocial risks may, in turn, affect the experience and career paths of new nurses [1, 2]. They can also act on some of the personal psychological resources that can be mobilized to meet the demands of the nursing environment. These risks stem from work-related factors and how they are managed [38]. Among the most frequently documented factors are work overload, high emotional demands, extended hours, and environments marked by understaffing and urgency, where supervision is often insufficient to support the adaptation and development of individuals [1, 2, 39]. The personal and organizational repercussions that result from these risks call for a shift in perspective: rather than focusing solely on work-related risk factors to alleviate ill-being states of new nurses, it is necessary to act on the levers of well-being that can strengthen their health and functioning in the profession. In order to improve practices, our study recognizes the contribution of perceived support as a protective factor in the context of professional integration.

Aligned with SDT, our results underscore the pivotal role of support acting as a key driver in the professional developmental trajectory of new nurses. In particular, the theory on the stages of clinical expertise [40] shows that new nurses have to be supported to acquire knowledge and skills in order to become self-reliant. In other words, they need to perceive that they are supported in order to carry out their work. Perceived workplace support in the nursing context thus appears to be closely intertwined with the creation of safe, empowering, and healthy work conditions [16]. Precisely, it is known to act as a protective factor against nursing work stressors [22]. In the presence of support, new nurses are more inclined to develop their full potential and to live experiences that are favorable to their adaptation. Also, it is undeniable that new nurses must have a good knowledge of their resources at work, especially in the context of inflexible and limited contextual resources [41]. Despite the stressors of nursing work, referents, who are generally formal, are becoming less and less present in clinical environments and, in some cases, completely absent. This is also true for informal referents, as nurses are exhausted and overworked [4]. Our study therefore calls for a reconsideration of the nature of support. Specifically, it is not the objective presence of support in the workplace that seems to matter most, but rather nurses' *perception* of that support. Hobfoll [42] indicates that this implicit aspect of support reflects how a person interprets or feels the support available to them. It provides information on the subjective evaluation of support, namely, the quality of one's interpersonal relationship as described by Senecal et al. [43] (degree of mutual understanding, feeling of being recognized, appreciated, and respected, ability to rely on the other person, and overall sense of contentment and satisfaction of the relationship). A telling example is the study of Gagnon-Béland et al. [44] which shows that the quality of interpersonal relationships at work serves as a lever for new nurses' adaptation. Thus, at the time of professional integration into a nursing career, perceived support from a workplace referent may influence the lived experience, given the critical importance of adaptation for new nurses. In this regard, nursing work often restricts the implementation of support mechanisms based on reflective processes, which is necessary to promote sustainable learning that is transferable to the professional trajectory. From another perspective, are nurses themselves the best placed to influence and shape the future of the profession through their many interactions on a daily basis? In light of changes in nursing, health institutions should empower experienced nurses to support new nurses [4, 45] and foster a culture responsive to early-career needs. Without limiting itself to a provincial context, certain legislation illustrates this trend—e.g., Quebec's Bill 27, which requires employers to assess work-related psychosocial risks and incorporate them into their prevention plans. This legislation also mandates, among other things, the active involvement of nurses. As a result, to facilitate the professional integration of new nurses, experienced nurses will have to adopt proactive health behaviors.

4.1.2 | Personal Psychological Resources

Our study adds to the knowledge since it targets the basic psychological needs of autonomy, competence, and relatedness, which, when they result from a workplace conducive to well-being, are the basis of adaptive behaviors [7, 8]. It also takes into account the psychological resilience of new nurses, or, more specifically, their resilient adaptation. Gaining deeper insight into the perceived support provided by workplace referents is crucial for understanding new nurses' workplace adaptation, the stressors they face early in their careers, and the coping mechanisms they employ.

Hypothesis 1 posited that the participants who benefit support from a workplace referent are likely to perceive their personal psychological resources at work more positively. Aligned with SDT, new nurses who perceived support in their workplace present better autonomy at work and better relatedness. In the nursing context, these results are partially in line with those of the systematic review by Slemp et al. [46], who emphasize need-supportive interventions to promote autonomy, competence, and relatedness-supportive behaviors or procedures in organizations. In contrast, our results were inconclusive regarding the need of competence. This result is not surprizing, given that feelings of competence and efficacy in one's job may be more closely tied to skill development. Indeed, research focusing on support for the need for competence involves actions that foster skills and know-how. To better support competence, the state of knowledge highlights the effectiveness of so-called situational interventions—related to a given intervention—(e.g., knowledge sharing, definition of realistic and motivating expectations, and constructive feedback), beyond their mere granting.

Also, our results were unconclusive regarding resilience. Given the low internal consistency of the resilience measure, our results should be interpreted with caution. The transition to nursing practice often represents a demanding period during which nurses' psychological resources may be particularly challenged. Studies have shown that a supportive work environment fosters resilience. While formal programs have proven effective, they are

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often limited in accessibility. Moreover, they are not sufficient on their own—just as informal training initiatives fall short when broader organizational factors are not taken into account [47]. Also, resilience is an adaptive resource linked to how new nurses perceive their work environment, reinforcing the importance of considering organizational and contextual resources that may influence the level of support perceived by new nurses, or their perception of that support. In this context, we deemed it pertinent to retain this variable in the analyses to explore its potential relationship with perceived support.

Moreover, support must be adapted to the context or a given situation [46]. A supportive work environment, characterized by the presence of trustworthy and caring persons that provides mentorship and guidance, appears to be a determining factor in the adaptation of new nurses at career start. Recent studies highlight that work support is a key organizational resource for the professional development and integration of new nurses, allowing them to consolidate the personal psychological resources necessary to meet the complex demands of their practice [1, 15, 49]. However, it appears that lack of appropriate support is often the cause of unmet needs [50]. Thus, the provision of support is not enough to ensure its quality or protective value, just as depending on the nature of a supportive relationship, it may not always be perceived as appropriate and useful [10] to the satisfaction of all personal resources.

4.1.3 | Health and Functioning at Work

In addition, to address hypotheses 2 and 3, our study takes into account differences in both positive indicators (vigor and affective commitment) and negative indicators (emotional exhaustion and turnover intentions) related to the occupational health and occupational functioning of new nurses. These indicators are part of continuums with opposite poles: emotionally, ranging from vigor to emotional exhaustion, and attitudinally, from affective commitment to intentions to leave the profession. These considerations provide a holistic view of the professional experiences of new nurses when they start their career, especially in a context where new nurses operate in settings that expose them to significant stress and workplace tensions, which are likely to affect their well-being and retention in the profession [22]. To abound in this direction, rather than focusing solely on challenges, efforts in support provision should also aim to highlight opportunities and promote the self-determination of new nurses. This new perspective must put forward new nurses' professional development in harmony with a safe and healthy workplace, shaped by an autonomy-supportive culture. This systemic perspective proposes a new integrated configuration of knowledge regarding health and optimal functioning marked by the presence of a state of psychological well-being in new nurses, supported by their colleagues and the organization. In summary, the positive health approach frames psychological occupational health in terms of overall well-being.

4.2 | Practical Implications

By adopting a broader perspective on support—based on its presence or absence rather than solely on its quality, healthcare institutions are encouraged to implement a formal policy to promote the creation of conditions conducive to well-being and, in this way, allow nurses to recognize themselves as true agents of change, co-responsible for their adaptation and health. In this regard, perceived workplace support at the onset of a nursing career should be actively fostered, if not through structured mentorship or preceptorship, then through informal supportive relationships, highlighting the importance of workplace referents, who are often difficult to access in some healthcare institutions. These persons, nonetheless, are important figures of reassurance, security, and support at career start [51]. In addition, "nurses must be equipped to lead, delegate, supervise, and challenge other nurses and healthcare professionals." ([52], p. 4). These standards already valued the quality of support through the concrete actions they generate. In addition, the prospects for the practice of the profession have established guidelines based on the idea that nurses must collaborate with training institutions in order to contribute to the supervision of the student nurses and new graduates. However, the implementation of such recommendations raises important questions regarding their implications for practice. What are the outcomes of implementing support practices co-developed through collaboration between training institutions and healthcare institutions, and how do these practices support the early career integration?

As far as we know, nurses are often poorly trained, or not trained at all, to support new nurses and also have no prior experience [51]. Yet, the social dynamics that are being developed at career onset are an important factor to new nurses' health and functioning [53]. Thus, nurses are routinely encouraged to strengthen their positive leadership practices; in other words, to exert a positive influence on others, particularly new nurses, through positive interpersonal and social relationships. More specifically in the context of professional integration, new nurses' perception of positive leadership practices from their workplace referent can enhance their sense of being supported, especially when their perception is influenced by positive emotions [54]. Similarly, these interactive processes, which involve contextual, relational, and psychological resources, should be established in a healthy work climate to contribute to favorable professional experiences [49]. Following up on that, the implementation of individualized development plans, providing targeted support, would contribute to more detailed knowledge of the specific needs of each new nurse [53]. It is therefore up to healthcare institutions to promote well-being in their workplace environments and thus create supportive practice environments. In doing so, they create avenues for developing more thoughtful and well-structured organizational strategies to address the enhancement, maintenance, or restoration of psychological resources conducive to adaptation in nursing practice at career start. They could help foster a supportive culture conducive to health and optimal functioning among new nurses. As nurses are more prone to states of psychological ill-being at work because they are exposed to workplace stressors and their challenges, such strategies would help mitigate the risks of new nurses' burnout and disengagement. From this perspective, an important avenue for future research lies in re-examining how support is conceptualized and enacted during professional integration in nursing. How does viewing each new nurse as the leader of their own professional trajectory reshape the role of the workplace referent, now centered on supporting self-management?

Here it is important to note that the psychosocial environment of nursing practice can have an effect on the perceived quality of work

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relationships, which may influence how new nurses perceive the support from a workplace referent. Indeed, nurses face particularly high demands due to the heavy workload, which may lead to the perception that professional practice now operates from an "everyone for themselves" perspective, with the ultimate goal being to merely manage to complete their tasks within the limits of their shift. In addition, supportive practices require time and energy, and current working conditions raise questions about whether experienced nurses truly have the psychological, physical, and social resources necessary to adequately support the professional growth and development of new nurses.

In order to limit the factors that have the potential to hinder the conditions conducive to new nurses' well-being at work, the creation of an environment that focuses on psychosocial safety is a promising path, especially since the support received depends largely on it [46]. It should also be noted that psychosocial security influences the proactivity of new nurses when they start working, and, as a result, they are able to identify sources of support, allowing them to mobilize the "right" resources. Since perceived support from a workplace referent was not associated with differences in the need for competence and resilience in our study, new nurses may need to rely more on self-management practices that allow them, to some extent, to facilitate their transition into a professional practice aligned with both their skills and needs [53].

4.3 | Limitations and Future Paths

This study has certain limitations that need to be addressed. First, it relied on a cross-sectional and descriptive research design, which does not allow for the temporal relationship between variables. A longitudinal design would allow us to account for the dynamic nature of the links investigated, and thus, we would have a better understanding of the differences studied. Moreover, with regard more specifically to resilience, which is considered a dynamic psychological resource, it is important to note that the reliability of our measure, as indicated by a suboptimal Cronbach's alpha (0.579), may threaten the validity of the construct assessed and weaken the interpretation of results, making the low score both understandable and expected. Second, data were collected during a period that coincided with cuts to the integration measures for newly graduated nurses in Quebec (e.g., reduced number of orientation days, elimination of training funds, and decreased availability of support). In addition, the professional licensing examination and the academic semester may have influenced participants' perceived support. New nurses may have felt under significant pressure, which could have distorted their perception of the support received or even led them to experience a complete absence of support. The interpretation of the workplace referent's role may vary, as may the expectations associated with it. In particular, the use of other collection tools (e.g., interviews) would have allowed us to increase our understanding of the phenomenon regarding the perception of the support from a workplace referent. In the same vein, the self-reported measures constitute a third limitation illustrating only the perception of new nurses. Indeed, it would have been interesting to collect data from the formal and/or informal workplace referent or from the organization in order to collect more information on, for example, the quality of support that new nurses can benefit from in the context of professional integration. Fourth, no contingency variables were experimentally controlled in the conduct of the study. However, MANCOVA analyses were conducted to examine the potential influence of these variables (e.g., age and work schedule), which were not experimentally controlled and may therefore have affected the results. Although contingency variables may influence personal psychological resources, adaptation factors, and/or work functioning factors, MANCOVA results indicate that the observed group differences are robust and primarily reflect the constructs of interest.

5 | Conclusions

This study paves the way for the importance of the support *adapted to the basic psychological needs and resources* of new nurses during their professional integration. To this end, we suggest that the active involvement of new nurses be considered a complementary strategy to support their transition into the nursing profession. The workplace referent actively contributes to the professional development of new nurses. Therefore, more than ever, we need to look at support from a broad and strategic perspective. Unequivocally, support is an important resource at work, especially at the beginning of employment. In order to keep nurses engaged and healthy throughout their professional career, we consider support not an individual but a shared, collective, and even organizational responsibility.

Author Contributions

Camille Gagnon-Béland, Stéphanie Austin, and Liette St-Pierre designed the study. Camille Gagnon-Béland collected and analyzed and interpreted the data. Camille Gagnon-Béland prepared tables and figures. The manuscript was written by Camille Gagnon-Béland, with Stéphanie Austin and Liette St-Pierre contributing through editorial suggestions and commentary.

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Disclosure

All authors have read and agreed to the published version of the manuscript.

Ethics Statement

This study was conducted in accordance with the Declaration of Helsinki and approved by the Research Ethics Board for human research of the University of Quebec in Trois-Rivieres (CER-23–295-07.02).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data are not publicly available to respect the privacy of research participants.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Supporting Information.** Detailed characteristics of both sample groups are included in the supporting information. The completed STROBE checklist is available from the corresponding author upon request.

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