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JOURNEYING THROUGH UNCHARTED TERRITORY:
THE ROLE OF HUMOUR IN ADAPTATION OF UNDERGRADUATE NURSING
STUDENTS IN THEIR FIRST YEAR OF STUDY

Marie-Josée Boulianne
20121247

Submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy



School of Nursing and Midwifery
The University of Notre Dame Australia

August 2021

Declaration of Authorship

This thesis is the candidate's own work and contains no material that has been accepted for the award of any degree or diploma in any other institution.

To the best of the candidate's knowledge, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018). The proposed research study received human research ethics approval from The University of Notre Dame Australia Human Research Ethics Committee (EC00418), Approval Numbers 018164F and 019062F.

Marie-Josée Boulianne

23 August 2021

Abstract

Newly graduated nurses adapting to their professional role have been studied, mainly in their first year of practice. The development of coping strategies, acculturation and other adaptations to the nursing world begin at the onset of the educational journey.

Understanding how these manifest early in the formative years can enable educators to tailor nursing programs to assist the future nurse to develop positive coping mechanisms and help pave the way to a successful transition into practice.

This research aimed to identify elements conducive to positive adaptation and wellbeing of nursing students during their first year of nursing studies, including the role played by humour. The current literature concerning nurses' transition into practice, the reality and demands of the nursing profession, and the beneficial and detrimental strategies used to cope with them guided the research.

The researcher used opportunistic sampling to recruit participants and follow them during their first year of nursing education. This mixed methods study obtained measures of coping, resilience and humour styles at baseline. Further enriching the data, the study was modified with the advent of COVID 19, and participants engaged in a series of reflective journals and interviews following clinical placements along a lengthier period of a full year. Data triangulation identified the main factors facilitating students' adaptation. Of these, the positive roles of relationships and humour were found to be intricately linked to students' adaptation in academic and clinical fields, and proved beneficial in coping with the demands and pressures experienced in nursing. Recommendations drawn from these findings inform nursing educators and workforce developers on vital elements to facilitate program completion and workforce sustainability.

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To my future self: Take a break, look back, and have a laugh. It was all worth it in the end.

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List of Publications

Presentations

Boulianne, M. (2019, May). *Laughing through the nursing journey* [Paper presentation]. Sigma Psi Alpha at-Large Nursing Research Symposium, Perth, WA, Australia. (Appendix U)

Boulianne, M. (2021, June). *Laughing through the nursing journey* [Masterclass]. Australian College of Mental Health Nurses: The Ripple Effect of Self Care on Others, Perth, WA, Australia. (Appendix V)

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List of Abbreviations

ADL	Activities of Daily Living
AHPRA	Australian Health Practitioner Regulation Agency
AIN	Assistant in Nursing
ANMAC	Australian Nursing and Midwifery Accreditation Council
AQF	Australian Qualifications Framework
ASN	Associate of Science in Nursing
CNA	Certified Nursing Assistant
CPNRE	Canadian Practical Nurse Registration Examination
COVID-19	Coronavirus
EI	Emotional Intelligence
EN	Enrolled Nurse
FYNS	First Year Nursing Student
GEN X	Generation X
GEN Y	Generation Y, Millennials
GEN Z	Generation Z
GN	Graduate Nurse
HECS	Higher Education Contribution Scheme
HRM	Holistic Reflective Model
HSQ	Humor Styles Questionnaire
LPN	Licensed Practical Nurse

LVN	Licensed Vocational Nurse
MMR	Mixed Methods Research
NCLEX	National Council Licensure Exam
NMBA	Nursing and Midwifery Board of Australia
NNCE	National Nursing Competency Examination
NS	Nursing Student
PRN	Pro Re Nata (as required)
RN	Registered Nurse
SANC	South African Nursing Council
STRN	Student RN
SWLS	Satisfaction with Life Scale
TEQSA	Tertiary Education Quality and Standards Agency
VET	Vocational Education and Training
WA	Western Australia
WACHS	WA Country Health Service

Prologue

It has always struck me how nurses have a witty and dark sense of humour. From my training days and subsequent employment, no matter the setting, whether palliative care, theatre, rehabilitation, mental health, general practice, infection control, private practice or academia, humour has been medicinal for both patients and nurses. I have observed humour during care provision to alleviate embarrassing situations, to lighten the mood or to attempt to distract a person receiving care (or their support person) in significant moments of stress. In all instances, it was never done to belittle or 'make fun of' someone, rather to soothe an otherwise intense situation. Nurses are also notorious for camaraderie, treatment room banter and break room antics. What turns the innocent, angelic looking nurse into the raucous black humour comedian, I wonder? Is it the work itself or the type of people working in the field? Are the trauma-prone situations inductive of this kind of coping mechanism? Is it indeed a coping mechanism or just a release valve?

I personally resort to humour to cope with most of what life throws at me. From the inception of my own nursing journey, I noticed how humour was such a significant part of my day-to-day events. Whether it was in the classroom, caring for people or among colleagues, I rarely noted humour to be disrespectful towards another human being. It was often self-deprecating, yet never intended to belittle someone else. I observed, and participated, most probably often initiated, interactions where humour had a significant thread. I used it to defuse difficult situations, to divert attention away when appropriate, or to reduce tension or embarrassment. With my colleagues, during catch-up talks, and mostly over food and definitely coffee whether in the break room or in a social setting, this humour invariably turned dark and hilarious.

Nurses are renowned for their sense of humour and the internet is filled with cartoons and memes to that effect. Despite this, most research papers and journal articles are devoted to the use of humour in the clinical area (Ghaffari et al., 2015; McCreddie & Wiggins, 2008; Tremayne, 2014). My interest and focus were centred on the nurse as a person and the role that it played in that nurse's personal experience. Difficult situations, such as emotionally taxing experiences, erode nurses' wellbeing, and bullying is still rife among the ranks (Bambi et al., 2019), and worse, it does not escape the nursing students (Minton & Birks, 2019). It is my view that as individuals, we must

find ways to maintain our own wellbeing while also having our colleagues' best interests at heart. If we can help one another to become stronger, utilise the resources we already possess and manage to come out the other end at least still standing, we owe it to ourselves, and to our brothers and sisters and the profession, to share what works.

I have introduced to you the reader my personal motivations and observations for embarking on this voyage. The solid development of future nursing colleagues, and their welfare through formative and practical years, is important to me, and I consider this wellbeing the actual foundation of good nursing. Without a solid foundation, no matter how beautiful the castle is, it will crack and fall. Our future nurses cracking and falling should be prevented in all possible ways. Granted, I am also of the personal belief that not everyone's journey may suit that of nursing, and this fact may well become apparent at a later stage in that student's or nurse's life. This personal journey is unique to all. Some may embark on their own voyage to discover that nursing is not for them. Others will utilise it as a platform to springboard into something different such as medicine or law. However, at the basis of it all, nursing begins with a deep and intricate connection to all of humanity, in its most ugly and beautiful forms.

I have personally always questioned why we seem to think of nursing as a 'thing to do' when in actual fact it begins at the very core of who we are, our intrinsic and powerful drive to be there and assist others when they are vulnerable. Yet nurses can be seen at times as behaving in totally opposite ways towards each other—bullying, deliberate exclusion, unwilling or unhelpful collaboration, dissing, and overt as well as covert attacking. What can possibly turn the iconic angel into the mean-spirited teammate? But more so to me, what are the elements that help the young nurse rise above the ashes and pull through difficult times, problematic behaviours and perplexing personalities? Could there be a way for us to encapsulate just a little of this, grow it in our incubators somehow and strengthen the personal foundations of nursing to produce meaningful health outcomes for not only the person receiving our care but also the very person entrusted in delivering it?

It is my hope that the reader will enjoy setting sail with me and the students, with the aspiration of finding treasures not only to help our students along their training journey but also to assist the profession as a whole.

This PhD may well be my biggest odyssey! No joke!

Chapter 1: Reasons to Embark on this Voyage

1.1 Introduction

This chapter will present contextual information on nursing in Australia. It will begin by providing a background into the current state of the Australian nursing workforce from recruitment to engagement and retainment. It will then provide detailed information regarding studying nursing in Australia and inform the reader on the structure governing the profession, accreditation of academic programs and their delivery, and the requirements for obtaining and maintaining registration as a registered nurse (RN). The chapter will also provide a summary of the issues encountered in the development of nursing students (NSs) and link these with the purpose and aim of the research. Additionally, specific research objectives will be provided along with the principal and secondary research questions that guided the project.

1.2 Background

In 2016, nurses in Western Australia (WA) comprised nearly 10% of the national nursing labour force (Australian Health Practitioner Regulation Agency, 2017; Bass et al., 2017) and over 3% of the Australian working population (Australian Bureau of Statistics, 2017). Their impact on system-wide health services and the health workforce is significant and requires adequate attention to promote professional maintenance and optimisation. The impetus to nurture nurses should be equally present during their training as throughout their careers.

Entrants to nursing practice programs contend with high attrition rates, varying between 35% (Department of Health, 2014a) and 50% (Australian Government, 2017c; Mooring, 2016), despite reasonable prospects of employment soon after graduation (Australian Government, 2017c). The current average age of an Australian nurse is 44.3 years (Australian Government, 2017b), and the profession is experiencing a replacement rate of 0.9% per annum (Australian Government, 2017d), a fact aggravated by employers seeking experienced nurses to the detriment of new graduates (Australian Government, 2017a). Finding strategies to retain and support NSs to graduation can assist in solving problems around workforce development.

The retention, engagement and productivity of nurses are tied to general employee welfare encompassing work environment, workload, stress and burnout (Lamont et al., 2017; Leiter & Maslach, 2009; Stone et al., 2009). Factors such as fatigue and violence experienced at work are known for their devastating effects and are addressed in organisational policies (Department of Health (WA), 2013, 2015). Despite their existence and promotion, current WA undergraduate nursing curricula do not specifically contain objectives to prepare NSs for the pernicious aspects of their future careers (Curtin University, 2018; Edith Cowan University, n.d.; Murdoch University, n.d.-a; The University of Notre Dame Australia, 2017). This is a significant deficiency likely to contribute to the vulnerability of the novice workforce with important economic and health consequences for both the nursing community and the populations it serves.

1.3 Studying Nursing in Australia

The following section will provide the reader with background information regarding studying nursing in Australia. It will first provide demographic statistics around nurses and NSs. A brief overview of the role and responsibilities performed by the Australian Health Practitioner Regulation Agency (AHPRA), the Nursing and Midwifery Board of Australia (NMBA) and the Australian Nursing and Midwifery Accreditation Council (ANMAC) will be provided. Information pertaining to the obtention of a nursing qualification and what awaits the NS once they become a graduate nurse (GN) follows. Finally, a brief introduction to psychometric tools to assess coping, resilience and wellbeing will be presented.

1.3.1 Nursing Statistics

The profession of nursing has traditionally been dominated by women. Typically, men in nursing account for less than 20% of the workforce. They represent almost 10% in the United States (Hodges et al., 2017), 10.5% in Israel (Ashkenazi et al., 2017), and 11% in the United Kingdom (Aubeeluck et al., 2017) and Canada (Kane et al., 2020), while Australia registers just over 12% (AHPRA, 2020a).

The high female representation in nursing remains consistent throughout the nursing field, whether they are practising or studying (Table 1.1). The gender distribution of practising nurses in Australia in 2019 was around 87% female to 12% male. Several research projects involving undergraduate NSs in Australia and around the world have

similar gender distributions in their samples (Asturias et al., 2021; Z. C. Y. Chan et al., 2019; Pickles et al., 2017).

Table 1.1: Distribution of Registered Nurses Practising and Studying in 2019

	Registered nurses ^a (as at 2019) n (%)
Gender	
Female	334,138 (87.9)
Male	45,936 (2.1)
Total	380,085 (100.0)

^a Source: Australian Health Practitioner Regulation Agency (2020a).

In 2019, Australia had 111,746 students enrolled in an undergraduate nursing program (AHPRA, 2020a). The gender distribution for these students for the same period could not be found in the published literature.

1.3.2 Australian Health Practitioner Regulation Agency

The *Health Practitioner Regulation National Law Act 2009* (National Law) was ratified in each Australian state between 2009 and 2010. Its aim was to establish a scheme for the registration and accreditation of a variety of health practitioners, which is referred to as the National Registration and Accreditation Scheme (the National Scheme) (National Health Practitioner Ombudsman, 2020). The AHPRA is responsible for implementing the National Scheme. The scheme's aims are to 'safeguard the Australian public by ensuring that only suitably trained and qualified practitioners are registered; facilitating workforce mobility across Australia; and enabling the continuous development of a flexible, responsive and sustainable Australian health workforce' (ANMAC, 2019a, p. 1 (online)).

The AHPRA is an umbrella agency that works in conjunction with the national boards of 15 health specialities, including the NMBA. The AHPRA supports all the national boards in protecting the Australian public in regulating all the above registered health practitioners under the National Scheme (AHPRA, 2021b). Individual national boards set standards and subsequent policies that their health practitioners must satisfy, while AHPRA provides the boards with administrative support in achieving this (2020c). This collaborative partnership seeks to promote the public's trust by ensuring that the

national health workforce across all disciplines is safe and consistent in standards (AHPRA, 2020b).

A Health Profession Agreement is drawn up between each board and the AHPRA. The agreement sets out details regarding fees, budgets and services that will be offered by the AHPRA. National boards can assign their authority over decision-making to committees at the national, state or territory level or choose to authorise the AHPRA to do so (AHPRA, 2021a). For example, the NMBA has delegated the AHPRA to collect evidence concerning a health practitioner's identity, professional indemnity insurance and criminal history (NMBA, 2021a).

1.3.3 Nursing and Midwifery Board of Australia

The NMBA governs the nursing profession in Australia and is responsible for setting the professional standards for the safe and professional practice of all nurses, which comprise RNs, Enrolled Nurses (ENs), Nurse Practitioners, and midwives, in Australia (NMBA, 2018). These professional standards include the Codes of Conduct, the Standards for Practice, and the Codes of Ethics (NMBA, 2021b).

The first set of standards developed by the NMBA is the Registration Standards (NMBA, 2021c). To meet the requirement for their initial registration, applicants must demonstrate adequate completion of an education program, provide a disclosure of criminal history and satisfy the English language skills (NMBA, 2021c). Other yearly requirements that must subsequently be demonstrated include compliance with recency of practice, holding professional indemnity insurance and the maintenance of continuing professional development (NMBA, 2021c). As discussed previously, the administrative task of collecting such evidence may be delegated to or appropriated by another entity such as the AHPRA.

The second set of standards developed by the NMBA is the Standards for Practice for the EN, RN, NP, and midwives (NMBA, 2016). In addition to these, the NMBA is responsible for developing the professional codes, guidelines, and policies relevant to all nurses and midwives. An example of such a code is the *Code of Conduct for Nurses* (NMBA, 2018).

The *Code of Conduct* includes a domain for the promotion of health and maintenance of wellbeing. One of its guiding principles, Principle 7.1, is centred around nurses' own health and that of their colleagues and seeks the nurturing of nurses' own emotional and psychological wellbeing (NMBA, 2018). It expects RNs to continuously work to a high level of practice while maintaining their physical and mental health, actively reducing the effects of stress and fatigue, and at the same time fostering help-seeking behaviours among colleagues. This is echoed in the *Standards for Practice* under Standard 3.1 (that will be discussed in more detail in the next section), which requires nurses to be attentive and respond to their own health and wellbeing as well as that of others in the context of their capacity for practice (NMBA, 2016). These principals and standards are general in nature.

1.3.4 Australian Nursing & Midwifery Accreditation Council

The Australian national standards regarding nursing education, training and assessment requirements in Australia are set by a collaborative process between NMBA and the ANMAC (2019a). The NMBA has appointed the ANMAC as the independent authority responsible for accrediting education programs under Australia's National Registration and Accreditation Scheme governed by the AHPRA. However, the final approval of the Accreditation Standards for EN, RN, NP and midwives is retained by the NMBA.

The ANMAC's main responsibilities rest on the following (ANMAC, 2019a):

- developing and reviewing accreditation standards for nursing and midwifery professions in Australia
- determining whether programs of study, and the education providers that provide the programs of study, meet the approved accreditation standards for the nursing and midwifery professions
- monitoring the approved programs of study and the education providers that provide the programs of study to ensure that they continue to meet the approved accreditation standards for the nursing and midwifery professions
- liaising with national and international professional bodies, regulators and educators on matters related to standards of education and practice.

To be listed as an NMBA-approved study program, education providers, such as universities, must first secure accreditation endorsement from the ANMAC, who then recommend their approval with the NMBA. The accreditation process undertaken by ANMAC reviews study programs against the current accreditation standards for the relevant nursing role, whether EN, RN, NP, or Registered Midwife (RM) (ANMAC, 2019b). Education providers are expected to base their curricula on the Practice Standards and demonstrate how their program delivery aligns with the application of the Accreditation Standards. Successful completion and graduation of an approved education program will enable the graduate to obtain registration with the NMBA. As the general intent of this study is the ultimate wellbeing of NSs, it is warranted to consider contributory factors pre-registration.

The RN (Division One) program of study must meet five accreditation standards (ANMAC, 2019b). Standards 3 to 5 relate directly to the program content, the student experience, and the program assessment. In most respects, the criteria set out for the learning content are general in nature, affording a reasonable amount of latitude to curriculum developers tailoring their programs of study.

The NMBA (2016) has developed the *Registered Nurse Standards for Practice*, which includes seven separate standards for practice (Figure 1.1). The ANMAC requires program providers to demonstrate the integration of these standards within the individual program's curriculum. The content and its learning outcomes must address, among several other things, these seven standards. One of these standards, Standard 3 pertaining to the RN maintaining the capability for practice, is directly relevant to this current research project. This standard states that 'the RN considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice' (NMBA, 2016, p. 4).

Figure: Removed due to copyright restrictions

Figure 1.1: Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016)

The NMBA's requirement to achieve Standard 3 is general in nature. It does so without specifically stipulating the mechanics of how to incorporate this standard within the education program or how NSs can attain it on a personal level (NMBA, 2016). The

standard does not include specifically the integration of coping and resilience skills into the curriculum to deliver such significant personal and professional competencies, yet it has been shown that they can be developed during the formative educational period (Cahill et al., 2018). Consequently, and without specific guidance, curriculum developers are required to address future nurses' wellbeing and its impact on nursing practice. Despite the criterion's broad designation, it is also in the education providers' interest to adequately prepare future nurses to develop and maintain self-care, and to acquire and tap into a reservoir of coping strategies to meet workplace expectations. These are often embedded in universities' goals, objectives, and graduate attributes; they seek for students to meet personal and professional standards beyond the attainment of their degree (The University of Notre Dame Australia, 2020b).

The concepts of coping and resilience are mostly absent from nursing curricula. The author perused the syllabus offerings for nursing undergraduate programs of all Western Australian universities for the academic years of 2019, which is when this study was conducted, and 2021. The search returned similar results across institutions. Generally, there was minimal to no reference to coping or resilience training in course learning outcomes (Curtin University, 2018; Edith Cowan University, n.d., 2021; Murdoch University, n.d.-a; The University of Notre Dame Australia, 2017). For example, in 2019, communication training was not delivered during the first year, apart from one university that offered it in the last semester of their degree (Curtin University, 2018). Reflective practice (RP) was addressed in the first undergraduate year (Curtin University, 2018; Edith Cowan University, n.d., 2021; Murdoch University, n.d.-a; The University of Notre Dame Australia, 2017) and reinforced in the last in most universities (Curtin University, 2018; Edith Cowan University, n.d., 2021; Murdoch University, n.d.-a; The University of Notre Dame Australia, 2017).

Only two out of the four universities in WA included in the search had learning outcome objectives that specifically mentioned self-care in any (one) of their units (Curtin University, 2018; The University of Notre Dame Australia, 2017). The profound importance of these foundational concepts demands that they be addressed early in a curriculum rather than later to foster integration into practice. Several aspects pertaining to NSs' wellbeing will be discussed in Chapter 2. The result of this search also highlighted that no university directly addressed the need to improve nurses' resilience through their unit or course descriptions in both 2019 and 2021 (Curtin University, 2018,

2021; Edith Cowan University, n.d., 2021; Murdoch University, 2021, n.d.-a; The University of Notre Dame Australia, 2017, 2018, 2021).

1.3.5 Australian Registered Nurse Qualification

In Australia, the RN qualification is obtained by completion of an approved undergraduate program at university level. As discussed above, the ANMAC sets out the requirements for the nursing program, although it must also meet the requirements of the Australian Qualifications Framework (AQF) and the Tertiary Education Quality and Standards Agency (TEQSA). These will now be discussed below.

The national policy governing the qualifications of all Australian education and training qualifications was introduced in 1995 and is referred to as the AQF. It comprises 10 levels of qualification, ranging from Certificate I to the Doctoral Degree.

Learning outcome descriptors are specific to each AQF qualification level. These descriptors include the level's purpose, and the expected knowledge and skills to be attained, as well as their application. Each level also includes an anticipated level of learning and a time frame. The learning outcome standards increase in complexity with each level (Australian Qualifications Framework Council, 2013).

Tertiary education qualifications are those from level 5 and above; levels 7 and above are delivered in the university setting. Vocation Education and Training (VET) programs of education are delivered at the tertiary level and are heavily focused on practical skills and less theoretical than university courses. They also lead to different qualifications and scopes of practice. For example, a Diploma of Nursing completed as a VET program enables a student to become an EN in Australia. Their scope of practice is less than that of an RN, and they must perform their duties under the supervision of an RN.

To safeguard the welfare of Australian students as well as the reputation of the education sector, the TEQSA was established in 2011 by the Australian Government. In 2019, the Australian higher education system contained around 1.5 million students. Approximately 465,000 of these were international students, representing 31% of the higher education population (TEQSA, 2021).

All universities, whether in the private or the public sector, offering higher education programs in or from Australia, must be registered with the TEQSA (2021). In addition to

maintaining the registry of accredited higher education providers and accrediting their programs, the TEQSA engages in compliance and quality audits of these education providers and provides its expertise to the Commonwealth Minister for Education regarding higher education matters, and collaborates with international counterparts (TEQSA, 2021).

Internationally, nursing registration has been moving towards the degree-entry level since early 2000 (DeBell & Branson, 2009). In England and Ireland, nurses can no longer access a diploma-entry registration to become an RN, and Ireland's nursing education moved to higher education as an undergraduate degree in 2002 (Clynes et al., 2020; DeBell & Branson, 2009).

However, in 2016 the United Kingdom announced a new apprenticeship pathway to a nursing degree, which can be achieved in 4 years (Department of Health and Social Care, 2016b). A new nursing role, with the title of 'nursing associate' was also created. Associate nurses can perform some tasks undertaken by graduate RNs but cannot replace them, releasing the GN to undertake more complex tasks. The nursing associate achieves a level 5 qualification, and the degree-level nursing apprentice achieves a level 6 qualification (Department of Health and Social Care, 2016a).

Other countries also offer nursing qualifications at the diploma level. Generally, the titles of EN, staff nurse, associate nurse, licensed practical nurse (LPN) and registered practical nurse all refer to nurses who qualified at the diploma level and who work under the supervision of an RN or simply identify as a nurse with no other description attached to it. Diploma-level nurses are still present in South Africa (Roets et al., 2016; South African Nursing Council [SANC], 2021a), England (Department of Health and Social Care, 2016a) and Canada (National Nursing Assessment Service, 2021). All these are presented in Table 1.2.

Irrespective of diploma-level qualifications still being accessible, the movement towards degree-level registration is encouraged internationally. Bachelor nursing education has been linked with a higher capacity for critical thinking, improved patient outcomes and lower mortality rate (Aiken et al., 2014; Jeppesen et al., 2017). Despite this, debates remain as to whether a traditional hands-on learning model is preferable (Oliver, 2019).

Table 1.2: Nursing Qualification and Corresponding Designation

Qualification (course length)	Course title	Designation	Country
Certificate			
6 months	Certified Nursing Assistant	CNA	USA
12 months	Licensed Practical Nurse	LPN	USA
	Licensed Vocational Nurse	LVN ^a	
18 months	Higher Certificate in Nursing	Nursing Auxiliary	South Africa
	Assistant in Nursing	AIN	Australia
Diploma			
2 years	Enrolled Nurse	EN	Australia
	Licensed Practical Nurse	LPN	Canada ^c
	Registered Practical Nurse ^b		
	Nursing Associate	Nursing Associate	UK
3 years	Associate of Science in Nursing	ASN	USA
	Diploma in Nursing	General Nurse	South Africa
Degree			
24 months	Bachelor of Nursing Accelerated Course (Enrolled Nurse)	EN	Australia
	Bachelor of Nursing Science (Graduate Entry)	RN	Australia
3 years	Bachelor of Science in Nursing Honours	RN	UK
3–4 years	Bachelor of Nursing, Bachelor of Science (Nursing)	RN	Australia
4 years	Bachelor of Science in Nursing	RN	USA
	Bachelor of Nursing	RN	Canada ^c
	Bachelor of Science in Nursing		
	Bachelor of Nursing	Professional Nurse and Midwife	South Africa

Note: ^a In the states of California and Texas, LPN is referred to as LVN; ^b In the province of Ontario only; ^c Excluding the province of Quebec and the Yukon, Nunavut and Northwest territories.
Source: Canadian Nurses Association (2015); National Nursing Assessment Service (2021); NurseJournal (2021); Nursing and Midwifery Council (2021); Royal College of Nursing (2021); South African Nursing Council (2021b).

Worldwide, nursing qualifications for RNs are not uniformly obtained at the same educational level. The degree-level nursing qualification in Australia generally consists of a 3-year university degree for the Bachelor of Nursing or the Bachelor of Science in Nursing (Table 1.2). Some Australian universities have programs that extend beyond that by one semester (Curtin University, 2021) or offer an honours program with an extra year (Griffith University, n.d.; Murdoch University, n.d.-b). Others offer dual qualifications, such as a Bachelor of Nursing/Bachelor of Midwifery (Deakin University, Edith Cowan University, James Cook University, La Trobe University, Monash University); Bachelor of Nursing/Bachelor of Business Administration (Australian Catholic University); Bachelor of Nursing/Bachelor of Public Health (Queensland University of Technology); Bachelor of Nursing/Bachelor of Public Health and Health Promotion (Deakin University); Bachelor of Nursing/Bachelor of Behavioural Science (Queensland University of Technology); Bachelor of Nursing/Bachelor of Paramedicine (Australian Catholic University); and Bachelor of Nursing/Bachelor of Psychological Science (Deakin University, La Trobe University) with course length of 4 years (48 months). In this respect, the United Kingdom is similar to Australia; however, programs in other countries such as the United States, Canada and South Africa take 4 years to complete (Table 1.2) (National Nursing Assessment Service, 2021; NurseJournal, 2021; SANC, 2021b).

Australian nurses do not have to sit a pre-licensure exam to achieve their registration. This is similar to England, Wales and Scotland (Nursing and Midwifery Council, 2021; Royal College of Nursing, 2021). In other countries such as the United States, Canada and Indonesia, this requirement is compulsory. American nurses need to successfully pass the National Council Licensure Exam (NCLEX) and Canadian nurses the Canadian Practical Nurse Registration Examination (CPNRE) (College of Nurses of Ontario, 2021), although this is with the exception of Quebec, which has its own licensure exam (Canadian Nurses Association, 2015; Ordre des Infirmières et Infirmiers du Québec, 2019). South African nurses need to pass the SANC Examination (SANC, 2021c), and the National Nursing Competency Examination (NNCE; Hutapea et al., 2021) is for Indonesian nurses. Despite the American exam being compulsory nationally, the pass rate standards have been the subject of

enquiries as they are not uniform across all states and are subject to violation (Foreman, 2019).

In summary, to be eligible to work as an RN in Australia, students must successfully complete an accredited university degree program. Such nursing programs, 3 years minimum in duration, have met rigorous criteria set by the NMBA, ANMAC and the TEQSA. This ensures that the standard of education is consistent nationally, not only on an academic level but also on the practical relevance of its content to nursing itself. Finally, in addition to completing a degree, the path to becoming an RN in Australia also requires a person to satisfy the criteria defined by the NMBA, such as English language skills, but does not include a pre-licensure examination. Once these have been satisfied, the graduate can obtain registration with the NMBA. A person can only begin to work as an RN once they have obtained their AHPRA registration number and are listed on the national nursing registry.

1.3.5.1 Nursing Curricula

The undergraduate nursing education program, or curricula, is required to cover a significant amount of content. It must first satisfy the requirements of an undergraduate nursing degree in terms of the qualification level attained (TEQSA, 2021), as well as gain approbation of its nursing content, including clinical placements (ANMAC, 2019b). Within its curriculum, and the length of time afforded by the degree, universities strive to develop the future nurse as best as they possibly can.

Competition among academic establishments can affect program development. Fees between universities can vary; however, the Australian Higher Education Contribution Scheme (HECS) provides upfront financial assistance to students by lending them the tuition fees, which are directly paid to the university. The HECS debt is slowly repaid by the individual once they achieve a certain income (Australian Government, 2003). The cost associated with obtaining a degree in Australia can place a significant financial strain on students (Gregory et al., 2018), and the HECS has been effective in encouraging students to enrol in university programs despite increases in program fees (Martinenghi, 2021).

As discussed earlier in this chapter, the broad outline of the nursing curriculum content is mandated and approved by the NMBA and ANMAC and delivered at the discretion

of education institutions. Therefore, the choice to include certain topics and the extent to which they are included rests on local decisions influencing the reputations of the universities and their students.

Universities evaluate their courses and teachers through student surveys. Clayson (2018) discussed how student evaluation of the teaching process was found to be unreliable because it was emotionally driven, students rating teachers based on likeability rather than performance. Students were also not found to consistently understand what they are asked to evaluate, producing unreliable results (Clayson, 2018). B. Stewart et al. (2018) found that student evaluation of teaching performance tools failed to capture improvements in teaching practice that had been identified in study results, suggesting they lacked sensitivity. Students' feelings can be influenced by educators' feedback (T. Ryan & Henderson, 2018), and this can in turn sway their opinions when assessing their teaching performance.

Nursing curricula are flooded with content (Finnell et al., 2018). Educators are called to identify learning content and concepts that can be scaffolded along the learning journey (Herrington & Schneidereith, 2017). This can require educators to adapt the content to suit the curriculum and be blended alongside other appropriate material, for example, addressing substance use by including screening in health assessment, motivational interviewing in a clinical speciality course, a neurobiology component with anatomy and physiology, and approved medication interventions in pharmacology (Finnell et al., 2018). The content is therefore not learnt as a 'one-off', rather extended across several modules. The development of critical thinking, which is vital in nursing, can be promoted by the development of an inquiry-based learning method that includes clinical reasoning and research finding prompts (Theobald & Ramsbotham, 2019).

In their efforts to improve engagement, learning and overall outcomes, educators and program developers need to develop and employ strategies to achieve these goals. D. Hampton et al. (2020) examined Generation Z (Gen Z) NSs' teaching preferences. They found that the most preferred and engaging teaching method (92.2% of students) was by attendance at lectures with an audience response clicker, with 94.1% of them stating that this was most effective for learning. Gen Z were least engaged in assigned readings (textbook, journals, and others) and researching the internet. They reported

engaging better in lectures, presentations enhanced with audio, visuals, and simulation (D. Hampton et al., 2020). In terms of teaching methods conducive to learning, they rated lectures, quizzes, and tests highly, but reported minimal to no learning benefit from reading journals or blogs (D. Hampton et al., 2020). These findings can help educators hone effective teaching methods, and enable blending these to improve interaction, engagement and learning outcomes within curriculum development and course delivery.

1.3.5.2 Attrition Rates in Nursing Education

Attrition rates in tertiary education nursing programs can reach 50%, of which 25–27% occur in the first academic year (Kukkonen et al., 2016; S. Stewart et al., 2006), with psychosocial factors, such as support, health or stress, and difficulty with workload, being the main reasons for students electing to depart their program (Australasian Survey of Student Engagement, 2011). Students can incur or, worse, continue to increase education-borne debt, which may not be repaid in a timely manner because of switching study programs or non-completion of degrees, ensuing non-employment in the field (Kubec, 2017). This has caused pressure on governmental funding resources and affected the public's perception of the tertiary education loan scheme, compounded by a subsequent burden on public finances (Braithwaite et al., 2020).

Early engagement at the onset of a program of study can benefit students. Summers et al. (2021) showed that a high level of online engagement by first-year nursing students (FYNSs) with their course content in the first few weeks of the semester was predictive of positive outcomes. Even those whose engagement declined during the semester performed better than students who started low and increased their engagement along the way. Early engagement was predictive of both future engagement and high academic results (Summers et al., 2021). At-risk students can be identified early through the use of engagement alerts generated by learning analytics systems; however, this may not provide information as to the cause of disengagement (E. Foster & Siddle, 2020). Engagement and retention are closely related (Tight, 2020). The use of online self-assessment including RP was demonstrated to improve students' engagement threefold and increase students' pass rate more than 20% (Swart & Meda, 2021).

Nursing education programs include several weeks of unpaid clinical placement spread out over the degree. The ANMAC requires a minimum of 800 clinical hours (or 20 weeks) (ANMAC, 2019b), although all Western Australian universities have included more than the required minimum number of hours in their curricula, ranging from 840 hours (21 weeks) (Curtin University, 2018; Edith Cowan University, n.d.; Murdoch University, n.d.-a) to 1,120 hours (28 weeks) (The University of Notre Dame Australia, 2017). Some universities also include additional simulation laboratories in lieu of physical placements, usually in the first year of the nursing curriculum (Curtin University, 2018; Edith Cowan University, n.d.).

1.3.5.3 Generational Considerations

Gen Z, born between 1997 and 2012, currently account for the highest proportion of all students in Australia (Australian Bureau of Statistics, 2020; Pew Research Centre, 2019). In 2019, they were represented by individuals aged up to 22 years of age. Baby Boomers are individuals born between 1946 and 1964. Generation X (Gen X) are people born between 1965 and 1980 (aged 36 and older, in 2019), and Generation Y (Gen Y), also referred to as the 'Millennials', are individuals born between 1981 and 1996 (aged 38 and older, in 2019) (Pew Research Centre, 2019).

Gen Z vary greatly from prior generations—the internet has been present throughout their lives; they are technophiles and adapt more quickly than their predecessors (Chicca & Shellenbarger, 2018; R. A. Smith, 2021; C. A. Williams, 2019). They are attracted to positions of leadership, yet they seek freedom and, like Gen X, value coaching and mentoring (Bresman & Rao, 2017) but have underdeveloped social and relationship skills (Chicca & Shellenbarger, 2018). They are often seen as more vigilant, persistent, pragmatic, resourceful and frugal than past generations, being the result of growing up in a fading middle class, with racism, bullying, unremitting worldwide wars, financial crises and recession (C. A. Williams, 2019).

Gen Y and Gen Z have similar communication styles. Both prefer clear rules, affirmation, and group work, and expect their opinions to be valued (Raslie, 2021). They prefer person-focused communications, face-to-face, and access to online visuals. Raslie (2021) reported that both generations lacked assertiveness and

communicated at a slower pace. Humour and music are however considered a powerful adjunct for them (Munsch, 2021).

Gen Y and Gen Z can be challenging to teach, especially for the Baby Boomer and Gen X teachers. Raslie (2021) compared the two generations and found that Gen Y are better at analysing information, especially that obtained from the internet, and managing heavier workloads and priorities. Traditionally rigid ways of teaching may not suit Gen Z best (Chicca & Shellenbarger, 2018). They expect more instantaneous feedback and concentrate on relationships rather than task completion. They expect technology-based teaching and prefer storytelling to reading books (Shatto & Erwin, 2016)—they do not read for more than 30 minutes per day (Seemiller & Grace, 2017).

Such differences require educators to consider alternatives in their teaching strategies. Students' attention spans can be accommodated by engaging in shorter lectures and combining videos, demonstrations, and discussions: varying the delivery of content through flipped classrooms, concept mapping, problem-based learning and case studies (Chicca & Shellenbarger, 2018). They prefer to practise skills rather than sit through lectures; they are doers (C. A. Williams, 2019) and gravitate to cooperative ways of learning (splitting tasks among group members while working as a group) instead of collaborative (sharing tasks) (Igel & Urquhart, 2012). Such strategies require educators to be flexible and adaptable, and to provide variation within their course structures.

1.3.6 Graduate Nurses

Once a person has obtained their right to work as a nurse, there are several avenues of employment offered to them in both the public and the private healthcare sectors (Department of Health (WA), n.d.-b). Typically, the junior nurse will endeavour to secure a graduate RN position; however, they can also secure any other entry level position available. It is the employer's discretion to decide whether to train the junior nurse in a formal program. This section provides information regarding the Australian healthcare system. It will then discuss options available to the new nurse; the information is centred around WA to align with the geographical location where this research project was conducted. However, similar options are available across the entire Australian country and the information provided in the following sections can

therefore be extended to other Australian states and territories. Internationally, other countries also offer support to newly registered nurses in their first year of practice through transition programs with the view to bridge the gap between theory to practice and to lessen the impact of the transition (Rush et al., 2019)

1.3.6.1 Australian Healthcare System

The Australian healthcare system is divided into two streams: public and private. At a federal level, the Commonwealth of Australia – Department of Health has several responsibilities, which duplicate some of the functions of individual states and territories (Department of Health, 2021). The federal government oversees Medicare, the Pharmaceutical Benefits Scheme, the funding of veterans' healthcare and Indigenous community-led primary healthcare organisations. In addition, the Australian Government regulates medicines, medical devices, and the purchasing of vaccines for immunisation programs. Among many other functions, it collects and publishes information regarding the health and welfare of all Australians, funds health and medical research, coordinates access to tissue and organ transplantation, and implements national responses to health emergencies, particularly evident with the advent of the Coronavirus pandemic (Department of Health, 2021).

Australia is divided into six states and two territories. WA is one of the six states; it is the largest geographically, covering 32.9% of the entire Australian mainland (Geoscience Australia, n.d.). In 2020, Australia's population was reportedly 25,693,059 people, of which 2,667,130 were in WA. Despite a vast land surface, 92% or more of the population lives in the south-west corner and around 79% in the Perth area (Australian Bureau of Statistics, 2018). These facts are particularly significant regarding the provision of education and healthcare, as well as employment prospects.

Under the National Federation Reform Council, the Australian Federal Government shares a number of priorities with the states and territories, including health (Department of the Prime Minister and Cabinet, 2020). States and territories are provided federal funding and are then responsible to manage certain public health areas including public hospitals, mental health services, public dental clinics, ambulance and emergency services, and a number of other services. In addition to

federal funds, each state and territory must also contribute to the health portfolio. In 2016–17, the federal government provided 41% while governments from each state and territory contributed 27% (Department of Health, 2021). Service users also contribute through co-payments for out-of-pocket expenses, amounting to around 17%. The remainder is provided by private health funds (9%) and non-government organisations (6%) (Department of Health, 2021).

Health services are delivered through public and private options. Australians can utilise their private health cover to access services, at times more rapidly, and have a choice of providers. The private sector does not offer the complete array of services that the public system does. For example, the current gold standard for surgical intervention for a patient presenting with a hip fracture is knife to skin within 48 hours (Lawless et al., 2020). This may not be available in a private hospital, where operating theatres may not be staffed after-hours, leaving only a public admission possible for the patient. In 2018–19, Australian public hospitals performed the most medical admissions (4.7 million) and childbirths (232,000), while private hospitals' highest admission rates were for specific interventions (such as elective procedures), with 932,000 versus 480,000 in the public sector and 59.4% of mental health admissions (Australian Institute of Health and Welfare, 2020). Thus, the two sectors differ in not only types of intervention but also their acuity.

The aged care sector is funded differently. The Australian Government subsidises the aged care providers through several subsidies, supplements, grants, and program funding (Department of Health, 2020). This is particularly relevant to this research as the NSs' placements took place in the aged care sector.

Points of difference regarding geographical location and health services affect both the NS and the GN at some point during their journey. For instance, students from remote areas of the state may have to relocate closer to the city centre to access nursing training. The same student nurse is likely to undertake clinical placements in both the private and the public system. Further, graduate programs are offered in both systems, with their respective advantages and disadvantages. Graduate employment opportunities are discussed in more depth in the next section.

1.3.6.2 Graduate Employment

Once registered with the NMBA and officially displayed on the AHPRA online registry, the new nurse can begin to work in a variety of positions. Particularly tailored for the new RN are the graduate programs offered by a number of hospitals, both public and private, and other primary care organisations such as general practices (IPN Medical Centre, 2021). GNs can opt to specialise in a specific speciality, such as mental health or paediatrics, by applying to hospitals and other facilities offering these types of health services (Child and Adolescent Health Service, 2021a; Department of Health (WA), 2021a).

The State of WA is divided into five distinct health services. The Perth metropolitan area is made of up of three health services, designated by their geographical location from the city centre: North, South and East Metropolitan Health Services (Department of Health (WA), n.d.-a). The fourth is the Child and Adolescent Health Service, providing specialised paediatric services including neonatology, community health, mental health and all other health needs of the child and young person (Child and Adolescent Health Service, 2021b). Outside of the three metropolitan areas, the rest of the state is serviced by the WA Health Country Health Service (WACHS). Covering 2.5 million square kilometres, the WACHS is the largest health service in the country (Department of Health (WA), n.d.-c).

Depending on personal interest and vacancies, the GN may be exposed to any of these health sectors, services, or specialities. While graduate program details, employment conditions and future career opportunities may differ between these, the programs are normally for a 12-month period, while some may offer extended support for another 6 or 12 months and can be full- or part-time (Child and Adolescent Health Service, 2021a; Department of Health (WA), n.d.-b, 2021a; St John of God Health Care, n.d.). Each program may differ slightly by employer, but they usually involve various clinical rotations (St John of God Health Care, n.d.) and may provide the opportunity to complete postgraduate education in selected universities (Department of Health (WA), 2021b). These factors will influence the student or GN at some point during their training and early career.

Graduate programs can be particularly beneficial to the new nurse in the context of their transition to practice and any adjustment difficulties they may encounter. The first year of nursing practice and the variety of obstacles faced during this time have been investigated in several research projects (Duchscher, 2008; S. O. Kim & Kim, 2021; Labrague & Santos, 2020). Termed ‘transition shock’ by Duchscher (Duchscher, 2009), the first year of practice sees the GN pass through various stages that will affect their professional roles and responsibilities, challenge their knowledge base, and affect their relationships. This may provoke various emotions including disorientation, loss, doubt and confusion (Duchscher, 2009). Transition shock is of enormous significance in the first year of nursing practice and understanding how students navigate the reality of their first year may add to the understanding of this concept. For this reason, transition shock will be covered in more detail in Chapter 2.

1.3.7 Humour, Coping and Resilience Tools

Several psychometric tools exist to assess humour, coping, resilience and general wellbeing and have been used in nursing populations including students. Of note, the Humor Styles Questionnaire (HSQ) by R. A. Martin et al. (2003), the Connor–Davidson Resilience Scale (25 items) (CD-RISC-25) developed by Connor and Davidson (2003) and the Satisfaction with Life Scale (SWLS) by Diener et al. (1985) are often cited.

The choice to include particular instruments in this study was multifactorial. The author was not only mindful of the popularity of the instruments in the literature but was alert to the availability of published data against the NS population. The reliability of the psychometric properties was a factor and whether any of the instrument had been examined by other researchers; this was the case of Silvia and Rodriguez (2020) who re-examining the HSQ. All these factors contributed to the selection of the HSQ, CD-RISC-25 and SWLS. Published results around NSs are presented in the literature review in Chapter 2, and their psychometric properties will

be discussed in depth in Chapter 4. They are mentioned here to inform and introduce them to the reader.

1.4 Current Study

This section will first present a summary of issues that have been identified to develop this research project. Second, the purpose of the study will be stated, followed by its aim and objectives. Following this, the main research question including its guiding questions will be presented. Finally, the modifications that were necessary to be made during the project will be discussed.

1.4.1 Summary of Issues

The impact of transition shock has been examined in relation to the newly graduated nurse (Duchscher, 2009; Rush et al., 2013), yet less attention has been devoted to the transition of the student nurse. Self-efficacy and motivation are influenced by the clinical practicum, and ultimately contribute to retention and program completion (Jeffreys, 2012; Kopp, 2019; Yao et al., 2021). Self-efficacy relates to one's perception and judgement of their degree of skill and success in attaining a particular objective, while motivation is the desire and willingness to embark on the activity. There is evidence that these two concepts influence each other in the nursing context (Hassankhani et al., 2015).

Attrition rates in tertiary education nursing programs can reach 50%, of which 25–27% are attributed to the first academic year (Kukkonen et al., 2016; S. Stewart et al., 2006). Psychosocial factors such as support, health or stress, and difficulty with workload are the main reasons for students electing to depart their program (Australasian Survey of Student Engagement, 2011). Levels of resilience and use of coping strategies differ greatly between individuals, and factors affecting coping and resilience can have a positive or negative influence on the outcome. Such factors therefore warrant in-depth investigation to increase the quality of graduating nurses and completion rate.

Having a sense of humour is often cited as a component of coping (Pryor, 2010) and resilience (Bennett et al., 2014), and is present in approximately 85% of nursing

interactions (Adamle & Ludwick, 2005). The beneficial effects range from improvement in morale and working conditions to teamwork, motivation, and effective communication. It is also said to assist nurses' experiencing grief and the demands of the profession (Robalo Nunes et al., 2018). However, it is a complex subject, reaching far beyond 'slapstick' and joke-making (R. A. Martin, 2007). Humour styles can be either adaptive (benefits self and interactions with others) or maladaptive (increases negative effects towards self and social interactions)—adaptive styles have been associated with general wellbeing (R. A. Martin & Kuiper, 2016). This research will centre around the successful transition and adaptation to nursing education at the onset of their first year of study, including corresponding clinical rotations, with baseline data being collected before the activity of nursing can directly affect the results.

1.4.2 Purpose

As previously discussed in the prologue, the researcher had already spent several years observing and participating in nursing humour through various education and employment settings. These observations brought her to wonder whether nursing humour was a common trait of the profession or whether it developed with exposure to the activity of nursing. The researcher had observed the group effect of humour in their personal interactions and was interested in finding out the impact of humour on an individual level. As there is currently no available answer as to the onset of nursing humour, this research seeks to identify the predominant style of humour employed by NSs at the onset of their degree. This is to also assist in the future identification of whether it is the activity of nursing that modifies nurses' humour style or emerging nurses share a common style from the inception.

Additionally, the study seeks to isolate the factors conducive to successful NS role adaptation. It endeavours to pinpoint in detail influential elements present in NSs' transitioning from a state of neophyte to that of student with low-grade responsibility. Baseline measures of resilience and wellbeing, and the identification of humour style(s) being favoured by NSs at the commencement of their degree, will be examined, as will the personal accounts of students' experiences during clinical rotations in the first year of their degree. Observation and analysis of these factors at

the inception of the nursing career may provide valuable insight into the role of humour in adaptation.

The original intention of the study was to observe whether the activity of nursing had direct effect on NSs. Initially, data from pre and post-tests were expected to be collected however the advent of COVID 19 and the cancellation of clinical placements required for the post-tests in the second comparative survey to be abandoned and replaced with additional interviews along the second semester and include an additional question. These will be discussed in more detail in section 1.4.6 – Modifications. Despite the unprecedented events, the intent of the study remained the same in seeking to identify elements conducive to coping and resilience and with particular emphasis on humour as one of the coping strategies. In parts, the disruption of COVID 19 effectively enriched the study by adding a degree of stress and provided a wealthy ground to obtain first-hand qualitative data that would otherwise not have been captured in the initial design. Through additional interviews the researcher was able to obtain deeper information that quantitative methods alone could not achieve. Additionally, due to the placements being cancelled, if the study had not been modified to account for this fact, it may have failed to produce sufficient quantitative data to answer the research question. The additional interviews corrected the situation without impacting on the quantity of data collected. This also ensured enough data was generated to enable comparison of results as planned in the research design.

1.4.3 Aim

Researchers have sought to identify factors promoting the wellbeing and retention of FYNSs and reducing dropout (Bakker et al., 2019; Dancot et al., 2021). Humour is well recognised as a protective factor in resilience (L. J. Thomas & Revell, 2016) and affects socialisation in the workplace (R. A. Martin, 2007). It is a free, accessible, and near-limitless resource, theoretically available to all. No research to date has specifically examined the role of humour in the undergraduate nursing context, other than by noting its presence (Hart et al., 2014). Understanding how resilience, coping, humour and transition, including transition shock, affect the nursing journey at its beginning could assist undergraduate curriculum developers in incorporating these aspects in their curricula.

Understanding whether and how a student's humour style and use contribute to their adaptation to nursing education may provide vital insight to educators and mentors in assisting students to succeed. The shock experienced by GNs transitioning into practice could exhibit similarities with the experience of the FYNS. Looking into both could assist in discovering new building blocks for developing effective learning programs combining education and personal growth could help in safeguarding the professional from the profession.

Students and GNs experience bullying and harassment in high numbers (Rush et al., 2013). Insufficient attention to these aspects can have grievous costs to self (the student or practising nurse) and to the community at large by creating and perpetuating a vulnerable and unstable workforce. All possible efforts should be implemented to facilitate transition to practice and retention (Department of Health, 2014b). Resilience and coping are all encompassing concepts with sub-elements including humour, self-esteem, self-efficacy, hope and positive relationships (Earvolino-Ramirez, 2007; B. M. Gillespie et al., 2007; Hart et al., 2014) that demand investigation to develop effective strategies to promote them.

At an educational level, belongingness and social connections, empowerment and resilience in nursing undergraduates have all been associated with course completion, prepares nurses for transition into their professional roles and positively affects the nursing workforce well beyond the formative years (Cleary et al., 2018; C. Perry et al., 2018; Snowden et al., 2018; Wray et al., 2017). Belongingness is a prerequisite to learning in the clinical area and promotes practicum success (Levett-Jones & Lathlean, 2008) and clinical site satisfaction (Borrott et al., 2016). It stimulates supportive workplace relationships (Braine & Parnell, 2011) and the feeling of being valued (Bradbury-Jones et al., 2011).

Humour styles, as a result of their adaptive or maladaptive consequence, can affect the quality of relationships, and how they affect a person on an emotional level and their general wellbeing (Marrero et al., 2020; R. A. Martin & Ford, 2018). Humour has been identified in numerous nursing activities and shown to bolster belongingness and group commitment (Willetts & Garvey, 2020). It has also been associated with sociability (Navarro-Carrillo et al., 2020) and identity construct including in the workplace (Sinkeviciute, 2019). The role of humour is multifaceted and can impact the

NS in fitting in not only in their peer group in the educational setting but also as part of the team and the profession in general when in the clinical setting.

1.4.4 Objectives

The following objectives guided the intent of the research and served to achieve its purpose:

1. To investigate what is known about coping, resilience, satisfaction with life and wellness in NSs.
2. To identify elements conducive to students' coping and adaptation in their first year of nursing studies.
3. To review the concept of humour in the nursing context and its specific role in coping, resilience and adaptation, and overall wellness, in NSs.
4. To investigate what is known about the use of humour by NSs in their education and clinical placement.
5. To explore the adjustment experience of NSs across theoretical, practical and personal domains, and discuss whether similarities exist with the transition shock experienced by GNs in their first year of practice through the use of reflective practice and interviews.
6. To discuss any potential need to include elements in the nursing curricula to bolster NSs' education program to enable coping and adaptation.

1.4.5 Research Questions

The principal research question was: How does humour influence the NS's wellbeing and coping mechanisms at the onset of their undergraduate degree?

The following research questions directed the study:

1. What is the humour style score of NSs pre first practicum?
2. What is the relationship between NSs' humour style and their overall resilience score pre first practicum?
3. What is the relationship between NSs' humour style and their satisfaction with life pre first practicum?

4. How do NSs perceive their engagement with the activity of nursing studies (both academically and during practicum), how it impacts on personal wellness, and contribute to their coping strategies?

1.4.6 Modifications

Halfway through data collection, the COVID-19 pandemic significantly disrupted how the world studied, worked and generally lived, which also meant that a portion of participants saw their clinical placements cancelled. This change happened suddenly and in the middle of the participants' semester. The stress placed on them, academic, financial, emotional and social, significantly affected their willingness and ability to participate in the study. Participants experienced significant disruption to the delivery of their academic content, which was no longer offered face-to-face on campus but delivered exclusively online. This required the researcher to seek permission to make changes in data collection methods to enable answering the research questions.

The cancellation of most clinical placements meant that the original plan to obtain post-test measures were inadequate in providing the information required to enable adequate statistical analysis and the generation of meaningful results. This additional stress placed on them might have affected the survey tool, potentially returning false results. Participants might have answered questions according to how COVID-19 had affected their life in general, rather than concentrating on nursing only. This would have meant that a meaningful comparison of results was not possible; the clinical placement would not have been the only intervention, COVID-19 being a significant confounding factor. The choice was therefore made to replace the post-test survey with a second interview. This meant that the researcher could remain true to the research questions while maintaining participants on topic.

However, COVID-19 also affected the data gathered from the interviews. The second interview included answers relating to two clinical placements only for the first group (Wave One – (W1)) since the second group's (Wave Two – (W2)) clinical placement was cancelled. To mitigate the disparity between groups, W1 participants were invited for a third interview. These modifications and their effect will be discussed more in depth in Chapters 4 and 5, where details are provided around the different data collection phases, and under the limitations of the study in Chapter 7, section 7.5.

1.5 Summary

The voyage into nursing is not just one of skills training—it is also one of self-discovery and actualisation. In this sense, the future nurse's undergraduate training can be the first significant voyage they will undertake. Likened to a voyage on a tall ship, the first-semester student will set sail and leave the shore of safety, and sail through calm waters and rough waves throughout out each semester of their undergraduate degree. The present thesis is therefore shaped as the itinerary for this voyage. It is divided into the following chapters:

- Chapter 2 provides an in-depth examination of the currently known and contemporaneous literature surrounding humour, coping, resilience, and adaptation. These concepts will also be in the context of the NS, nursing education or nursing in general where appropriate. This chapter will also present the reader with the gaps this study is seeking to address.
- Chapter 3 presents the reader with the conceptual framework and theoretical approaches, those of humour and the transition shock model, underpinning this study. Additionally, it will discuss RP and provide an overview of the various stressors and stress relievers identified in NSs' wellbeing.
- Chapter 4 provides an in-depth description into how the journey was planned: the methodological approach chosen, and the strategy, design and method. It details how the data were collected and through which instruments. This chapter also addresses the rigour and quality of the study, its ethical considerations, and its limitations.
- Chapter 5 focuses on the participants before embarking on their first-year journey. It examines baseline measures regarding coping, resilience, and humour style.
- Chapter 6 centres on the practical exposure of the students to nursing itself through their first year of study including practical placements. This is done in two ways: first, through RP while students are on their first clinical placement and, second, through individual interviews. These interviews were conducted after the first and second clinical placements and examined the nursing exposure more in depth by engaging in semi-structured interviews with participants. The goal of these was to extract more information concerning

students' personal experiences in the clinical, academic, and personal fields, particularly concerning humour, coping and adaptation.

- Chapter 7 merges the study results and analyses the findings in the context of current literature, addresses the relationships of the findings to the original research questions and discusses the research's limitations.
- Chapter 8 discusses the implications of the research findings and proposes recommendations in line with these findings.

Chapter 2: Literature Review

2.1 Introduction

Chapter 1 introduced the research project, discussing aspects of studying and working as an RN in Australia with emphasis on the West Australian experience. It detailed the research project's significance, identified the research questions, and outlined the general thesis structure. Chapter 3 will present the theoretical basis of the research project.

Meanwhile, a review of relevant literature will be provided in this chapter, focusing on humour, coping, resilience, and adaptation in FYNSs, with discussion of their impact on life satisfaction and overall wellbeing, as well as the transition shock model as applied to GNs and NSs, including FYNSs. The literature review will be divided and presented in three sections (Figure 2.1). The first will review research on humour and NSs, followed by coping, resilience and wellbeing. The last section will examine adaptation and will also incorporate a discussion of the transition shock model. Details of the literature search, databases and key terminology used will be provided to inform the reader on how the literature was captured.

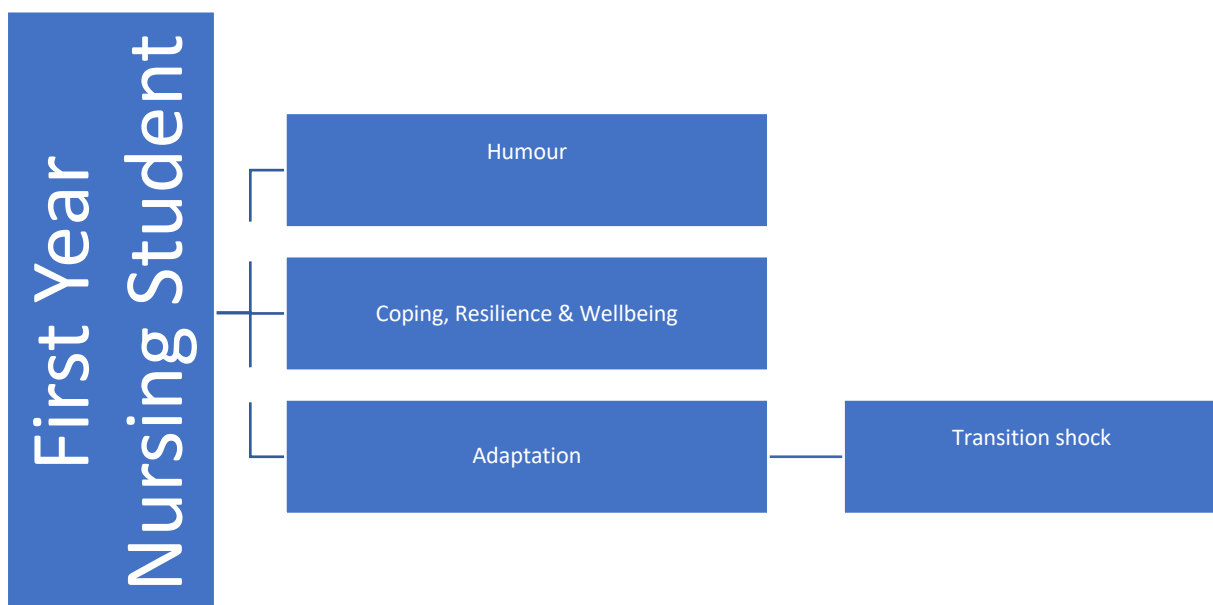


Figure 2.1: Literature Review Structure of the First Year Nursing Student

2.2 Literature Search

A search of the literature was conducted using multiple databases. These included CINAHL, Informit, OVID (including JBI EBP, Embase, Emcare, Medline, Global Health and PsychINFO databases), the Cochrane Library and Google Scholar, as well as grey literature.

The dates utilised were initially between 2010 and 2022, the starting date being extended to 2003 because of a dearth of studies. Papers prior to this date were selected according to relevance and captured through reference lists, particularly humour research, which prompted examination from 1994.

Several search terms were used. Searches using these terms were completed individually, and then in combination. Database functions relating to SmartText searching were also used to extend the yield.

The main key terms used related to nursing education, transition shock, humour, resilience, and satisfaction with life, including relevant subject terms and indexed terms. Specifically, these were:

1. Nursing education:
 - a. Nursing Students, Students Nursing
 - b. First Year Nursing Students
 - c. Teaching methods
 - d. Education Nursing
2. Transition shock:
 - a. Transition
 - b. Duchscher
3. Humour:
 - a. Humour or humor or laugh or laughing or laughter or comedy or jokes; wit and humor
 - b. Humour Style Questionnaire, HSQ, Humor Styles, Questionnaire

- i. Excluding: Helpers Stay Quit, Health-care System Quality, Home Screen Questionnaire, High Sleep Quality, Help-Seeking Questionnaire, Health Status Questionnaire, Home Situations Questionnaire, Half-Squat, Hydrogen Silsesquioxane, Headache Screening Questionnaire, Health Survey Questionnaire

4. Resilience:

- a. Connor–Davidson, CD-RISC
- b. Coping strategies, coping skills, coping, cope

5. Satisfaction with life:

- a. Diener, SWLS

All entry titles and abstracts were scrutinised to assess their relevance to the term or theme searched, and their relevance to the NS. Those that did not relate to the subject were excluded. Of those selected, reference lists were scrutinised for the possibility of additional publications missed by the databases and search engines. Other older published documents were included where relevant or when current literature was sparse, and their inclusion provided added context and background.

Overall, 43 papers relevant to humour in nursing education were included, of which 8 were directly relevant to the HSQ. For coping and resilience, 93 papers were located, of which 15 included research with the CD-RISC instruments (either full or reduced version). Finally, concerning wellbeing, 21 papers were referenced, of which 14 included research using the SWLS instrument. Finally, surrounding adaptation and transition shock, 41 papers were included in this literature review.

2.3 Literature Review

In the next three sections, the reader will be presented with a literature review covering humour, coping and resilience, and finally transition and adaptation in nursing, focusing particularly on FYNSs where possible and extending to NSs and nurses in general where necessary.

2.3.1 Humour

The following section will discuss what is currently known of the relationship between humour and FYNSs (Figure 2.2). It will provide an overview of humour in nursing, and then focus on education in the undergraduate nursing space. It will present humour investigations that have been conducted and any interventions that have been delivered to NSs, together with a summary of studies that have utilised the HSQ and their findings.

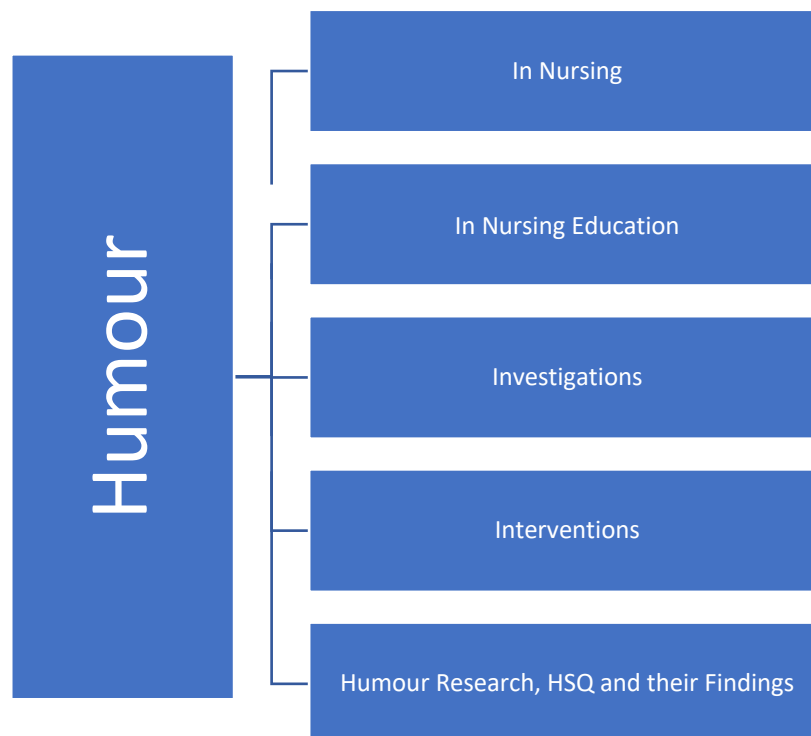


Figure 2.2: Current Literature on Humour, Nursing and Nursing Education

2.3.1.1 Humour in Nursing

Within positive psychology, humour is regarded as a significant contributor to happiness, as well as being multifaceted and incorporating cognitive, emotional and interpersonal aspects (Rush & Hofmann 2017). Researchers have explored particular qualities of humour (Thorson & Powell, 1993), and its relationship to personality types and traits (Mendiburo-Seguel et al., 2015; Ruch, 1998), and have developed several measurement scales (Mallak & Yildiz, 2016; R. A. Martin, 1996; Roeckelein, 2002), as well as skills programs to foster its development (Fredrickson, 2004; K. H. Williams et al., 2013). Humour styles can exist within adaptive or maladaptive boundaries, which

can be blurred (R. A. Martin & Kuiper, 2016), and are influenced equally by genetics and environmental factors (Vernon et al., 2008). These studies suggest that humour styles can be manipulated to some degree to produce positive coping strategies.

Therapeutic interventions utilising humour in nursing have demonstrated positive effects. Humour interventions with patients have been shown to reduce symptoms of depression and anxiety, increase wellbeing, and improve sleep quality and cognitive function (Zhao et al., 2020). Studies have demonstrated therapeutic benefits of humour, including improved muscle relaxation (Fry, 1992) and beneficial hormonal secretion in depression (Mobbs et al., 2003). Programs have been developed to cultivate humour (McGhee, 2010), aiding both the ill in recovery and the helper in maintaining good health and spirits. Day-Calder (2016) discussed the consequences of using humour in the clinical practice space and called for professional codes to be reviewed to address the best avenue for patients to be listened and responded to.

Undergraduate nurses can greatly benefit from engaging in adaptive styles of humour, the influence of which assists role transition, adaptation, coping, hardiness and distancing (N. A. Kuiper, 2012), as well as the formation of interpersonal bonds with colleagues and healthcare consumers (Lehane, 2008). It can be an impressive teaching and mediating tool with wide-reaching versatility (Bakar & Kumar, 2019; Roeckelein, 2002). It can positively influence multiple psychological variables, and enhance interpersonal relationships and individual wellbeing (R. A. Martin & Kuiper, 2016), and is correlated with nurses' job satisfaction, and benefits nurses and patients simultaneously (Ergözen & Ugurlu, 2019; Moore, 2008). Humour similarly influences workplace bullying and leadership styles (Mills et al., 2019; Mortensen & Baarts, 2018) and nurses' psychological wellbeing (Navarro-Carrillo et al., 2020).

Humour is also featured in non-research papers. For instance, Geanellos (2005) considered the characteristics of a nurse and identified humour as part of their general friendliness. Several obituaries written by nurses celebrating colleagues and their distinguished careers identified humour as a positive quality trait (Ajaj & Gray, 2007; Grundy, 2007; Lougher et al., 2008; Price, 2005). Other authors offered their personal opinion on the benefits and detriments of using dark humour in nursing (Lloyd, 2021), and alluded to the fact that nurses' dark humour may cause difficulty for some (Harnischfeger, 2020).

2.3.1.2 Humour in Nursing Education

In this section, the reader will be presented with literature concerning the use of humour in tertiary education. Particularly, it will focus on the humour between student and teacher. It will also discuss its manifestation as a coping mechanism during the student's clinical experience.

Humour can assist with motivation, increase cognitive processing and recall (Frymier et al., 2008; Mobbs et al., 2003), and be a beneficial adjunct in the classroom (Wanzer et al., 2010), particularly in the online learning space (McCabe et al., 2017). In nursing, as well as other professions requiring a student to complete clinical components of their studies, such as medicine, education, physiotherapy and counselling, the 'classroom' can extend to the real-world setting offered by the clinical environment (Chiarello, 2010; Ghaffari et al., 2015). The benefit of humour as part of a holistic approach to care, with inclusion as a complementary therapy in the undergraduate nursing degree curriculum, has also been discussed (C. A. Braun, 2018).

Researchers and academics have explored and mused over the use of humour in the classroom and educational space. Ulloth (2003) observed three seasoned nursing educators in separate schools who routinely infused humour into their classroom teaching and found that humour enhanced communication and education in the learning and teaching environment. Struthers (1999) investigated the use of humour by community mental health nurses and noted that their professional use of humour was without adequate educational preparation, and nurses deciding on its use generally derived from intuition and experience, with no scientific reference to draw from. The author recommended increasing the use of awareness of humour by both students and practising nurses for its spontaneous and appropriate use, also calling to broaden research into the topic to compare both inpatient and community settings (Struthers, 1999).

Others have investigated humour around its artistic and communicative features. Story and Butts (2010) discussed the use of Caring, Comedy, Creativity and Challenging (the four C's) to produce authentic co-learning opportunities, while Englert (2010) commented that to be effective as a teaching strategy, humour must assist in achieving the teaching objective. Chauvet and Hofmeyer (2007) examined the impact

and challenges associated with the use of humour as a communication style in problem-based learning situations and proposed strategies for tutors to introduce humour into their teaching, including the appropriate use of humour, boundary setting and the sharing of mutual stories. Similarly, others have discussed how humour can assist in learning, teaching, and various ways of actualising teaching methods and combining technological opportunities, offering their personal experience in doing so (Baid & Lambert, 2010; Lee & Lamp, 2003; Parrott, 1994; Polek, 2007).

The literature reports on humour experiences and observations between various relationships in nursing. It is discussed around that of the student and teacher (Bakar & Kumar, 2019; Winters, 2019), student or nurse to patient (Gelkopf, 2011; Tremayne, 2014), patient to nurse (Haydon & Riet, 2014), and nurse to nurse (De Clercq et al., 2020). Some studies have highlighted the need for students to develop self-awareness of humour and its uses (Lamminpää & Vesterinen, 2018; Launer, 2016). This can be achieved through group discussions, such as café-style, which have been shown to help students grow in confidence with difficult conversation topics while developing humour in the process (Blankley & Dowsett, 2019; L. Johnson & Marriott, 2019). However, Blankley and Dowsett (2019) recommended for these group discussion sessions to be kept short, while L. Johnson and Marriott (2019) advocated for increasing the frequency of these sessions.

The use of humour combined with exercise has been found to be effective in reducing NSs' anxiety and helping them cope. O'Brien (2013) trialled a new teaching strategy designed to reduce NSs' clinical practice anxiety. Their 4-week mindfulness meditation was intermixed with humour. Their results showed a reduction in students' anxiety and an improvement in their mindfulness and use of humour. Ozturk and Tezel (2021) used a sample of 75 NSs and devised a study to assess the effect of laughter yoga on their mental symptoms and cortisol levels. They observed a significant decrease in cortisol levels and concluded the intervention helped NSs cope with stress and reduce related mental symptoms.

Similarly, the value of humour in clinical learning has been identified. Cramer and Davidhizar (2008) investigated the effect of a course dedicated to providing additional help to students to help them successfully complete licensure requirement examinations. The faculty member in the study began each of the classes by

demonstrating coping strategies, including humour, enhancing students' content integration, linkage of theoretical and clinical concepts, and incorporation of wellness concepts into their psychiatric learning. To improve simulated learning experiences, Kaylor et al. (2018) developed a fictional, humoristic standardised patient character, Ms Bibby. Their initiative helped to produce conducive learning conditions, reduce NSs' anxiety, and improve information retention. Chaponniere and Hall (2020) examined over 512 NSs' journal entries written by students on an international clinical field trip to identify coping skills practised during the experience and associated culture shock. Humour was identified among the positive coping skills.

In another study of those teaching NSs, Lovrić et al. (2014) questioned NSs regarding their expectations and perceptions of clinical faculties' competencies. These competencies centred on teaching abilities; nursing competence; and clinical faculty members' relationships with students, patients and the health team, and their general personality. Overall and after having completed their clinical practicum, NSs of all years found their clinical faculty members to be humorous and have a better sense of humour than they had originally expected. This was particularly important for first-year students, who had high expectations of their faculty member, in search of a role model (Lovrić et al., 2014).

2.3.1.3 Humour Investigations with Nursing Students

Research into humour in an NS population is somewhat limited. Carbelo et al. (2001) explored the views of 150 Spanish NSs as to requisite qualities of social relationships and humour, as well as the application of humour, attitudes towards it and means of expressing it. The majority of students (82%) estimated that they regularly used humour and were in favour of specific training in this area. It was concluded that humour not only was a daily feature of the NSs' experience but also contributed to their positive dispositions towards life (Carbelo et al., 2001). Similarly, Baquero and Pérez (2002) reported that FYNSs considered humour their most highly appreciated quality in others (36%), ranking above intelligence (33%). Flynn (2020) found that NSs' use of humour in the clinical setting with staff and service users was affected by gender, age, culture and ethnicity. They discussed the need for students to be able to identify their own triggers for humour and to improve their ability to recognise others' use of humour to facilitate interactions.

Older studies on humour and education in nursing populations exist. Shea (1991) investigated the use of humour in nursing programs by questioning students and faculty members, and observed that despite similarities of perceptions of the use of humour, faculty and students differed in the extent of its use in the classroom and clinical settings, and its overall professional appropriateness. This somewhat parallels the paper by Chauvet and Hofmeyer (2007) discussed previously concerning humour parameters in the classroom. Kuhrik (1996) examined the difference in humour between traditional NSs (students who commenced university studies after high school) and non-traditional NSs (mature-age students), and found that both groups scored high on the use of humour as a coping mechanism but differed in how they used it; traditional students used humour frequently in most situations, whether pleasant or unpleasant, while non-traditional students used humour mostly as a stress moderator. Nahas (1998) investigated the effect of clinical teachers' use of humour on 48 Australian NSs in educational situations. They found that the majority of NSs preferred teachers with a sense of humour, helping them to cope with anxiety-producing situations.

Hayden-Miles (2002), on the other hand, found that NSs' description and interpretation of humour was limited to its value in 'looking on the light side' (p. 421). Despite this, their findings highlighted the benefits of humour in building trusting, effective partnerships between student and teacher, adding that a teacher's sense of humour improved students' learning experiences (Hayden-Miles, 2002). Some years later, Leef and Hallas (2013) investigated the effectiveness of a clown training workshop on 131 NSs, designed to foster emotional literacy, develop peripheral awareness skills and improve their engagement with patients. Their 18-month post-evaluation survey revealed that most respondents reported using the lessons learnt in the workshop in all types of nursing practice.

These studies highlight the diversity of assistance that humour provides to teachers and students alike. Humour is versatile, present in all levels of interpersonal relationships, and promotes learning and social interactions. There is also a suggestion that the knowledge acquired through these can have a long-lasting impact on students and their practice across nursing settings.

2.3.1.4 Humour Interventions

Research into direct humour interventions in undergraduate NS populations, particularly FYNSs, is scant. Stephens's (2012) randomised control trial study of 70 university NSs was an educational intervention designed to enhance resilience through five protective factors, including humour. They did not measure changes in humour, only resilience score, and will be discussed later in this chapter in the resilience section. The healing potential of humour in a therapeutic setting was investigated by Minden (2002), who developed a humour group by engaging male psychiatric patients and NSs in humorous group activities. Students on a 16-week clinical placement were required to plan and lead one humour group session following a 2-hour class on the therapeutic use of humour, with a subsequent debrief with their instructor. The student-led group sessions were run over a 4-year period with ten cycles of 6–8 weeks, with 66 sessions being delivered by NSs until the project was cancelled because of a curriculum change. Interviewed patients reported significant improvement in mental health (100%), social interactions and skills (77%), and physical and spiritual health (46% each). A majority (83%) of patients found the humour group beneficial and stated they would like to participate again. The groups helped students and patients refute the assumption that therapeutic group work and treatment had to be serious. Unfortunately, Minden's results focused more on the patients' experience and only offered minimal findings relating to students.

More recently, Mathews (2016), devised an experiment with 146 college students (discipline of study was not specified) with a humour-generated task. Students were required to first recall an event that induced a specific negative emotion (e.g. anger, loneliness, frustration, stress or sadness/hurt) and write one or two paragraphs at their own pace. They were then instructed to engage in an adaptive, maladaptive or neutral humour task (according to condition group) and write their response. During specific times, participants were asked to rate their level of positive and negative emotions. Emotional and humour responses were correlated to assess the effectiveness of humour in emotional regulation. Results showed that engaging in adaptive humour upregulated positive emotional responses and downregulated emotional negativity, confirming the effectiveness of humour in developing coping strategies for emotional regulation.

Despite the limited volume of research, these creative humour interventions produced positive results. More research is needed to further assess the efficacy of direct humour interventions as applied to NSs. What the above-mentioned studies highlight is the wide range of possibilities within the educational space to use humour to help students cope and to add to their range of therapeutic skills.

2.3.1.5 Humour Research with Humor Styles Questionnaire and its Findings

An extensive literature search located one study examining university NSs with the HSQ (Table 2.1), which was conducted in Turkey by Demir Gökmen and Firat (2020). Another 10 published studies examining students were located, of which six included 'university students' samples (G.-H. Chen & Martin, 2007; Gignac et al., 2014; Hiranandani & Yue, 2014; Kazarian & Martin, 2004), two 'college students' (Zhao et al., 2014), and one each 'psychology students' (Cann & Collette, 2014) and 'education students' (Huang & Lee, 2019). Some of these published studies included two distinct samples that could be analysed independently and compared with each other; for example, Hiranandani and Yue (2014) had a Chinese and an Indian sample, while G.-H. Chen and Martin (2007) had a Chinese and a comparative unpublished Canadian sample within their results.

Table 2.1: HSQ Studies for University Students

Authors (year)	<i>n</i>	nf	%f	nm	%m	Location	Area of study	Aff		S-E		Agg		S-D	
								Score	<i>SD</i>	Score	<i>SD</i>	Score	<i>SD</i>	Score	<i>SD</i>
Demir Gökmen & Firat (2020)	212	134	63.2	78	36.8	Turkey	Nsg Stds, College	39.26	8.69	36.02	8.74	22.05	8.18	25.97	8.32
Gignac et al. (2014)	309	201	65	108	35	Australia	Uni. Stds	46.34	6.93	38.08	7.87	29.41	7.68	31.07	8.59
Cann & Collette (2014)	120	93	78	27	23	N/A	Psych. Stds	46.48	6.80	36.48	8.96	27.12	7.68	23.84	8.24
Rnic et al. (2016)	208	145 ^a	70	62 ^a	30	Canada	Psych. Stds ^b	47.63	6.39	36.28	8.48	29.61	7.31	26.76	8.08
Huang & Lee (2019)	260	168	64.6	92	35.4	China	Education Stds	38.16	5.68	38.80	6.80	27.08	6.56	25.12	7.20
Hiranandani & Yue (2014)	101	76	75	25	25	China	Uni. Stds	36.91	6.75	32.89	6.8	29.74	4.93	32.08	5.49
Hiranandani & Yue (2014)	102	41	40	61	60	India	Uni. Stds	39.75	8.92	36.54	7.99	28.91	6.83	30.52	7.43
Yue et al. (2010)	500	364	73	136	27	China ^c	U/G Stds	38.78	7.96	23.17	6.13	15.81	7.07	12.78	5.94
Yue et al. (2010)	300	181	60	119	40	China ^d	U/G Stds	34.84	5.94	21.27	3.95	25.19	6.40	18.24	4.60
Zhao et al. (2014)	477	274	57	203	43	China	College Stds	38.6	8.03	22.43	6.08	15.58	6.53	12.42	5.26
G.-H. Chen & Martin (2007)	354	230	65	124	35	China	Uni. Stds	43.55	7.79	35.18	8.26	23.36	6.45	22.68	7.59
Martin ^e	388	213	55	175	45	Canada	Uni. Stds	46.4	7.17	37.3	8.33	28.5	8.79	25.9	9.22
Zhao et al. (2012)	525	292	56	233	44	China	College Stds	38.7	N/A	22.49	N/A	15.53	N/A	12.46	N/A
Kazarian & Martin (2004)	401	221	55	180	45	Beirut	Uni. Stds	43.2	7.74	35.1	8.45	28.7	7.45	25.5	8.05

Note: *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg Stds = nursing students; Uni. Stds = university students; Psych. Stds = psychology students; U/G Stds = undergraduate students; Aff = affiliative humour style; S-E = self-enhancing humour style; Agg = aggressive humour style; S-D = self-deprecating humour style.

^a Estimated number of participants calculated from published percentage; ^b First-year psychology students; ^c Mainland students; ^d Hong Kong students; ^e Unpublished results, included in G.-H. Chen and Martin (2007).

Results from these studies produced similar trends for the adaptive humour styles. All samples had their highest two scores in one of the two adaptive styles of humour, while most higher-ranking results were for the affiliative style, apart from the sample of 260 Chinese education students investigated by Huang and Lee (2019), who scored highest in the self-enhancing style. The lowest-scoring styles were either of the two maladaptive humour styles, and this varied across samples. Interestingly, most samples scored higher in aggressive humour, apart from the Turkish nursing sample (Demir Gökmen & Firat, 2020), the Australian university sample (Cann & Collette, 2014), and two university samples investigated by Hiranandani and Yue (2014)—one Chinese and one Indian. Overall, this points towards the predominance of use of affiliative humour styles by students.

In this section, the reader has been presented with evidence from the current literature pertaining to humour in nursing, particularly in nursing education and among NSs. An overview of research studies together with trialled interventions and their results have been discussed, with additional reference to a summary of published research utilising the HSQ in nursing and student populations.

2.3.2 From Coping to Resilience

The following section discusses the trajectory of NSs from coping to resilience, and is summarised in Figure 2.3. The author will succinctly outline the psychological wellbeing continuum, and then present a brief overview of related concepts. There will be discussion of current knowledge of coping and resilience and interventions trialled in nursing undergraduates, including FYNSs. Finally, evidence of research using the psychometric instruments used in this study, the CD-RISC and SWLS, including a summary of their findings and recommendations, will be presented.

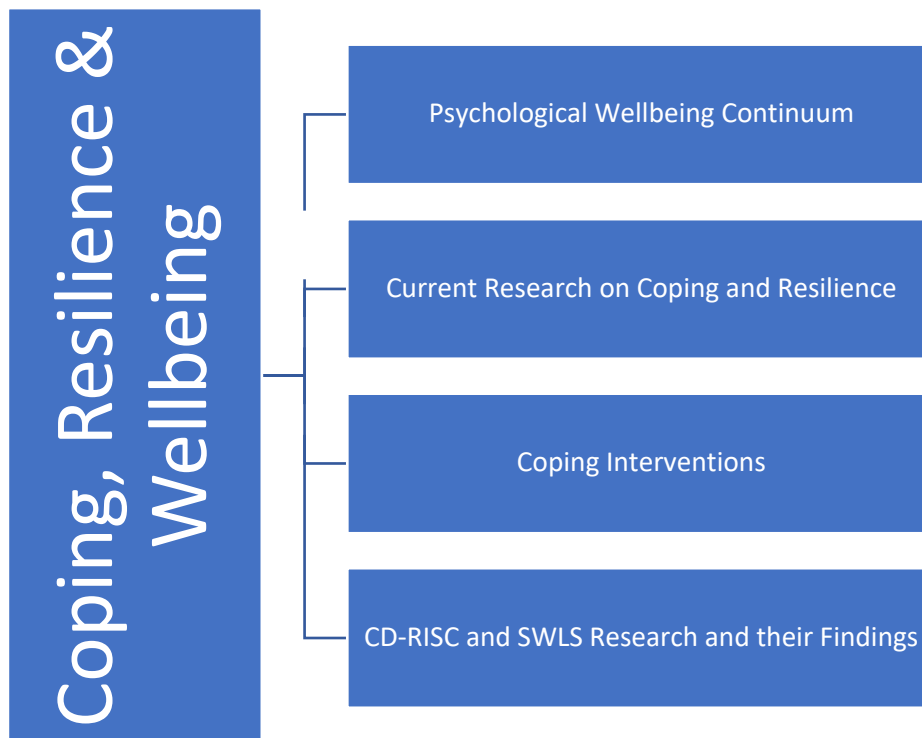


Figure 2.3: Current Literature on Coping and Resilience in Nursing Education

2.3.2.1 Psychological Wellbeing Continuum

The themes of coping, salutogenesis, adaptation and resilience follow each other in a progressive manner by means of definition (Figure 2.4). However, they are frequently discussed in combinations of two or more, such as ‘coping and resilience’, ‘resilience and adaptation’, and ‘coping and adaptation’. Salutogenesis is often better understood under the umbrella term of ‘protective factors’ (Keyes, 2014). They will be elaborated on individually to provide understanding and context.

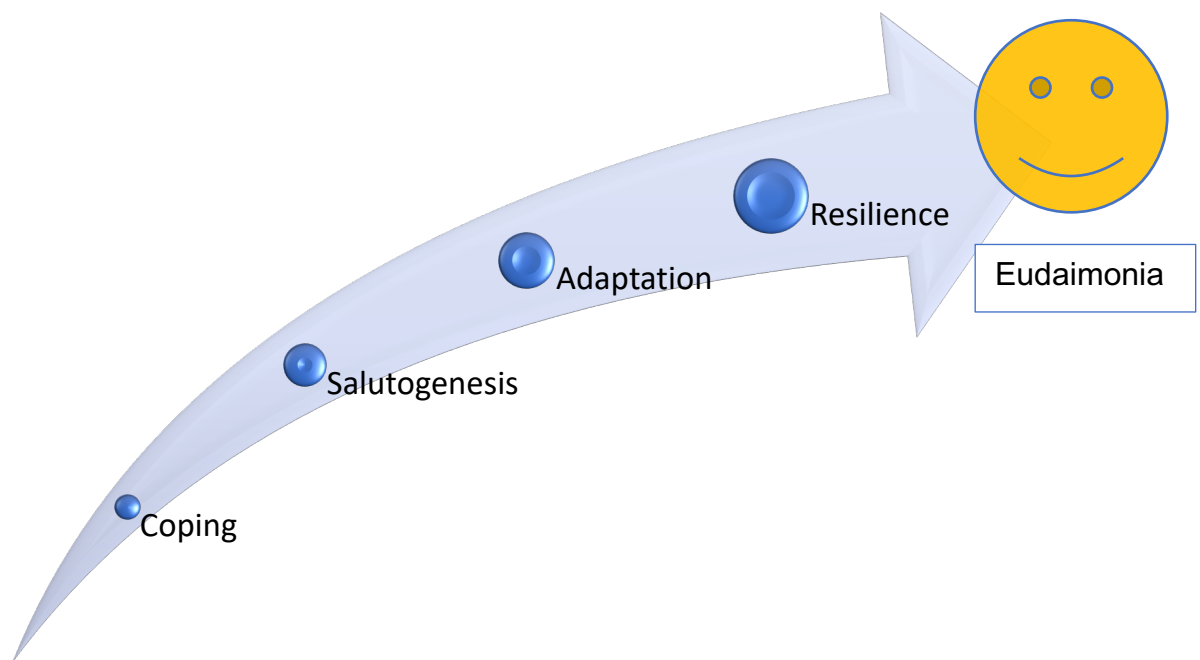


Figure 2.4: Pathway to Psychological Wellbeing

A number of definitions have been offered for 'coping'. Lazarus and Folkman (1984) defined coping as 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (p. 141), while Compas et al.'s (2001) definition included 'a person's deliberate and wilful attempts to regulate their response, whether emotional, cognitive, behavioural or physiological, and environmental factors following stressful experiences and conditions'. They both refer to a person's need for constant appraisal and adjustment of responses in the face of a stressor or other adversities.

Salutogenesis was coined by the medical sociologist Antonovsky and refers to how a person can survive and adapt in the face of stressful, even life-threatening, experiences (Mittelmark et al., 2017). Sakari and Bengt (2008) added that people with sufficient available and applicable personal resources develop a strong sense of coherence. These resources can be found within the person and within the environment. Sakari and Bengt (2008) highlighted that it is critical not just whether resources are available but that a person can use and re-use them in accordance with their desired intent and purpose.

Antonosky (1987) asserted that individuals are able to remain in a good state of health providing that stressors and stresses do not violate their sense of coherence. Three elements comprise a sense of coherence: a sense of *comprehensibility*—a sense of order and understanding of the reasons for the occurrence of events; *manageability*—a belief that one has the required resources needed to handle the events and with adequate control; and a sense of *meaningfulness*—that life events are of interest, that pleasure can be derived from them, and that there is a worth and purpose in experiencing life (Antonosky, 1987).

Adaptation involves the state one reaches from facing specific stressors while preserving initial resources (Wong-Parodi et al., 2015). In discussing cognitive adaptation, Taylor (1983) commented on the extraordinary capacity of the human psyche to not only withstand but also successfully overcome personal tragedy. Adaptation is when the individual ‘comes out the other end’ despite severe adversity; it is a key component of resilience, particularly in nursing (A. L. Cooper et al., 2020).

Beyond adaption sits resilience. Resilience refers to the overall ability to not only overcome challenges but often at times become even stronger by the process (Wong-Parodi et al., 2015). The events have left a legacy by adding an extra layer of veneer to the individual’s overall coating of personal strength. A. L. Cooper et al. (2020) propose the following working definition of resilience in nursing: ‘Resilience is a complex and dynamic process which when present and sustained enables nurses to positively adapt to workplace stressors, avoid psychological harm and continue to provide safe, high-quality patient care’ (p. 567). Resilience goes beyond the day-to-day experience; it shapes its future too.

The terms coping and resilience are at times used interchangeably or refer to definitions that are difficult to tell apart. For example, a recent systematic review examining the interventions designed to foster resilience in healthcare students utilised a definition that aligns more towards the concept of coping than resilience (Kunzler et al., 2020). Their stated definition was that ‘resilience can be defined as maintaining or regaining mental health during or after significant adversities such as a potentially traumatising event, challenging life circumstances, a critical life transition or physical illness’ (p. 1). This definition only refers to the maintenance of, or return to, equilibrium during adversity and does not account for any progress or gains achieved

by the individual. In this sense, their definition relates more closely to coping than it does to resilience. However, the authors discussed the definition of resilience, addressing the different approaches usually attached to it, namely, resilience as a personality trait, resilience as an outcome, and the more recent concept of resilience as a dynamic and multidimensional process. This includes influential psychosocial factors such as a positive emotion, self-esteem, self-efficacy, meaning, purpose and life satisfaction, hardiness, cognitive flexibility, and social support (Kunzler et al., 2020). A lack of clarity around the definition used in research papers around resilience has also been pointed out by Brewer et al. (2019), who reviewed 72 studies and reported that nearly a third of the papers did not provide a clear resilience definition. Within the current project, coping includes all the strategies used by an individual, and resilience is the by-product of those strategies used to adapt to a situation and foster resilience as an outcome.

Finally, along the existential journey, the individual not only seeks happiness but also will strive to achieve eudaimonia, the living of life well. The process is continuously dynamic, peppered with stressors, adversities, wonderful surprises and countless memorable moments that shape our existence. Research has demonstrated that students derive more meaning from their university studies when they are eudaimonically oriented, therefore improving their education (Cruce et al., 2020). This study is looking at NSs' wellbeing across this whole spectrum.

2.3.2.2 Coping and Resilience Research

Numerous studies have been conducted regarding resilience in nursing, including in the educational space and healthcare in general. In their systematic review of effects of interventions designed to foster resilience in healthcare students, Kunzler et al. (2020) reviewed 30 randomised control trials and concluded that despite positive effects, there was a very low level of evidence for the effect of resilience training on several attributes including anxiety; stress, including stress perception; and overall resilience. Their recommendations called for improved study designs, high-quality replications, and attention to particular aspects including an agreed definition of resilience as discussed previously.

The following section will provide a summary of the main stressors experienced by undergraduate NSs. It will then present coping interventions that have been trialled within the educational space. Where possible, the evidence will be related specifically to the FYNS.

2.3.2.2.1 Stressors Affecting Coping and Resilience in Nursing Students

In this sub-section, the major stressors affecting NSs during their education will be examined. These include stress and anxiety, the effects of bullying, self-esteem, interpersonal communication, and the impact of exposure to the clinical space.

2.3.2.2.1.1 Students' Experience of Stress and Anxiety

The stress and anxiety experienced by undergraduate NSs has been examined in several studies (Cornine, 2020; García-Izquierdo et al., 2018; Gibbons et al., 2011; He et al., 2018; Kolanko, 2003; Mathad et al., 2017; Savitsky et al., 2020). Kolanko (2003) investigated NSs with a learning disability and identified anxiety, social isolation from peers, and difficulty in processing and completing tasks as problematic. NSs utilised a variety of helpful elements, including the positive attitude of instructors and humour, as effective coping strategies (Kolanko, 2003). Li and Hasson (2020) reviewed published evidence and concluded that NSs' levels of stress were high while resilience was considered moderate, which affected wellbeing, prompting them to advocate for improving students' coping skills.

Specific interventions designed to reduce stress and improve life outcomes have been trialled with NSs. Using a waitlist control trial, Mathad et al. (2017) recruited a group of nursing and midwifery students to participate in a yoga intervention over a 2-month period. Of all the students, 48.75% (intervention group: $n = 22$, 55%; control group: $n = 17$, 42.5%) were first-year students. The intervention combined a series of breathing exercises, yoga poses and meditation. The authors measured several parameters including mindfulness, self-compassion, resilience, life satisfaction, empathy and perceived stress. They observed improvements in all measures in the yoga group, while the waitlist group demonstrated declines in all measures apart from their life satisfaction, which only improved marginally (2% increase); this difference however was less than for the yoga group (4% increase). The difference was not statistically significant within or between groups.

NSs typically experience high levels of stress. Researchers have identified that NSs experience greater stress towards the final year of their degree than at the onset (Jimenez et al., 2010), although the assumption that mature-age students have high levels of resilience due to previous life experience is not evident at all levels (Chung et al., 2017). Resilience has also been shown to directly affect academic performance, and emotional exhaustion was predictive of student health (García-Izquierdo et al., 2018) as well as being the most significant predictor of psychological wellbeing (He et al., 2018). Additionally, self-efficacy has been demonstrated to have a moderating effect on learning and teaching distress (Gibbons et al., 2011).

The clinical setting has been identified as the most anxiety-producing component of the study program (M. Elliott, 2002). Some of the difficulties experienced in the clinical setting directly result from their interaction with peers, patients and clinical facilitators (Bartlett et al., 2016; Jun & Lee, 2017). These may negatively affect a student's sense of self and adequacy, engendering feelings of fear, frustration, anger, ambivalence, hopelessness, inferiority, loneliness and exclusion (Admi et al., 2018; Arieli, 2013; Shipton, 2002); general psychological health; and course and career satisfaction (Gibbons et al., 2011). Older students were reported to experience lower levels of anxiety in the same setting (A. H. Wang et al., 2019). It is necessary for educators to consider these factors in developing programs for optimal student outcomes.

Stressful events cannot always be predicted. With the advent of COVID-19, researchers benefited from capturing data that included an extraordinary event affecting every one of their participants. Savitsky et al. (2020, 2021) assessed first- to fourth-year NSs' level of anxiety and coping strategies during, and once emerging from, a severe lockdown in Israel and differed between religious affiliations. The Jewish and Christian NSs' anxiety levels reduced once restrictions were eased; however, the opposite was true for Muslim NSs, who experienced an increase of anxiety rather than a decrease. The authors discussed that this could potentially be explained by several factors relating to dissemination of public information, including delays and breadth, as well as difficulties in accessing computers and internet at home for online education. However, the authors also identified coping strategies helpful to NSs. Resilience accounted for the most variance at both points in time, together with the seeking of information and mental disengagement. The other two factors identified

at point one (3 weeks into the lockdown) were spiritual support and humour, although they did not feature once the restrictions had lifted. Mental disengagement was identified through questions relating to the use of alcohol, sedatives and comfort eating for emotional regulation. Interestingly, other researchers have demonstrated that the use of humour produces a buffering effect against acute stress (Sliter et al., 2014), and this could be comparable to those afforded by food, drugs and alcohol. Investigating humour as a strategy for mental disengagement could provide healthier and perhaps more productive strategies to reduce mental load during stressful situations. On the other hand, mental disengagement was linked to higher anxiety levels, while humour was associated with significantly lower levels (Savitsky et al., 2020). These findings suggest a careful exploration of coping strategies, including humour, with special consideration of their uses and outcomes.

2.3.2.2.1.2 Bullying

Students and GNs experience bullying and harassment in high numbers (Birks, Budden, et al., 2018; Rush et al., 2013). Bullying is defined as a pattern of undesirable actions or conduct committed by a person or group against another (person or group), resulting in immediate negative effects in the recipient. This can create a risk to their health and safety (Fair Work Ombudsman, n.d.), with the potential to negatively affect group members, including workplace colleagues, because they witness the bullying (Alisha H. Johnson & Benham-Hutchins, 2020). Insufficient attention to this can grievously affect self (the student or practising nurse) and the community by creating and perpetuating a vulnerable, unstable workforce. All possible efforts should therefore be made to facilitate healthy transition to practice and workforce retention (Department of Health, 2014b), while also considering that the first exposure is likely to occur during clinical practica.

Bullying has been demonstrated to affect a person physically and psychologically, and has been identified in nursing and students (Fernández-Gutiérrez & Mosteiro-Díaz, 2021). NSs used various coping strategies to cope with bullying. Some reported strategies included implementing barriers against the aggressor (Janet R. Cooper et al., 2011); using humour, acceptance or self-punishment; seeking refuge in religious practice; substance use; and behaviour imbalance (Mabrouk & Rahman, 2014). Others sought support from friends and relatives (Janet R. Cooper et al., 2011),

although reporting to educational staff and nurse mentors was often unproductive for NSs (Ren & Kim, 2017).

Courtney-Pratt et al. (2018) interviewed 29 NSs including five in their first year. Students reported being bullied not only in the clinical setting but also in the classroom. These experiences left NSs disengaged in the classroom, exiting the program or questioning their choice of career. Rather than reporting these incidences formally, NSs sought support and advice from trusted academic staff and debriefed with their peers or utilised a provided counselling service. The study also identified that NSs believed the university had not prepared them adequately to address bullying and highlighted the value of debriefing and peer support (Courtney-Pratt et al., 2018).

These studies demonstrate that NSs coped with bullying in different ways and emphasised the role played by relationships, both positively and negatively, in doing so. Helping students develop or strengthen interpersonal relationships and communication with others could assist them to mitigate the impact of bullying encountered in nursing education and practice.

2.3.2.2.1.3 Self-Esteem and Communication Skills

As seen in the previous section, self-esteem and social connections are contributors to effective coping strategies and resilience. The incorporation of strategies to improve self-esteem and communication skills has been discussed by Gurdogan et al. (2016). They surveyed a sample of Turkish NSs across all educational years through self-reported instruments and short interviews, finding that NSs believed that they had good communication skills and with more than half reporting to have high self-esteem. They also found that self-esteem reduced with age, FYNSs scoring higher than their seniors. This reduction in score along the years was also true of communication skills (Gurdogan et al., 2016). The authors argued that the increase in stress towards the end of the degree might have reduced students' self-esteem, reinforcing their view of the importance of including educational and social activities to improve communication skills and self-esteem, such as problem-based learning and intergroup drama training (Gurdogan et al., 2016). This accords with Leef and Hallas's (2013) research previously discussed on the benefit of clown training for NSs.

Communication skills were also identified as one of the major skills hospital nurse leaders expect from NSs. Sortedahl et al. (2017) surveyed 221 nurse leaders, who identified six different essential categories of characteristics, namely, ability for change, communication skills, conflict management, leadership and self-awareness. Communications skills rated the highest, with 72% of nurse leaders, followed by self-awareness at 14.4%. Communication comprised effective listening, communication with others (peers, patients, family members, superiors and other health providers) and the ability to conduct difficult conversations, and assertiveness. They deemed these characteristics as necessary to be developed in NSs during their education (Sortedahl et al., 2017). In a separate study, Cowin and Johnson (2015) found that some NSs' qualities remain static across educational years while others vary. They found that good communication, dedication, honesty and trustworthiness remained unchanged, while understanding, respect and helpfulness declined during the graduate year.

This section has discussed contributing factors to NSs' self-esteem. The section touched on fostering nurturing relationships and managing difficult ones. It has also discussed how developing awareness and effective communication skills are helpful to students not only during their studies but also during their interactions with educators and patients. Ultimately, addressing these can assist NSs to reduce avoidable stress in their professionally formative years.

2.3.2.2.1.4 The Clinical Environment

The clinical setting in itself is a stressful environment for NSs. A study by Mahat (1996) identified FYNSs' interpersonal relationships in the clinical setting as their most stressful event and that they coped using a variety of strategies. These included problem-solving, seeking social support, self-control, and tension reduction (such as crying, self-soothing and praying). Dzurec et al. (2007) investigated 53 FYNSs and endeavoured to discover elements contributing to students feeling down and sad. The main factors were feeling overwhelmed due to workload, loneliness or isolation, difficulty in transitioning to higher education, and a sense of inadequacy. Similarly, Seyedfatemi et al. (2007) reported on NSs intrapersonal and interpersonal sources of stress, with the majority of stressors being linked to social interactions (making new friends, working with unknown individuals) and workload. They also found that those

sources of stress were greater in FYNSs than senior NSs. Their study revealed several coping strategies including self-actualisation, self-reliance and social support (Seyedfatemi et al., 2007). Yamashita et al. (2012) also identified academic, clinical and relationship factors as sources of stress.

Alshahrani et al. (2018) surveyed FYNSs in South Australia to elucidate the specific helpful factors and strategies conducive to a positive first clinical experience. Students reported receiving beneficial support from various helpful social sources. These included debriefing with clinical lecturers, seeking support and advice from nursing staff, and seeking out their friends and family. The effect of these interpersonal relationships was also discussed by Lee (2019), who reported on the positive effect of reducing NSs' intolerance of uncertainty and stress in a sample of NSs of all years. J. Lee (2019) also stated that resilience skills, including self-regulation, perceiving and controlling one's emotions, and positive tendencies, resulted in increased feelings of happiness.

Clinical placements far exceed the function of providing an opportunity for students to practise clinical skills (Stayt & Merriman, 2013). They play a pivotal part in improving confidence and self-efficacy, promoting students' empowerment from being valued (Bradbury-Jones et al., 2011) and welcomed (John Cooper et al., 2015). They ultimately contribute to the retention of students in their course and the development of constructive attitudes and skills to the benefit of the profession as a whole (Jeffreys, 2012; Kopp, 2019). Combining elements to promote motivation, self-efficacy and self-competence in academic learning tasks and clinical placements can optimise learning opportunities and support course completion.

Collectively, or as singular events, clinical experiences can traumatise the undergraduate nurse, especially in the case of bullying (Birks et al., 2017). Nursing educators have a duty of care to the profession and their students to provide a high level of preparation and overall safety prior to clinical placement commencement. It is necessary to equip NSs with an array of strategies that will adequately prepare them to care not only for others but for themselves (Brewer & Sanderson, 2017). This aspect relates to the previous two sub-sections examining bullying, self-esteem and communication.

Surprisingly, and more recently, Bhurtun et al. (2021), who surveyed FYNSs in the clinical environment, reported that NSs rarely experienced stress according to psychometric measurements, and when they did, it was mostly related to a lack of knowledge and skills. They identified that stressors experienced by FYNSs also included their difficulty in communicating with patients, educators and other health providers, such as doctors, and getting along with peers (Bhurtun et al., 2021). Female students were more likely to report high levels of perceived stress and to use avoidance as a coping strategy. Helpful coping strategies identified were transference (such as sleeping, feasting and talking with one another), problem-solving and remaining optimistic (Bhurtun et al., 2021). One commonality between studies such as Bhurtun et al. (2021), Brewer and Sanderson (2017), and Birks et al. (2017) is the role played by interpersonal communications and rapport with others as important factors in the clinical setting.

Some elements reported by researchers are categorised differently yet include similar coping strategies. For example, 'stay optimistic' in Bhurtun et al. (2021) includes 'to cry, to feel moody, sad, helpless', which mirrors Mahat's (1996) category of stress reduction. Yamashita et al. (2012) reported the benefits of humour as coping strategies; however, others did not. This may be due to information gathering means not specifically addressing the concept of humour, researchers not specifically looking for it, or participants not being given the option of commenting on it directly, humour remaining therefore hypothetically undetected or not categorised or captured similarly to other studies. This fact does not necessarily mean that humour is neither present nor beneficial, but potentially concealed.

In summary, research evidence consistently shows that NSs, including those in their first year, experience several stressors in the clinical setting. The role played by interpersonal relationships and communication is evident, and students use a variety of coping strategies to overcome their difficulties, some being more effective than others.

2.3.2.2.2 Coping Interventions

Coping and resilience are concepts that include the sub-elements of humour, self-esteem and self-efficacy, hope, and positive relationships (Earvolino-Ramirez, 2007;

B. M. Gillespie et al., 2007; Hart et al., 2014). Levels of resilience and the use of coping strategies differ greatly between individuals. Factors affecting this, either positively or negatively, warrant investigation to strengthen graduating nurses and increase undergraduate degree completion rates. The following section discusses academic strategies, such as mentorship, assignments and simulation, to address students' wellbeing in their undergraduate nursing courses.

Nurses from varied backgrounds have sought to find antidotes to the negative effects of practising nursing. Interestingly, employment during undergraduate nursing studies is a protective factor against emotional distress, anxiety and depression (Moxham et al., 2018). Nurses in fields, including clinical practice, research and ethics, discussed how moral resilience could be developed in clinical practice education to develop supportive policies (Rushton et al., 2017), encourage the use of emotional intelligence (EI) to overcome anger and frustration (Meires, 2018), and offer self-care strategies (Hossain & Clatty, 2021), all of which would refer back to coping and resilience. Such strategies can be included in the nursing curriculum to enable nurses to implement those they find helpful.

Resilience training in undergraduate nursing curricula is mostly informal yet is embedded in activities. These range from journaling to engaging in RP and promoting peer support. Recommendations have been made to improve resilience education uniformity with a view to decrease early professional exit and better prepare novice nurses (L. J. Thomas & Asselin, 2018).

Researchers have also trialled coping interventions with FYNSs and discussed their effectiveness (Cornine, 2020; Jenkins et al., 2019; McCarthy, Trace, O'Donovan, O'Regan et al., 2018; Mills et al., 2020; Onan et al., 2019; Yüksel & Bahadır-Yılmaz, 2019). Cornine (2020) conducted a review of 17 studies that supported student-led, faculty-led behavioural and structural interventions and stated that most interventions were reported to be effective in reducing NSs' anxiety. However, they concluded that the outcomes of some interventions, such as relaxation techniques, were not convincing. This conflicts with earlier studies, namely, those discussed earlier by O'Brien (2013), Ozturk and Tezel (2021), and Van der Riet et al. (2015), who delivered a series of 1-hour stress management and mindfulness programs to FYNSs and midwifery students that aimed to build resilience, reduce stress, and improve

concentration. The intervention proved effective and helped students reduce negative thoughts. The difference between the interventions might have been in how they were delivered, students' adherence and control for contamination between groups. All these interventions were not seen to be detrimental to the NSs.

Educators have used different platforms and means to deliver their interventions. Waddell, Spalding, Canizares, et al. (2015) and Waddell, Spalding, Navarro, et al. (2015) devised a series of workshops delivered over 2 years centred on career planning and resilience. NSs in the intervention group developed confidence and self-direction in taking an active part in their academic pursuits and achieving their career goals. Some researchers have developed psycho-education interventions. McCarthy, Trace, O'Donovan, O'Regan et al. (2018) reported a significant increase in coping skills, including a reduction in mental disengagement and restraint, while emotional and social support increased. A coping course delivered by Onan et al. (2019) also reported a significant increase in self-perception and social resources upon course completion.

Social media and digital technology play a major role in NSs' life (Hay et al., 2017). Stephens and Gunther (2016) used this platform to deliver educational messages and questions via tweets to enhance protective factors such as social support and received positive feedback from students. Ferguson et al. (2016) found that FYNSs' benefits from social media use, such as Facebook, included independent learning and access to learning resources, and that it helped the development of relationships that were not limited to class time or geographical locations. Students could become acquainted and connect with their cohort peers more easily. In a recent study by Ribeiro et al. (2020), NSs were invited to participate in a 10-week self-esteem building intervention course delivered via Facebook. They reported a high level of engagement throughout the weeks, and post-test results showed that the intervention significantly increased NSs' levels of perceived self-esteem.

The above scoping of interventions indicates the wide breadth of possibilities available to educators in devising and delivering effective coping and resilience interventions to NSs, whether through face-to-face or online means. The following sub-sections will discuss some of these further, in particular, the roles of mentorship, academic

assignments and simulations as strategies to increase NSs' ability to cope with their studies.

2.3.2.2.1 Mentorship

Another type of intervention trialled by researchers was mentorship. Demir et al. (2014) paired 66 FYNSs with their fourth-year counterparts. Pairs had weekly contact, and mentors provided information and support. The mentorship program was successful in increasing FYNSs' internal locus of control and improving their ability to cope with stress. More recently, a similar experiment was conducted by Yüksel and Bahadır-Yılmaz (2019). Their mentorship program was conducted over 8 weeks, pairing more than 100 FYNSs with fourth-year student peers. Mentor selection criteria were having achieved high academic results and to have been known for their likeability among friends. The study demonstrated the effectiveness of the program in increasing social and academic adjustment, self-confidence, optimism and preparedness to seek social support. It also proved beneficial in decreasing levels of submissivity and helplessness.

Other studies have paired students in similar mentorship initiatives in the clinical setting, also with beneficial outcomes (Sprengel & Job, 2004; Walker & Verklan, 2016). Some students were paired one-on-one (Giordana & Wedin, 2010); another study investigated one or two mentors for a cohort of junior peers (Zentz et al., 2014); others studied mentorships lasting between 2 and 10 days (Austria et al., 2013; Broscious & Saunders, 2001; King, 2010), all being beneficial. The effectiveness of mentorship and pairing was also seen as beneficial by Cornine (2020).

At an educational level, fostering belongingness and meaningful relationships, empowerment, and resilience in nursing undergraduate courses potentially bolsters course completion, prepares nurses for transition into their professional roles, and positively affects the nursing workforce well beyond the formative years. Belongingness is a prerequisite to clinical learning and promotes clinical placement success (Levett-Jones & Lathlean, 2008) and clinical site satisfaction (Borrott et al., 2016). It stimulates supportive workplace relationships (Braine & Parnell, 2011) and feelings of being valued (Bradbury-Jones et al., 2011). Darling et al. (2007) discussed how most sources of stress in undergraduate students stemmed from various

relationships and affected their academic performance. All these studies suggest the effectiveness of interpersonal relationships, including mentoring, in helping FYNSs cope with the demands of the academic and clinical environments. This further prompts educators to consider the potential afforded by mentoring to improve the learning experience of FYNSs.

2.3.2.2.2 Academic Assignments

Some studies utilised academic assignments to assess the experience of FYNSs. Jenkins et al. (2019) collected 89 surveys from first- and second-year NSs who were completing an accelerated 2-year degree program. As part of a core unit, the students had been required to undertake a self-care assignment. Students identified and investigated any incidences, challenges or circumstances in their lives that might have been causing distress or generating feelings of anxiety. Supported by evidence-based research and theories, students were also tasked with identifying helpful resources to develop a personal toolkit enabling them to draw from and assist with their mental health needs. Resources included current self-care strategies and those they wished to explore further. The assignment included a compulsory written component and was designed around an academic RP. Students could also submit an optional creative component; they did so by presenting expressive pieces such as journals, artwork, poetry and videos. As part of the research project, students also completed a 16 open- and closed-ended question survey to investigate the impact of the assignment on their self-care learning and practices pre and post assignments. Results revealed that the assignment was beneficial in involving students in self-care activities and helped them manage their stress, effectively allocate time for fun among the demands of their nursing course, and maintain relationships with friends and family (Jenkins et al., 2019).

Similarly, Mills et al. (2020) analysed over 100 academic assignments completed by FYNSs. The assignment was a reflection completed by students towards the end of their first year of nursing education. Students had to reflect on the influences on their own health and wellbeing since the beginning of their nursing journey. Results indicated that the vast majority of students experienced stress affecting all aspects of their lives. They all coped differently but commented on acquiring insight and tools since the beginning of their journey, demonstrating adaptation during their first year.

Additionally, students' reflections revealed the importance of social support from like-minded peers as a coping strategy (Mills et al., 2020).

These findings tie in with and add weight to the helpful nature of relationships in managing stress, as discussed previously in this chapter. These studies also point towards the effectiveness of using academic assignments including coping or resilience content to assist students along their formative journey. Several of these assignments included RP as part of their tasks.

2.3.2.2.3 Simulations

Researchers have endeavoured to maximise students' learning experiences while attempting to bridge the gap between the classroom setting and clinical environment by utilising simulations (Pines et al., 2014; Struksnes & Engelién, 2016; Stunden et al., 2015; Venkatasalu et al., 2015) and, in conjunction with laboratory work, these are sometimes offered to students in their first semester of study (Curtin University, 2018; Edith Cowan University, n.d.; Murdoch University, n.d.-a). Simulation interventions were also used by Pines et al. (2014) to deliver psycho-education and simulated training, utilising resilience, empowerment, and conflict management scenarios to help mental health NSs prepare for clinical practice. Stunden et al. (2015) investigated the literature for effective coping strategies in reducing students' anxiety prior to skills assessments. They found that while students experienced anxiety about their upcoming skills assessment, they viewed preparation as an effective coping strategy. This preparation was offered through simulation activities, and despite performance anxiety from the simulation itself, it was found that students who had engaged in simulation prior to the assessment coped better. Venkatasalu et al. (2015) interviewed students regarding the effectiveness of simulation in preparing them to attend to end-of-life care in the clinical setting. Simulation was successful in preparing students, helping them translate knowledge into practice and prepare them to deal not only with clinical possibilities but also the emotional experience.

Interestingly, Struksnes and Engelién (2016) investigated the learning experience of FYNSs following simulation and later compared their clinical experiences, with mixed results. In the first instance, students found that playing both the role of the nurse and the patient helped them develop knowledge, skills and appreciation of the vulnerability

experienced by patients. However, in the second instance, the authors also compared a group with previous caring experience to one without. Of those without prior experience, their appreciation, perceived benefit and self-confidence achieved from the simulation learning following exposure to the clinical setting had diminished, prompting the authors to question whether pre-clinical skills experience required structural modifications for those students to achieve better results (Struksnes & Engeliën, 2016).

This section has presented the reader with an overview of the literature concerning NSs' coping and resilience. It has discussed how experiences in the clinical environment affect students, including stress, anxiety, interpersonal relationships, and difficulties such as bullying. The section has also presented coping interventions trialled by researchers in the hope of finding ways to help students manage these stresses successfully and progress through their education. These interventions consisted of mentorship initiatives, purposely designed academic assignments and simulations.

2.3.2.3 Nursing Students and the Connor–Davidson Resilience Scale

Researchers have investigated nurses and NSs' level of resilience using a variety of psychometric instruments. Instruments used in the NS population have included the Psychological Resilience Questionnaire (PRQ) (Friborg et al., 2003), Coping Behaviour Questionnaire (COPE) (Carver et al., 1989), the Ways of Coping Inventory (WCI) (Folkman & Lazarus, 1988), Transition, Wellbeing, Help-seeking, and Adjustments Scale (TWHAS) (Sanagavarapu et al., 2019), Transition Shock Scale of Newly Graduated Nurses Scale (Kim et al., 2017), and the Connor–Davidson Resilience Scale (Connor & Davidson, 2003). The latter's complete format includes 25 questions (CD-RISC-25); a shorter version includes a selection of 10 of its original questions (CD-RISC-10). The CD-RISC is a widely used instrument across multiple settings and populations (Connor & Davidson, 2003) with specific data published that include a nursing student population (Mathad et al., 2017), and Australian samples (Hamadeh Kerbage et al., 2021). As the present research project utilises the CD-RISC, the following section will focus on published literature on coping and resilience in NSs using this instrument.

Study results have shown that FYNSs' level of coping and resilience has been commonly measured as moderate to high. Overall score ranges are between 0 to 100 with higher scores, generally 75 or above, being considered as high (Devi et al., 2021; Hamadeh Kerbage et al., 2021). Some studies' samples have returned high results, and these are presented in Table 2.2. For example, Gibson et al. (2020) reported a mean score of 78.44 ($SD = 11.60$) in a relatively small sample of 45 NSs, while Fowler et al. (2020) surveyed 148 FYNSs and reported a mean score of 77.25 ($SD = 13.12$). However, most other studies reported moderate resilience scores between 66 (SD N/A) (Hamadeh Kerbage et al., 2021) and 74.12 ($SD = 15.96$) (Dong et al., 2021).

Table 2.2: CD-RISC-25 Studies of Nursing Students

Authors (year)	Location	Population	Sample					CD-RISC-25	
			<i>n</i>	nf	%f	nm	%m	Score	<i>SD</i>
Fowler et al. (2020)	USA	1st yr Nsg Stds	90	85	94	5	6	77.25	13.12
Hamadeh Kerbage et al. (2021) ^{a,b}	Australia	U/G Nsg Stds	121	106	88	N/A	N/A	71 ^c	N/A
Hamadeh Kerbage et al. (2021) ^{a,b}	Australia	U/G Nsg Stds	121	N/A	N/A	15	12	66 ^c	N/A
Hamadeh Kerbage et al. (2021) ^{a,b}	Australia	U/G Domestic Stds	99	N/A	N/A	N/A	N/A	70 ^c	N/A
Hamadeh Kerbage et al. (2021) ^{a,b}	Australia	U/G International Stds	22	N/A	N/A	N/A	N/A	75 ^c	N/A
Devi et al. (2021)	Indonesia	U/G Nsg Stds	336	240	71.7	95	28.3	68.61	15.08
Dong et al. (2021)	China	U/G Nsg Stds	698	634	90.8	64	9.2	74.12	15.96
Gibson et al. (2020)	USA	U/G Nsg Stds	45	41	91	4	9	78.44	11.60
Lekan et al. (2018)	USA	Senior U/G Nsg	27	22	81	5	19	73.26	10.70
Sahu et al. (2019)	India	U/G & P/G Stds	102	96	94	6	6	71	11.50
Mayor-Silva et al. (2021)	Spain	1st yr Nsg & Physical Therapy Stds ^d	194	189	77	56	23	70	11.1

Note: CD-RISC-25 = 25-item Connor–Davidson Resilience Scale; *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students; U/G = undergraduate students; P/G = postgraduate students.

^a Separate statistics available for the same sample; ^b Data collection during COVID-19 pandemic; ^c Median score, not mean; ^d Full sample was composed of 245 nursing and physical therapy students. Each study group was divided into a control and two intervention groups. Resilience score only provided for the combined discipline group; results were not available for nursing students only.

As discussed in earlier in this section under humour interventions, Stephens (2012) trialled a randomised control trial resilience intervention program. The sample of 70 NSs, all aged between 19 and 23, were sent online messages through a private Twitter account over a 6-week period. The experimental group participants were sent messages designed to enhance protective factors, namely, social support, positive emotions, humour, knowledge of health behaviour, self-knowledge and effective coping. Participants in the control group were also sent tweets to mimic those of the experimental group, but these were related to nursing knowledge and trivia. Baseline measures of CD-RISC-25 pre-intervention were high for both groups (Experimental: $M = 75$, $SD = 13.17$; Control: $M = 74$, $SD = 11.07$). Both groups' resilience score improved following completion of the intervention (Experimental: $M = 78$, $SD = 12.72$; Control: $M = 77$, $SD = 11.25$); however, the experimental group returned to their baseline measure at follow-up ($M = 74$, $SD = 13.3$), while the control group returned a higher score than at baseline ($M = 79$, $SD = 11.079$). The study could not provide an answer to these unexpected results; however, the intervention delivery period was brief. The author also suggested an abandonment effect post-intervention as a possibility, which could be indicative of the role played by engagement and disconnection in promoting resilience in NSs (Stephens, 2012).

More recently, some studies have been emerging following the advent of COVID-19. Hamadeh Kerbage et al. (2021) collected data from 121 undergraduate NSs in Melbourne, Australia. Their sample was predominantly female ($n = 106$, 88%) and returned a median score of 71, score slightly higher than males ($n = 15$), who reported a median score of 66 (SD N/A), although the difference was not significant (mean scores were not published). The authors' statistical analysis did not return any significant differences, whether across year levels or between domestic or international students (Hamadeh Kerbage et al., 2021).

Other researchers have utilised the CD-RISC-10 to sample NSs (Table 2.3). High resilience scores were reported in a large sample of NSs investigated by Z. Zhang et al. (2021) ($n = 6348$, $M = 35.41$, $SD = 8.29$) and also in their sub-group of first-year students ($n = 634$, $M = 35.41$, $SD = 8.29$). A sample of 439 Saudi NSs also returned high levels of resilience during the pandemic ($M = 32.26$, $SD = 5.04$) (Grande et al., 2021). However, in other studies, the rural American samples in Keener et al. (2021)

were moderate ($M = 27.88$, $SD = 6.64$), and Cao, Wang et al. (2021) did not publish the mean score for their sample. These results point towards a trend that undergraduate students, including NSs, have adequate levels of resilience.

Table 2.3: CD-RISC-10 Studies of Nursing Students

Authors (year)	Location	Population	Sample					CD-RISC-10	
			<i>n</i>	nf	%f	nm	%m	Score	<i>SD</i>
Z. Zhang et al. (2021) ^a	China	1st yr Nsg Stds	1765	N/A	N/A	N/A	N/A	35.02	8.25
Chow et al. (2020)	Hong Kong	1st yr Nsg Stds	195	156	80	39	20	24.6	5.10
Fernández-Martínez et al. (2017) ^b	Spain	1st yr Nsg Stds	48	36	75	12	25	29.42	5.18
Fernández-Martínez et al. (2017)	Spain	1st – 3rd yr Nsg Stds	134	107	80	27	20	28.61	5.54
He et al. (2018)	Australia	U/G Nsg Stds	538	458	85	77	14	39.43	6.24
García-Izquierdo et al. (2018)	Spain	2nd yr Nsg Stds	218	165	75	53	25	31.47	6.08
Grimes et al. (2020)	Australia	2nd & 3rd yr Nsg Stds	66	57	86	9	14	29.72	N/A
Grande et al. (2021) ^a	Saudi Arabia	2nd & 4th yr Nsg Stds	439	303	69	136	31	32.26	5.04
Avrech Bar et al. (2018)	Israel	4th yr Nsg Stds	111	86	77	25	23	29	N/A
Keener et al. (2021) ^a	USA	U/G Nsg Stds	152	143	94	9	6	27.88	6.64
Kong et al. (2016)	China	U/G Nsg Stds	377	308	82	69	18	28.2	5.61
Ríos-Risquez et al. (2016)	Spain	Final-year Nsg Stds	113	85	75	77	68	34.7	4.82
Z. Zhang et al. (2021)	China	Nsg Stds	6348	5737	90	611	10	35.41	8.29
Li et al. (2015)	China	Vocational Nsg Stds	202	202	100	0	0	23.96	6.56
Mathad et al. (2017)	India	Students/Intervention	50	50	100	0	0	23.2	5.93
Mathad et al. (2017)	India	Students/Control	50	50	100	0	0	24.33	6.05

Note: CD-RISC-10 = 10-item Connor–Davidson Resilience Scale; *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students; U/G = undergraduate students.

^a Part study sample; ^b Data collection during COVID-19 pandemic.

Several studies have been published using samples of nurses. Compared with the general university student population, nurses are reported to have lower levels of resilience (Table 2.4). Only a few published results were deemed high, with median scores between 76.45 (Schock, 2020) and 91.49 (Gabriel et al., 2011). Interestingly, both samples were relatively small (between 20 and 57 participants), American, and had been surveyed nearly a decade apart and prior to COVID-19. The only results available for nurses during the pandemic were those of Afshari et al. (2021), with a moderate level of resilience ($n = 387$, $M = 61.35$, $SD = 13.12$). All other mean scores presented in six other studies ranged between 57.35 ($SD = 1.51$; Mao et al., 2021) and 73.2 ($SD = 13.38$; Rees et al., 2019). These results suggest that the high level of resilience scores present in undergraduate students appears to decline during nursing practice and provides an additional reason to uncover conducive factors that promote resilience.

Table 2.4: CD-RISC-25 Studies of Nurses

Authors (year)	Location	Population	Sample					CD-RISC-25	
			<i>n</i>	nf	%f	nm	%m	Score	<i>SD</i>
Schock (2020)	USA	Graduate Nurses	20	17	85	3	15	76.45	8.70
Schuller et al. (2020)	USA	P/G Nsg Stds	91	81	89	10	11	80.04	10.64
Leng et al. (2020)	China	Nurses	2981	2816	94	165	6	61.35	13.12
Afshari et al. (2021)	Iran	Nurses	387	236	61	151	39	61.18	14.80
Gabriel et al. (2011)	USA	Nurses	57	55	97	2	4	91.49	13.42
Guo et al. (2017)	China	Nurses	1061	1037	98	24	2	63.77	12.8
Hegney et al. (2015)	Australia	Nurses ^a	949 ^b	N/A	N/A	N/A	N/A	70.38	12.56
Hegney et al. (2015)	Australia	Nurses ^a	339 ^c	N/A	N/A	N/A	N/A	69.06	13.01
Hegney et al. (2015)	Australia	Nurses ^a	232 ^d	N/A	N/A	N/A	N/A	69.17	13.47
Mao et al. (2021)	China	Nurses ^e	53 ^f	N/A	N/A	N/A	N/A	57.35 ^g	1.51 ^g
Mao et al. (2021)	China	Nurses ^e	53 ^f	N/A	N/A	N/A	N/A	69.12 ^h	1.69 ^h
Mao et al. (2021)	China	Nurses ^e	50 ⁱ	N/A	N/A	N/A	N/A	60.81 ^g	1.48 ^g
Mao et al. (2021)	China	Nurses	50 ⁱ	N/A	N/A	N/A	N/A	60.82 ^h	1.66 ^h
Hudgins (2016)	USA	Nurses	89	77	87	3	3	84.6	11.13
Rees et al. (2019) ^j	Australia	Nurses	1884	1702	92	144	8	73.2	13.38
Yu et al. (2020)	New Zealand	ICU Nurses	93	68	73	25	27	73.0	9.6

Note: CD-RISC-25 = 25-item Connor–Davidson Resilience Scale; *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants.

^a Registered Nurses and Enrolled Nurses combined, of which 92.5% were female; ^b Participants from Major Cities only; ^c Participants from Rural area only; ^d Participants from Remote area only; ^e Total sample was *N* = 103; ^f Intervention group; ^g Baseline score; ^h Post-intervention; ⁱ Control group. Only received daily briefing in meetings; ^j 38 participants did answer the question pertaining to gender, resulting in discrepancy between total sample and specified number of females and males.

2.3.2.4 Nursing Students and the Satisfaction with Life Scale

In examining NSs' experience, researchers have also assessed them for their overall satisfaction with life using the SWLS developed by Pavot and Diener (2008). Their results are summarised in Table 2.5. Most studies have identified NSs as being slightly satisfied with their life at the time of enquiry (Bodys-Cupak et al., 2021; Chattu et al., 2020; Dayapoglu et al., 2016; Hawker, 2012; Kupcewicz et al., 2020; Mathad et al., 2017; Por et al., 2011; S. D. Martin et al., 2022; Yildirim et al., 2013), while some students were slightly dissatisfied (Berduzco-Torres et al., 2020; Ruiz-Aranda et al., 2014). The sample investigated by Berduzco-Torres et al. (2020) contained 46% NSs and 54% medical students; however, the SWLS score was only reported for the entirety of the sample ($M = 18$, $SD = 5$) and not separated by discipline. The female sample investigated by Jun et al. (2015) was slightly dissatisfied, while their male counterparts were reported to be dissatisfied. Also dissatisfied with life were a sample of Thai NSs (Ratanasiripong & Wang, 2011). Only one study reported a group of Spanish NSs to be satisfied (Arribas-Marín et al., 2021); they were all in their second, third or fourth years of nursing study.

The trend for university students in general also suggests that they are somewhat satisfied with life. A comparative list of studies involving students from other disciplines all indicated that most were slightly satisfied (Table 2.6). Only one group of Chinese college students (Zhao et al., 2014) and a group of Turkish university students (Aslan et al., 2020) were slightly dissatisfied.

Similar to resilience, along their nursing journey and when they become nurses and continue to work in the profession, results do not indicate improvement in scores. Lankau et al. (2017) surveyed 150 Polish nurses who reported being neither satisfied nor dissatisfied, with an overall score of 20.1 (SD N/A), which translates as being neutral on the matter. However, a separate Polish study found that 60% of a group of Polish nurses ($N = 472$) reported being satisfied with life to a low or moderate level (scores of 24 or less) (Uchmanowicz et al., 2020). This was also the case for a group of 237 UK mental health nurses who reported being slightly satisfied with life (Oates, 2018).

Table 2.5: Satisfaction with Life Scale (SWLS) Studies for Nursing Students

Authors (year)	Location	Population	Sample					SWLS		Interpretation
			<i>n</i>	<i>nf</i>	%f	<i>nm</i>	%m	Score	<i>SD</i>	
Yildirim et al. (2013)	Turkey	1st yr Nsg Stds	N/A ^a	N/A ^a	N/A ^a	N/A ^a	N/A ^a	21.82	5.72	Slightly satisfied
Berduzco-Torres et al. (2020)	Peru	U/G ^b	1503	628	90	72	10	18	5	Slightly dissatisfied
Arribas-Marín et al. (2021)	Spain	2nd – 4th yr Nsg Stds	586	486	83	100	17	26.92 ^c	4.73 ^c	Satisfied
Bodys-Cupak et al. (2021)	Poland	Nsg Stds	307	295	96	12	4	20.82	5.72	Slightly satisfied
Chattu et al. (2020)	West Indies	Nsg Stds	84	N/A	N/A	N/A	N/A	23.11	6.06	Slightly satisfied
Dayapoglu et al. (2016)	Turkey	Nsg Stds	353	274	78	79	22	22.05	6	Slightly satisfied
Hawker (2012)	UK	Nsg Stds	215 ^d	198	93	14	7	22.9	6.6	Slightly satisfied
Jun et al. (2015)	Korea ^e	Nsg Stds	236	231	98	-	-	18.94	5.95	Slightly dissatisfied
Jun et al. (2015)	Korea ^f	Nsg Stds	236	-	-	5	2	14.60	6.26	Dissatisfied
Ruiz-Aranda et al. (2014)	Spain	Nsg Stds	88	88	100	0	0	18.93 ^c	0.3 ^c	Slightly dissatisfied
Mathad et al. (2017)	India	Nsg/Intervention	50	50	100	0	0	21.6	5.02	Slightly satisfied
Mathad et al. (2017)	India	Students/Control	50	50	100	0	0	22.35	5.07	Slightly satisfied
Kupcewicz et al. (2020)	Poland	Nsg U/G	404	365	90	39	10	21.46	6.28	Slightly satisfied
Kupcewicz et al. (2020)	Spain	Nsg U/G	208	171	82	37	18	24.04	6.13	Slightly satisfied
Kupcewicz et al. (2020)	Slovakia	Nsg U/G	390	379	97	11	3	22.40	5.64	Slightly satisfied
S. D. Martin et al. (2022)	USA	Nsg U/G	417	377	90	40	10	23.61	6.72	Slightly satisfied
Por et al. (2011)	UK ^e	Nsg U/G	130	117	90	-	-	23.7	4.2	Slightly satisfied
Por et al. (2011)	UK ^f	Nsg U/G	130	-	-	13	10	23.9	4.8	Slightly satisfied
Ratanasiripong & Wang (2011)	Thailand	Nsg U/G	200	18	91	19	9	13.86 ^c	2.77 ^c	Dissatisfied

Note: *n* = number of participants; *nf* = number of female participants; %f = proportion of female participants; *nm* = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students; U/G = undergraduate students.

^a Gender distribution of sample not available; full sample all study years combined: $n = 396$; $nf = 390$, 99%; $nm = 6$, 1%; ^b 46% of the sample ($n = 700$, $F = 625$, $M = 72$) were nursing students but no independent SWLS score for them; ^c Adjusted score; ^d 2 participants were missing from the results; ^e Female sample only of all health disciplines combined; ^f Male sample only of all health disciplines combined.

Table 2.6: Satisfaction with Life Scale (SWLS) Studies for Non-Nursing Students

Authors (year)	Location	Population	Sample					SWLS		Interpretation
			n	nf	%f	nm	%m	Score	SD	
Zhao et al. (2014)	China	College Stds	477	274	57	203	43	18.54	5.57	Slightly dissatisfied
Çalışandemir & Tagay (2015)	Turkey	Students (primary)	287	248	86	39	14	23.54	5.58	Slightly satisfied
Chattu et al. (2020)	West India	U/G ^a	535	383	72	-	-	22.59	6.72	Slightly satisfied
Chattu et al. (2020)	West India	U/G ^b	535	-	-	152	28	22.16	6.74	Slightly satisfied
Cann & Collette (2014)	N/A	Psychology Stds	120	93	78	27	23	24.9	6.70	Slightly satisfied
Huang & Lee (2019)	China	Education U/G	260	168	65	92	35	24.2	5.75	Slightly satisfied
Durak et al. (2010)	Turkey	University Stds	547	346	63	201	37	21.91	6.18	Slightly satisfied
Aslan et al. (2020)	Turkey	University Stds	358	200	56	158	44	16.72	6.81	Slightly dissatisfied

Note: n = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students; U/G = undergraduate students; P/G = postgraduate students.

^a Female sample only of all health disciplines combined; ^b Male sample only of all health disciplines combined.

The impact of COVID-19 on life satisfaction has been reported in the university student population. Rogowska et al. (2021) showed that most students in six out of nine countries (Slovenia, Czechia, Germany, Ukraine, Russia, Israel and Columbia) during the pandemic were slightly satisfied, with scores ranging from $M = 21.26$ ($SD = 6.18$) to $M = 24.46$ ($SD = 5.43$), while Turkish students were slightly dissatisfied and Polish students were neutral on the matter. The authors discussed a number of factors that played a role, including exposure to the virus, disruption to studies and gaining qualifications, and impact on financial situations and relationships (Rogowska et al., 2021). Aslan et al. (2020) also revealed that Turkish students, from 14 different Turkish establishments, reported being slightly dissatisfied with life ($M = 16.72$, $SD = 6.81$) during the pandemic.

Researchers have also investigated the impact of COVID-19 on students' and nurses' life satisfaction. Pizarro-Ruiz et al. (2021) measured the effect of mindfulness intervention delivered to Spanish education and NSs via smartphone applications during the pandemic. The intervention proved successful in improving not only satisfaction with life but also mindfulness abilities, forgiveness towards self, and intellectual and interpersonal strengths, and in reducing negative affect. Köse et al. (2021) trialled a motivation intervention in a group of Turkish ICU nurses. The intervention and control groups' SWLS pre-scores were similar (intervention: $M = 14.2$, $SD = 2.3$; control: $M = 14.1$, $SD = 4.1$) and interpreted as being slightly dissatisfied. The intervention consisted of sending a number of positive text messages to nurses at five separate times throughout the day for 21 days. Messages were composed to instil hope, optimism and life satisfaction. Nurses were allowed to take a short break during their shift to access the motivational messages. The control group were not sent any messages and performed their shift as usual. Post-test results showed that both groups' satisfaction with life increased but more so in the intervention group (intervention: $M = 17.4$, $SD = 2.0$; control: $M = 16.0$, $SD = 3.7$). However, the study had several limitations and could not exclude a cross-over effect from other colleagues. These studies nonetheless demonstrate that interventions can be effective in improving perceived life satisfaction in students and nurses.

Overall, educators can utilise several means to assess and address NSs' coping, resilience and satisfaction with life. This section on coping and resilience has presented research and interventions in the nursing education space. Different strategies and

means of fostering engagement and delivering interventions are available, including digital platforms, primarily social media and text messaging, and can be delivered in the classroom, in clinical practice and in the virtual space. These can also be easily imbedded in academic assignments to improve knowledge and optimistically translate into positive outcomes for students.

2.3.3 Transition and Adaptation

This section will present the concepts of transition and adaption that NSs undergo during their formative years. The sub-sections will introduce more specifically transition shock, transition to practice program, and what is known around transition shock in NSs. These aspects will also be discussed around their implication for NSs' wellbeing. The following sections are visually presented in Figure 2.5.

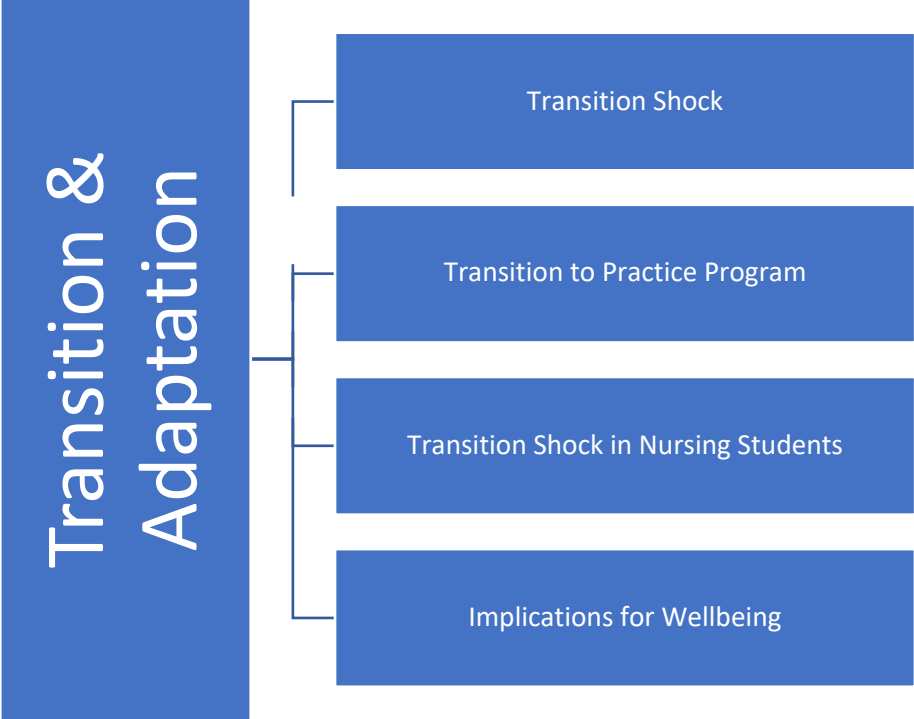


Figure 2.5 Current Literature on Nursing Students' Transition and Adaptation

For several decades, researchers have investigated how GNs adjust to their working life once registered. Kramer (1974) first discussed the concept of reality shock, following two cohorts of students who participated in an anticipatory socialisation program against a previous cohort who had not been exposed to the program and who served as a control group. The program proved beneficial in preparing NSs to adapt to professional

demands more than the control group. Later, Duchscher (2008) further developed the concept, considering how the process of transition affects, and is affected by, physical, emotional, intellectual and sociocultural factors. Duchscher's theory will be discussed in more depth in Chapter 3 as this theory is an important underpinning of the current study. It is briefly presented in this section to assist logical flow.

NSs navigate through role identity with difficulty, with particular challenges being presented in the clinical environment (Terblanche & Cilliers, 2021). M. Johnson et al. (2012) discussed how NSs' role identity undergoes both construction and deconstruction throughout their learning journey, affected by their mentors, teachers and clinical environments. Students of different age groups have different needs, and supporting them accordingly can improve program retention and completion (Donaldson et al., 2010).

In embarking on a new journey, individuals typically experience uncertainty from a lack of familiarity, and the impact of transition shock has been examined in relation to the newly graduated nurse (Duchscher, 2009; Rush et al., 2013). However, less attention has been devoted to the transition of the student nurse, and when considering the student nurse, researchers have devoted most of their attention to the final-year student (Borrott et al., 2016; Nash et al., 2009). NSs commencing their journey have not yet developed set habits, whether good or bad, leaving them both vulnerable and malleable.

As there is a potential for NSs to experience transition shock during their first year, the transition shock model (Duchscher, 2008) will be used to compare our findings. Therefore, the following sub-sections will discuss the transition shock and its four domains in the nursing context. It will present what is currently known in the literature about transition to practice programs and will briefly discuss the presence of transition shock in NSs. Finally, transition shock will be linked back to wellbeing.

2.3.3.1 Transition Shock Domains

The transition shock model relates to four domains—physical, emotional, intellectual and social (Duchscher, 2008). Each are observed in the GN and can be linked back to the NS population. However, there are minimal research results available in the published literature about NSs and transition shock. This lack of evidence does not

preclude NSs from experiencing transition shock but highlights a need for further research.

Nursing is a physically demanding occupation. Nurses' level of fitness affects patient care (Chappel et al., 2017), and their health profile has been found to have multiple vulnerabilities to adverse health outcomes (Heidke et al., 2020), with costly presenteeism and absenteeism repercussions of A\$439–598 per person per month (Lui et al., 2018). Poor physical fitness has also been demonstrated in NSs (Klainin-Yobas et al., 2015), including low levels of physical activity (Blake, Stanulewicz & McGill, 2017); however, contradictory results of general fitness self-assessment (Spurr et al., 2021) may give them a false sense of wellbeing. Despite the physical toll experienced by GNs and the exhaustion felt from continuous shift work and difficulty in maintaining an effective work–life balance (Ho et al., 2021), this aspect was not always the most significant factor in transition shock for GNs (Cao, Li, & Gong, 2021). Despite being undoubtedly present, the physical aspect is perhaps not as significant as the other three in the transition shock model, although empowering NSs during their education could improve positive health-promotion attitude (Blake et al., 2017), help them become future effective health-promotion role models (Nevins & Sherman, 2016), and better prepare them to efficiently manage their own transition. This also prompts a need for further research and education.

The emotional impact of the transition to practice is felt on several levels. GNs report initial emotional impacts of not being offered help, and feeling unsupported and alienated, although this sentiment eased as time progressed (Ho, Stenhouse, & Snowden, 2021). Weekly group counselling sessions were demonstrated to improve all measures of transition shock (Xu et al., 2021), although interestingly all pre- and post-test results in the control group also saw an improvement, indicating that all aspects improved over time without the intervention. The only aspect that did not improve was students' sociocultural and developmental aspect. Their initial score was already mid-range (median interquartile pre = 21 and post = 21.97), and unfortunately the authors did not discuss this or offer a potential rationale for this result. A possible explanation may be that effects and changes to socialisation begin earlier during education rather than the first year of practice.

Intellectually, GNs are confronted with cognitive dissonance between what they have been taught and what they see and experience in practice. This aspect has been reported as rating highest in its impact on transition shock (Cao, Li, & Gong, 2021) affecting nursing competency, particularly critical thinking and research aptitude (F. Chen et al., 2021), and significantly associated with adverse patient events (Labrague & Santos, 2020). Having access to well-trained preceptors resulted in GNs having more confidence in their ability to provide optimal and safe care to patients (Clipper & Cherry, 2015), while ward-based simulations have also been seen as a possible effective strategy to prepare NSs as advanced beginners (Graf et al., 2020). The successful pairing of NSs in clinical practice as well as simulation opportunities could therefore help NSs ease into their transition.

The emotional, sociocultural and developmental factors, as well as the preceptors' experience, also significantly affected graduates' nursing competency (F. Chen et al., 2021). Here again, the successful pairing of GNs with adequately trained nursing preceptors improved their ability to develop effective working relations with their peers and help ease transition shock (Clipper & Cherry, 2015). Positive nursing settings were also seen to assist GNs adapt to their working life (Cao, Li, & Gong, 2021) and had a flow-on effect on personal and home life (Ho, Stenhouse, & Snowden, 2021). Adequate staffing, working relationships and nursing resources were specifically highlighted (Ho, Stenhouse, & Snowden, 2021; S. O. Kim & Kim, 2021) in influencing transition shock.

Research studies have linked the effect transition shock had on nurses' resilience (Cao, Li, & Gong, 2021; S. O. Kim & Kim, 2021). Transition shock was significantly negatively correlated with resilience, social support and the nursing practice environment, and significantly predicted intentions to leave, highlighting the importance of developing resilience, as well as enhancing social support and a healthy work environment in supporting GNs (Cao, Li, & Gong, 2021). Similarly, S. O. Kim and Kim (2021) also reported significant negative associations between transition shock, resilience, working conditions, and interpersonal as well as interprofessional relationships.

The social aspect of NSs' experience during their formative years has been discussed in previous sections in this chapter. Interactions with peers, educational staff, patients, family and friends play a vital part in students' experiences. These social connections and interactions are influential on all levels, contributing to a significant fraction of the

transition shock experienced by new nurses. Addressing these early could diminish their transition shock.

2.3.3.2 Transition to Practice Program

To assist GNs navigate their first year of practice, graduate programs (sometimes called transition to practice programs) are offered. Their efficacy has been investigated, particularly in the last few years, and proven beneficial in assisting GNs (Edwards et al., 2015; Spector et al., 2015; Tuckett, Eley & Ng, 2017). However, Machesky (2017), exploring whether having a graduate program affected career satisfaction and retention, found that there was no statistically significant difference in satisfaction between the two groups, raising questions of program efficacy around career satisfaction and intention to stay. Spector et al. (2015) found that hospitals that used an established transition program that included several elements combining communication and teamwork, feedback, reflection, and evidence-based practice had better outcomes in supporting GNs. How the transition program is structured is evidently vital in producing positive outcomes.

The practical experience offered to final-year students, interns and GNs improves their transition to practice (Kaihlanen et al., 2018). Ong (2013) reported that well-structured final-year clinical placements can assist in managing transition shock. Incorporating a simulated assessment within the program was also found to improve GNs' critical thinking and confidence (Phoenix Bittner et al., 2017). Simulation has also been incorporated through ward-based immersive experiences (H. Davies et al., 2021) and in nursing internship programs, although at times proving difficult to accommodate nurses' working schedules (Sanchez & Fuselier, 2020). Additionally, matching student interns with nursing ward speciality of choice, personality type and stress levels proved efficacious in reducing turnover rate from 29% to 13.9% (Sanchez & Fuselier, 2020). Dedicated education units have been effective in combining teaching, experience and mentoring, although present challenges in their long-term management would benefit from formal evaluation to improve their planning and implementation (Marcellus et al., 2021). These findings demonstrate that developing programs to maximise learning opportunities combining skills, aptitudes and experience can assist students along their transitional journey.

Effective working relationships play a significant part in the GN's experience. Ebrahimi et al. (2016) investigated the expressed barriers in RNs supporting GNs. Among their findings, they reported that RNs were less inclined to help GNs if they displayed a lack of support-seeking behaviour and ineffective communication; for example, RNs were less inclined to support a GN if they did not display interest and motivation. The lack of confidence in their own skills as preceptor or appreciation given for the increase in work load in supporting GNs was also a deterrent for them (Ebrahimi et al., 2016).

2.3.3.3 Transition Shock in Nursing Students

There is a paucity of published literature on transition shock and NSs, with most of the evidence being centred on the newly graduated nurse. Imposteur syndrome has been identified in fourth-year NSs, which was weakly associated with preparedness to practise (Christensen et al., 2016). A scoping review of nonclinical transition to practice educational units identified that only 58% of them directly addressed transition shock within their content (K. B. Hampton et al., 2021). Factors affecting NSs' adaptation to clinical practice have been examined in third- and fourth-year students (S. Y. Kim & Shin, 2018; Noh, 2017; Wareing et al., 2017). Therein lies a need for further research to assess whether FYNSs also experience transition shock and its extent.

Initial clinical placements can have a strong impact on students. Cummins et al. (2014) examined the experience of midwifery students following their first clinical placement. Their findings helped them develop workshops that were imbedded within their semester of learning. This enabled educators to introduce concepts earlier in the curriculum to minimise students' culture shock in practice.

McCloughen et al. (2020) investigated NSs following their first clinical experience. They found that students experienced emotional difficulties during their placement and valued the helpful nature of interested clinical facilitators and RN mentors. These findings further add weight to the role played by supportive relationships during nursing education. Chesser-Smyth and Long (2013) investigated FYNSs and found that a number of factors affected students' self-confidence positively (e.g. being given responsibility, clinical familiarity, and being part of the team) and negatively (e.g. fear of making a mistake, stress, isolation, and little or no communication with staff). These factors were related to the emotional, intellectual and sociocultural aspects of Duchscher (2009) transition shock; however, none related to the physical aspect.

2.3.3.4 Implication of Transition Shock in Wellbeing

As previously discussed, there is abundant evidence that transition shock is affecting GNs. There is also emerging evidence that NSs also experience factors during their education, particularly in the clinical field, that may predispose them to aspects of transition shock. Additionally, researchers have discussed how transition shock is not exclusive to the novice nurse but also affects the experienced nurse seeking opportunities in different specialities (Windey, & McGuire, 2020), transitioning from the acute care setting to a specialist community role (Ellis & Chater, 2012), and pursuing postgraduate studies such as a doctorate (Dodd-Butera & Smith-Stoner, 2016). They also found that support (Dodd-Butera & Smith-Stoner, 2016; Ellis & Chater, 2012), mentorship, work-related resources, and the development of skills and further education were necessary to facilitate their transition (Ellis & Chater, 2012). This points towards transition shock as being present across the whole education journey, initiating potentially when students commence their first class and continuing well beyond graduation.

The transition shock model (Duchscher, 2009) has been developed as a consequence of observations from GNs' experience once they began work as RNs. According to the current, though admittedly sparse, literature, the evidence is that transition shock may well begin during the formative years. From the literature review presented in this chapter, it seems that signs of transition shock appear to increase according to exposure to the reality of nursing, beginning during nursing education, in the academic space, intensifying with clinical placements, and reaching its peak during the working years of the RN. This is depicted visually in Figure 2.6.

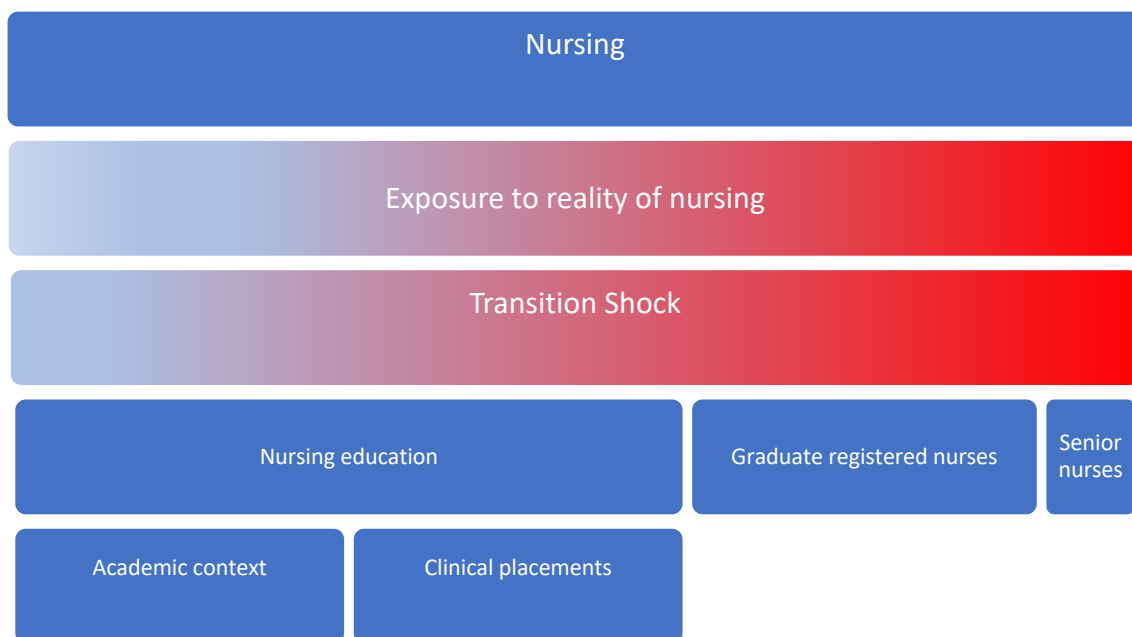


Figure 2.6: Transition Shock against the Exposure to Reality of Nursing Conditions

Understanding how transition shock, whether as a whole or in its separate aspects, affect NSs' overall coping, resilience and wellbeing can help educators adequately support and prepare students through their nursing studies and ultimately after graduation and commencement of practice, potentially lessening the impact of transition shock.

The literature on transition shock mostly relates to the GN. Little research is available concerning transition shock and the NS, particularly in the first year of nursing studies. Additionally, investigative efforts into resilience and wellbeing have often centred on students towards the end of their degree, in third or fourth year. Similarly, study into coping mechanisms employed by NSs to manage their formative years often either combine all study years or investigate them in the second half of their program. As a specific coping mechanism, humour has rarely been examined in the FYNS population.

Moreover, the combination of humour, resilience, wellbeing, and transition shock have not been examined together in the FYNS population. There exists a gap in the literature in comprehensively examining the experience of the FYNS and the contributions to their successes and/or failures. The first year is instrumental in setting up students for

maximising their learning experience and implementing healthy strategies likely to endure throughout their nursing journey and ultimately their career.

2.4 Chapter Summary

This chapter presented a literature review of current knowledge of humour, coping, resilience and wellbeing in the NS population. Following this, published evidence was presented regarding transition and adaption of NSs, and included a discussion of the transition shock model as it relates to NSs.

The author then discussed current gaps in the literature, presented the information used to inform the current study project, and highlighted the gaps the study is aiming to address.

In the next chapter, Chapter 3, the author will present the theoretical foundations of this study. In Chapter 4, the author will discuss the project methodology in detail, including the framework it was built upon. Elements relevant to the research design, data collection methods and analysis, as well as ethical considerations, will be described and discussed.

In subsequent chapters, the researcher will present the results of the data collection and provide an analysis, namely, in Chapters 5 and 6. In Chapter 7, the quantitative and qualitative results will be combined and compared with the literature. Finally, Chapter 8 will present the implications of findings and the subsequent recommendations derived from these findings.

Chapter 3: Theoretical Foundations

3.1 Introduction

Chapter 1 introduced the reader to the research project, providing background into studying and working as an RN in Australia, while also focusing on the local reality in the State of WA. The first chapter also detailed the research project's significance, identified the research questions, and outlined the general thesis structure. In Chapter 2, the literature review was developed around the theoretical approaches underpinning the study and the factors affecting wellness in nursing, including psychological wellbeing, stressors, stress relievers and considerations to becoming a nurse.

This current chapter will discuss the conceptual frame of the research and the theoretical approaches underpinning it. It will provide a history of humour research and will detail how Martin's HSQ (R. A. Martin et al., 2003) was derived to distinguish between two types of humour, its spontaneous use, and the resulting effect on interpersonal relationships and an individual's ability to cope with life's stress. It will then discuss the transition shock model developed by Duchscher (Duchscher, 2009), which describes how novice nurses adapt to their role and their progression through stages of the process. The research will then introduce the concept of RP in nursing education, including the models used. Following on from this, and as the underlying intention of this project is to investigate the wellbeing of FYNSs, this chapter will also look at the main stressors and stress relievers that have been identified in nursing and that are also applicable to FYNSs. As humour tends to have a positive effect, it can also present a lesser beneficial side. Because of its potential double-edge impact and the fact that it forms an essential part of the research question for this project, it will first be discussed. The sub-section on stressors and stress relievers will identify those other than humour. Finally, the chapter will end by discussing the theoretical underpinning of this study and presenting the gaps the researcher aimed to address.

3.2 Conceptual Framework

To help with the cognitive process of research, conceptual frameworks are often utilised (P. Smith, 2018). They synthesise complex information and data into a visual representation that increases readability and understanding (Börner et al., 2019). This

research is underpinned by two main theories, namely, Judy Duchscher’s (2008) transition shock and Rod Martin’s (2007) humour styles, yet seeks to observe a student’s journey along their first year of nursing school through other anchor points. These anchor points relate to personal coping and resilience. The complexity of this observation is simplified and made visually available through the following conceptual framework (Figure 3.1).

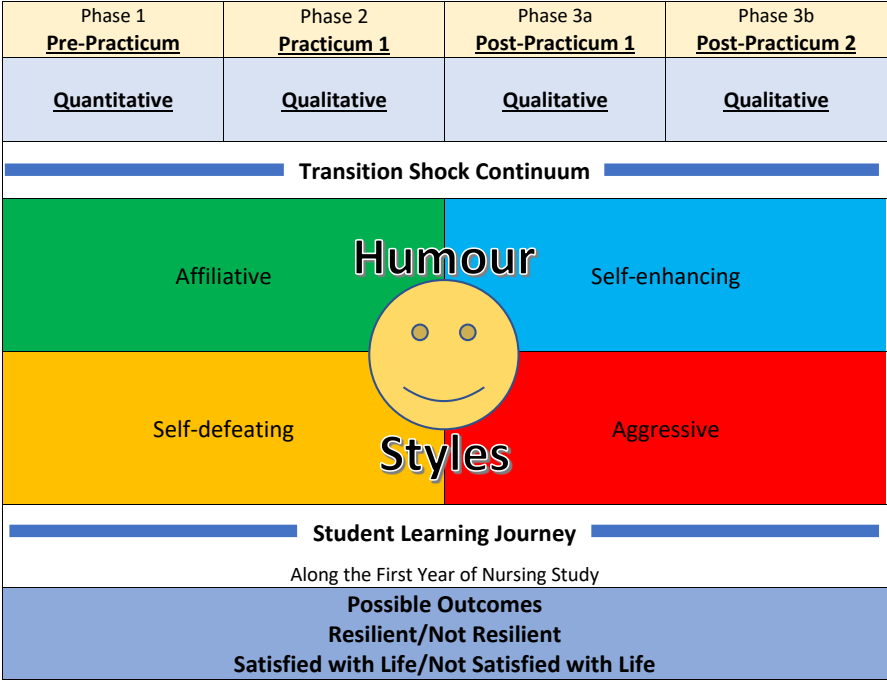


Figure 3.1: Conceptual Framework

The relevance and interplay of these concepts and theories within this research were first introduced in the literature review and will be discussed in depth in the methodology section of this dissertation.

3.3 Theoretical Approaches

The following section will provide an overview of the two theoretical approaches underpinning the research project, which are represented in Figure 3.2. First, it will examine humour theories and discuss how humour styles relate to a person’s personality and affect their wellbeing and relationship with self, as well as their relationships with others. Next, an overview of transition shock theory will be discussed, adding further depth following its introduction in Chapters 1 and 2.

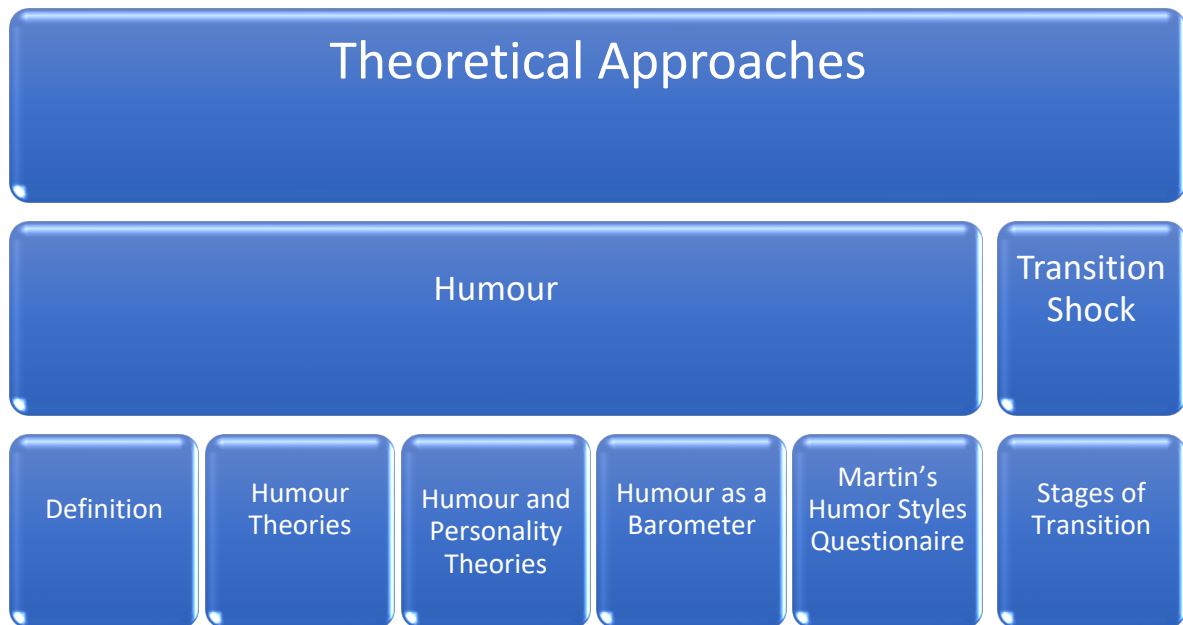


Figure 3.2: Theoretical Approaches

3.3.1 Humour

The concept of humour is vast and can be considered from various angles. In this section, the researcher will provide insight into its definition, plus discuss the major humour theories, how it relates to personalities and how it can serve as an ambiance barometer. This current research is supported by the humour styles described by Martin and these styles will therefore be discussed in detail.

3.3.1.1 Humour Definition

Humour has seemingly been part of our daily life since the beginning of time. It is thought that humour was part of evolution and subsequent brain development and that Neanderthals had little use for humour although it was present in hunting stories (MacDonald & Roebroeks, 2013). Nonetheless, humour is now present in our day-to-day life, sometimes inducing belly laughs and at other times so clever and subtle that it can go undetected. Babies have been observed to smile as early as 17 days of age (Kawakami et al., 2006) and infants to perceive humour at 5 months of age (Mireault et al., 2015). Despite being different, humour and laughter are not always differentiated in studies (Gonot-Schoupinsky et al., 2020).

Humour serves several functions. It relieves tension, promotes homeostasis, and has a positive effect on blood pressure regulation from cardiovascular efficiency (Fry, 1992; Fry & Savin, 1988). It can delay complications from chronic diseases such as diabetes (Noureldein & Eid, 2018) and has been proved to positively contribute to an improvement in the severity of ankylosing spondylitis (Cousins, 1979). Despite the lack of clinical evidence, the use of humour is generally considered safe, and laughter in itself is unlikely to cause death (Sahakian & Frishman, 2007).

‘Humour’ is a Latin word meaning ‘bodily fluids’. It takes its origins from the words for ‘moisture’ or ‘liquid’ (*humor*) and ‘humid’ (*ūmēre*) (Collins Dictionary, 2021b). It was originally posited by Hippocrates (c. 450 – c. 380 BCE) and Galen (129–200 AD) that the body was composed of four humours, all of which served to regulate the body’s chemistry (Lester, 1990; Stelmack & Stalikas, 1991). The balance of humours promoted health, while an imbalance signified illness and affected the general temperament, or mental disposition, of a person. Later, in the 16th century, the concept transformed into the senses and a person’s ‘mood’ as well as ‘whim’ and relates to the contemporary ‘sense of humour’ (R. A. Martin & Ford, 2018). There is no definition of humour in nursing.

3.3.1.2 *Humour Theories*

There are several theories on humour. Relief theory affirms that humour and laughter have a positive effect on the body by discharging it of any tension, such as fear and distress, and by re-establishing a sense of wellbeing (R. A. Martin, 2007). This was discussed by Freud (as cited in R. A. Martin & Ford, 2018), who, departing from the writing of philosopher Spencer (1820–1903), suggested that the function of humour was to expel unnecessary nervous energy from the body. On an evolutionary level, it is also believed that humour was a part of mankind’s confrontation with, and successful adaption to, adversity (R. A. Martin, 2007).

The theory of superiority pertains to one person’s use of humour against the calamity of another. Humour therefore is not restricted to the jovial but can also display an offensive side. It can be equally flagrant or subtle and has its foundation in hostility and aggression. Aggressive humour has been observed in ancient texts such as the Old Testament (Koestler, 1964), in World War II Nazi soldiers laughing sadistically at Jews attempting to flee to safety (Lefcourt, 2001), or in the cruel jokes children play on each

other (R. A. Martin, 2007). In this sense, the use of humour can be as damaging as it can be constructive—it has the potential to be a double-edged sword.

In the 1960s and 1970s, a vast body of research focused on the role physiological arousal played on emotions. Experiments were devised to examine the response of humour against variable activations of the sympathetic nervous system. Researchers have demonstrated the positive correlation between higher levels of autonomic arousal, the expression of mirth, and perceived amusement following a humorous stimulus (Schachter & Wheeler, 1962). Results have also demonstrated that activation of the sympathetic nervous system is present in all emotional expression (Dror, 2017). Some research projects have focused on participants' skin conductivity and heart rate while watching a funny movie (Averill, 1969; de Wied et al., 2012). Other researchers found that the level of arousal prior to humour exposure directly correlated with the degree of perceived comedy (Cantor et al., 1974), and that perceived enjoyment was equivalent to the intensity of the source, irrespective of whether it was negative or positive, meaning that equivalent intensity of energy was transferred to mirth, excitation, or overall arousal (Cotton, 1981; Suls, 1976).

Incongruity theories moved away from the social and emotional components of humour and focused specifically on the cognitive process required in finding something funny. The concept of 'bisociation' was developed by Koestler (1964) and refers to the mental capacity of creativity for combining elements from two unrelated fields to produce a new meaning by means of comparison, categorisation, abstraction, metaphors and analogies. For example, punch lines in jokes are surprising endings that are inconsistent with the beginning of the joke, or they may also highlight two thoughts or concepts that are incompatible. Ritchie (2004) discussed how linguistics can attempt to answer, in part, how humour is constructed and provides pieces to the vast puzzle of what constitutes humour.

The presence of incongruity in humour is pervasive in humour literature. It is discussed that laughter and humour are derived from the collision of known concepts or objects, and their representation in reality that is contrary to the original expectation, resulting in peculiar, surprising, incongruous or unusual objects or representations thereof. The philosopher Beattie, speaking of humour, described it as 'two or more inconsistent, unsuitable, or incongruous parts or circumstances, considered as united in one complex

object or assemblage, as acquiring a sort of mutual relation from the peculiar manner in which the mind takes notice of them' (Morreall, 2012, online). Meanwhile, I. Kant (1931) wrote: 'Laughter is an all action arising from a strained expectation being suddenly reduced to nothing' (p. 83).

Despite the number of theories as to what constitutes humour, there is not one that encapsulates, or is able to describe in entirety, all of what humour truly is. Each theory addresses aspects of humour and confirms just how complex the subject is. Humour is a universal language—multi-layered, multisensorial, transcendent of all barriers and a vehicle for communication (Coogan & Mallett, 2013; Han Song, 2015; Johnston, 1990).

3.3.1.3 Humour and Personality Theories

Attempts to describe what constitutes a person's personality and how it is developed have long preoccupied science. As previously discussed, Hippocrates (c. 450 – c. 380 BCE) identified four types of humour in the body, and Galen (129–200 AD) associated each with a respective temperament, a term used interchangeably with personality. These temperaments were believed to affect a person's moods, emotions, actions and attitudes. There are four temperaments: choleric, melancholic, phlegmatic and sanguine. The choleric temperament refers to the ambitious leader type, motivated by power, and can be ruthlessly aggressive—the 'Type A' personality (Lundin, 2015). The phlegmatic type is the relaxed person in the background, quietly watching, apathetic, and lacking energy and interest (Lundin, 2015; Merenda, 1987). The thoughtful, introverted, sad, depressed person, the one likely to retreat rather than advance, the deep thinker type, is associated with the melancholic temperament (Merenda, 1987). The sanguine temperament is associated with the expressive, talkative, impulsive, pleasure-seeking, social and outgoing type of person (Lundin, 2015). Thus, the characteristics of a sense of humour were assigned to the sanguine temperament (Lester, 1990; R. A. Martin & Ford, 2018). Further, temperaments have been referred to by psychologists and utilised in the construct of personality types (Lester, 1990; Merenda, 1987).

The terms introversion and extraversion were presented by Carl Jung (1875–1961) (Jung et al., 2013). They were coined to describe a state of being and referred to the origin of personal gratification (Thorne, 2004). Introverts are generally quieter, reserved and contemplative in nature. They re-energise in quiet solitary activities, usually away

from others. Conversely, extroverts tend to be outgoing, sociable, talkative and assertive. They are stimulated in the presence of others (Jung et al., 2013). Ambiverts are those that are said to be comfortable in near equal proportion between the extremes of the introvert–extrovert spectrum (Cohen & Schmidt, 1979), although Jung was of the opinion that all individuals had elements of both sides, with one being more dominant than the other. Most models of personality, such as the Myers–Briggs Type Indicator (Myers, 1962) and Big Five Model (Digman, 1990), include the concepts of introversion and extroversion.

Humour has been studied as a function of particular personality traits and has been weakly correlated with extroversion (M. Martin et al., 2018). In addition, humour types have been generally derived from Freud’s tendentious (sexual and aggressive) and non-tendentious (harmless) jokes (Freud, 1928). Researchers have found associations between a person’s appreciation of a particular type of humour and a given personality trait. The consistency of their findings led to the development of humour tests, which in turn have served to assess personality traits indirectly (Ruch, 1998).

Humour research in the field of psychology then moved to define and measure one’s sense of humour. Some concentrated on particular aspects, such as humour appreciation, while others attempted to identify and differentiate between multiple facets of the sense of humour (Eysenck, 1952). Research on personality and humour continue to this day, there having been an explosion of various new validated instruments that are currently being used in a multitude of studies across many disciplines (Leyla et al., 2019; Perchtold et al., 2019).

The field of humour research has produced several measuring instruments. The most notable and often used of these include the Sense of Humour Questionnaire (Svebak, 1974, 2010), the Coping Humour Scale (R. A. Martin & Lefcourt, 1983), the Situational Humour Response Questionnaire (R. A. Martin & Lefcourt, 1984) and the Multidimensional Sense of Humour Scale. In more recent years, humour has also been measured in work environments with the Questionnaire of Occupational Humorous Coping (Doosje et al., 2010) and the Humour Climate Questionnaire (Cann et al., 2014). Finally, and notably, the HSQ (R. A. Martin et al., 2003) is of particular significance and relevance to this study and will be discussed further below.

3.3.1.4 Humour as a Barometer

Humour can, to some degree, become a barometer for the emotional toll nursing can have on its practitioners. Humour style can indicate a person's disposition. Self-defeating humour can indicate negative emotions, neuroticism, depression, and dysphoria (Dozois et al., 2008; H. S. Kim & Plester, 2018; R. A. Martin & Ford, 2018). Identifying its recurring use in a colleague can point towards personal difficulties, which may be due to work conditions and affect work performance. To some extent, self-defeating humour can be seen as self-bullying—it has been demonstrated to reduce self-esteem (Gidwani et al., 2021).

Organisational structure has an influence on the expression of humour (Plester, 2015). Humour in the workplace can be witnessed in many different forms. Research by Plester (2015) in 12 workplaces over a 7-year period found that displays of humour included verbal humour (such as teasing, banter, wisecracks, one-liners, and prefabricated or 'canned' jokes), humour on display (which includes cartoons, memes photos, drawings, and humorous emails) and physical humour (for example, practical jokes, pranks and horse play). Verbal humour was found to be the most prevalent form of humour used in those workplaces (Plester, 2015). Despite increasingly being controlled and managed through workplace policies (R. A. Martin & Ford, 2018), visual humour has been shown to create a relaxed atmosphere that promotes creativity and problem-solving (De Napoli et al., 2018). Physical humour can have a positive impact on work relations but can be a means of workplace bullying, perpetuated by superiors, co-workers, and work groups in general (Mardanov & Cherry, 2018).

Humour can positively affect working relations and problem-solving. Research conducted by De Clercq et al. (2020) showed that employees' use of adaptive humour styles can counter the negative effects of job dissatisfaction, preventing negative or deviant behaviour. While traumatic stress in the workplace can lead to post-traumatic stress disorder and burnout, coping humour has been demonstrated to be protective (Sliter et al., 2014). Planned humour training can decrease mental health symptoms and improve wellbeing outcomes (Tagalidou et al., 2018). Humour can indicate employees' current mental dispositions and assist in managing job demands.

Shared humour has been shown to improve people's desire to affiliate and connect with each other and presupposes consideration towards the recipient (Fiadotava, 2020). The

act of sharing humour (for example, laughing together) does not automatically guarantee that there is a perceived similarity (laughing at the same thing) in that moment of humour (Kurtz et al., 2017). The complexity of humour is shown in its inherent allusion to sociocultural nuances that define the funniness of the content (Reddy et al., 2002). Avoidance of engagement in shared humour can reduce perceived liking or wanting to connect with others (Kurtz et al., 2017). However, a person may behaviourally share humour and laughter with another yet may not be connecting on the same level or taking part with the same perceived intention.

It is possible to manage humour in the workplace without suppressing it. North (2018, pp. 4–5) proposed seven steps for promoting a positive work humour culture. The essence of these steps is that each employee must:

1. become self-aware by reflecting on their use of humour and how they experience it (for example, whether they are the joker, the target, or the spectator)
5. educate themselves as to the receptiveness of their colleagues to humour styles
6. raise the humour issue by generating conversation among colleagues and strive to extrapolate more information from the group
7. pay attention to pitfalls and risk areas, particularly around interactions with service users and other third parties, communication means (internal or external), and whether the humour is best delivered within or outside of working hours
8. gain consensus on how organisational values are expected to be displayed within the workplace and what humour is acceptable and what is not, as well as establish clear guidelines on deviations from expectations that might occur and how these can be managed
9. participate in educational opportunities concerning appropriate and respectful use of humour, as both preventative and management strategies
10. lead by example, especially those in a position of organisational seniority because of their influence on others' behaviour.

Because workplace humour has the potential to increase distress and disharmony (Plester, 2015), the potentially negative consequences of humour in the workplace should not be ignored in deference to the positive. The above steps can pave the way to achieve balance between the two. These steps can be implemented within the

university setting and serve to educate future nurses within a collegiate context as the education setting is strongly associated with career motivation and development (W. Fang et al., 2018). Perceived organisational support can reduce the incidence of workplace aggression (Cao et al., 2016; Enwereuzor et al., 2021). Consequently, increasing education as to the use of humour can beneficially influence the early career nurse; promote a healthy workplace environment; and add to the stability, wellbeing, and positive influence of future nursing leaders. Additionally, it can help NSs during their clinical placements.

3.3.1.5 Humor Styles Questionnaire

As discussed previously, several questionnaires were developed around a person's use of humour, experience, or sense of humour. Humour is expressed in a variety of ways, produces widely varied results, and is often interpreted by each of us differently. It is not the joke or the humour per se that is necessarily positive or negative in quality but rather how it is utilised and expressed in daily occurrences. The use of humour will elicit either an adaptive or maladaptive response in the recipient. The nature of the response plays a role in an individual's wellbeing, affecting their sense of self and their relationships.

Martin and his team developed a self-reported instrument devised around a person's use of humour, the HSQ (R. A. Martin et al., 2003). The HSQ addresses four different contexts where humour is used, and this corresponds to the four humour styles. Two of the styles generate positive, or adaptive, outcomes, while the other two may have a negative impact on a person's sense of self or their relationships and are therefore said to be maladaptive (Figure 3.3). Adaptive styles seek to promote relationships, whether with the self (self-enhancing) or with others (affiliative) (R. A. Martin et al., 2003). The absence of self-defeating humour (making fun of oneself)—maladaptive type—and the presence of both adaptive styles (affiliative and self-enhancing) are associated with wellbeing (Fritz, 2020; Jovanovic, 2011; Veselka et al., 2010).

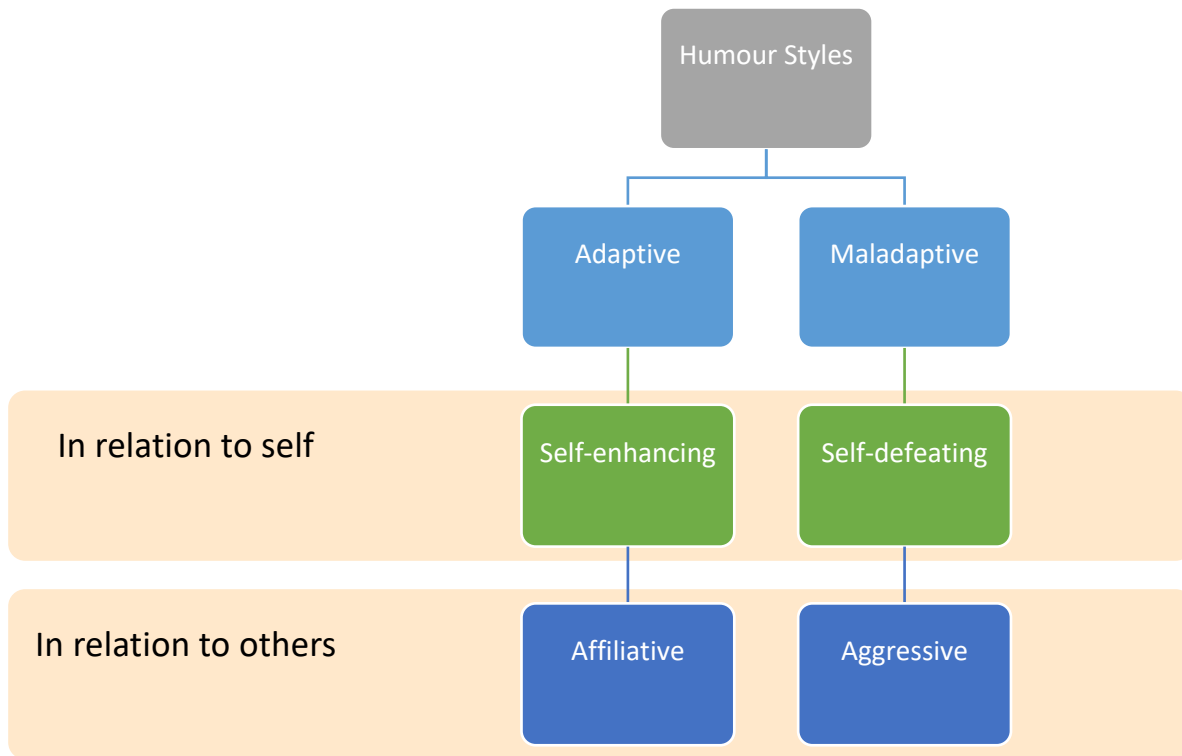


Figure 3.3: Humour Styles (adapted from R. A. Martin et al., 2003)

The HSQ scale has been used extensively for several decades. It has however been the subject of further recent research. Silvia and Rodriguez (2020) argue that despite its numerous strengths, the instrument would benefit from some adjustment. They first identified that a rating scale with fewer items, namely, from a 7- to a 5-item rating scale, would improve its performance. Additionally, they noted that some items could benefit from some slight alterations of the sub-scales to address the uneven endorsement of some of the sub-scales, particularly the affiliative style, which is easier to endorse, and some reworking of particular items to improve reverse scoring and discrimination and decrease local dependency (Silvia & Rodriguez, 2020). Heintz's (2019) research also supported some potential changes to the self-defeating scale. They found that all scales supported convergent validity, with the exception of the self-defeating one, and that external criteria for the maladaptive personality converged with all other scales, apart from the self-defeating one (Heintz, 2019). However, because of its popularity and validated strengths, the HSQ is still one of the most commonly used scales in research today (Scheel, 2017).

This is of particular relevance to the study of humour in nursing because the use of humour is so very prevalent in the profession—it is practised among colleagues and with patients. Its resulting effect can either assist or hinder wellbeing, which in turn can affect coping and resilience (N. A. Kuiper, 2012), for nurses as well as those they encounter during the course of their work. The four sub-scales will be discussed in detail below.

3.3.1.5.1 Self-Enhancing Humour

The self-enhancing humour sub-scale was designed with items pertaining to the ‘perspective-taking humour, a tendency to maintain a humorous outlook on life, and use of humor in emotion regulation and coping’ (R. A. Martin et al., 2003, p. 71). A number of the items are built around the inclination to engage in humour irrespective of being in the presence of others or not. This sub-scale is associated with self-esteem, joviality, satisfaction with social support, and general wellbeing. It aligns with extraversion and openness and relates to the traditional view of humour as an adaptive defence or coping mechanism (Freud, 1928; R. A. Martin et al., 2003; Vaillant, 2000). This humour style has also been demonstrated to be the most adaptive style around self-esteem and self-regulatory strategies (Leist & Müller, 2013).

Self-enhancing humour has a beneficial effect on occupational wellbeing. It has been significantly correlated with self-esteem and has been shown to mitigate occupational role conflict and burnout, and positively influence work engagement (Van den Broeck et al., 2012). Additionally, the use of self-enhancing humour has been demonstrated to improve employees’ and subordinates’ trust in their superiors (D.-r. Lee, 2015).

Having trust in people of higher authority is of particular significance to NSs and those working with them. NSs will find themselves in a position of perceived superiority before those they care for during their clinical placements and conversely be prone to feel powerless in their role as a student (A. James & Chapman, 2010). Further, clinical mentors and lecturers assume a similar position of authority around students. Used positively, the language utilised by nurses or students in these positions of power can greatly assist the activity of nursing (Dahlke & Hunter, 2020). Each person taking on such roles can enhance the trust placed in them and subsequently contribute to positive relationships and learning and health outcomes.

3.3.1.5.2 Affiliative Humour

The affiliative sub-scale relates to one's propensity to be the jokester in the group, to tell funny stories or be witty, and to laugh and have fun with others. Here again, this sub-scale relates to extraversion. People who score high on this scale tend 'to be socially extraverted, cheerful, emotionally stable and concerned for others' (R. A. Martin et al., 2003, pp. 70–71).

The use of affiliative humour is prevalent in nursing, and patients have been known to use humour to connect with the care team (McCreddie & Payne, 2014). On a personal level, nurses predominantly use affiliative humour and tend to avoid aggressive humour (Majumdar & Kumar, 2017). Nurses with an affinity for positive humour, such as the affiliative style, were found to be generally happier, satisfied with life, hopeful and more sociable than those who did not (Navarro-Carrillo et al., 2020).

On an organisational level, the use of positive humour styles, whether affiliative or self-enhancing, has been shown to promote job satisfaction, a sense of organisational pride and belongingness (Mesmer-Magnus et al., 2018). However, no meaningful difference was identified between the two humour styles—whether a leader resorted to affiliative or self-enhancing humour, both styles contributed equally to satisfaction with a person's occupation (Cody, 2018) or with their superior (de Souza et al., 2019; Romero & Arendt, 2011; Wisse & Rietzschel, 2014).

3.3.1.5.3 Self-Defeating Humour

The self-defeating sub-scale relates to an individual's propensity to utilise humour largely in a self-disparaging manner and to willingly surrender as the butt of a joke. R. A. Martin et al. (2003) states that it is used 'as a form of defensive denial to hide underlying negative feelings' (p. 71). A high score in self-defeating humour is associated with 'depression, anxiety, hostility, aggression, bad mood, psychiatric symptoms and is negatively related to self-esteem, psychological well-being, intimacy, satisfaction with social supports, and femininity (communion)' (R. A. Martin et al., 2003, p. 71). It is also found to be strongly associated with loneliness (Hampes, 2005; MacDonald et al., 2020).

Self-defeating humour can have positive effects in certain situations. Branney et al. (2014) demonstrated how men with penile cancer used self-defeating humour to cope with their diagnosis and promote relationships with healthcare providers. Nurses can utilise different humour styles depending on situations, providing they are mindful of the intention behind the effort.

Research into the effect of self-defeating humour on organisational structures has produced mixed results. Some research results have not found self-defeating humour to meaningfully affect the perceived leadership–follower relationship (Wisse & Rietzschel, 2014), while others have identified its use in leaders to be one of the contributing humour styles significantly affecting organisational deviance (Neves & Karagonlar, 2020). Whether as a lecturer, clinical educator, supervisor or otherwise, these results suggest caution in using this type of humour in efforts to avoid ruptures in relationships, reduced trust, or inadvertently fostering negative behaviour in the learning or clinical environment.

3.3.1.5.4 Aggressive Humour

The aggressive humour sub-scale relates to one's use of humour to criticise or manipulate others without regard for the impact on the recipient. It is conveyed through sarcastic comments and teasing. Aggressive humour is predictably associated with aggressivity and hostility and indicates a sense of not taking things seriously; it is more common in men than women (Falanga et al., 2020; R. A. Martin et al., 2003).

The intended motive of the use of humour can significantly affect how others perceive a person. The humour effort—the ability to make someone laugh—may be appreciated by an audience; however, the intent or meaning behind humoristic repartee may put a person's likeability at risk: an individual using aggressive humour may not be viewed favourably (Cann et al., 2016). The difference in roles between positive and negative humour highlights the importance of being able to adequately identify the intent behind the humour and the target audience (Cann & Kuiper, 2014). The nursing context is not only a workplace to the nurse but also a milieu where health services are provided and consumers form an integral part (Australian Commission on Safety and Quality in Health Care, 2019), and humour can influence a patient's experience (Haydon & Riet, 2014). Understanding and sensitive consideration of elements that could contaminate this

environment for a service provider or service user is vital to facilitating a positive patient experience.

Communication, socialisation and engagement are crucial elements that shape nurses and nursing, and they can create strong emotions (McCloughen et al., 2020; Vihos et al., 2019). The ability to decipher how humour is used and delivered can shape all these three aspects (Mak et al., 2012). Research findings by C. Browne et al. (2018) have demonstrated that NSs know the importance of connecting with others early on, at the onset of their nursing degree. The first clinical placement is where a student develops their socialisation into nursing and may have their first encounter with incivility (Vuolo, 2018).

Research findings from a study conducted by J. Thomas et al. (2015) demonstrated how NSs' experience of incivility can be disguised behind aggressive humour. The repercussion of this can lead the students to feel disillusioned with their student role and to acquire a sense of dislocation (J. Thomas et al., 2015). NSs have been shown to validate their personal and professional identities during their clinical placements and through interactions with their preceptors (Vihos et al., 2019). It follows, therefore, that how individuals conduct themselves and interpret the behaviours of those they professionally interact with can have career-long repercussions.

The student, and the nurse, must be able to tell the difference between banter and actual aggressive content, with key differences being the intent behind the exchange and the power relationship between parties (Evans, 2018). Bullying is differentiated by the harmful intention behind the action. Banter can disguise offensive behaviour and lead to legitimised bullying (Steer et al., 2020). Banter will promote relationships, while aggressive content will lean towards unacceptable social behaviour such as bullying (Buglass et al., 2020). Bullying is destructive to teamwork and rapport with service users (Schoville & Aebersold, 2020); has a negative impact on patient safety, staff retention and academic performance (Olsen et al., 2020); adversely affects a person's sense of self and reduces confidence (Homayuni et al., 2021); and leads to poor outcomes in nurses' psycho-physical health and wellbeing (Karatuna et al., 2020).

NSs will be confronted with situations that utilise various communication means, with which they may not be initially comfortable (J. J. Lee et al., 2019). Incivility is experienced by NSs not only in the clinical field but also in the classroom (Vuolo, 2018).

Education is increasingly delivered online or utilises technology and online means to deliver content (Jowsey et al., 2020). Students utilise a variety of social media and platforms to keep in touch with peers, complete assignments or socialise (A. M. Price et al., 2018). Additionally, health service delivery is increasingly being delivered by web-based telehealth, which NSs need to be prepared for (Holland, 2018). Identifying the difference between aggressive humour intended as banter rather than bullying can be difficult, especially for the young person (Steer et al., 2020). NSs will be required to navigate online and face-to-face situations where they will need to be able to adequately assess the intention of verbal and non-verbal communication, as well as manage their own.

As previously discussed in Chapter 1, communication skills are generally taught in the first semester of nursing studies. NSs will be called upon to interact with their peers and academic staff, to form relationships in the clinical setting, and to develop rapport with people they care for. Being able to ‘read the room’, using humour to good avail, as well as being mindful of how their verbal or non-verbal communication can be interpreted, can improve nurses’ experience and that of others (Mak et al., 2012). When in a state of uncertainty or conflict, the student also needs to be able to manage this situation effectively to resolve any real or potential conflict (Arveklev et al., 2018).

This section has presented the reader with the theoretical approach of humour as used in this study. It has discussed how humour can be defined, different humour theories, how humour has been linked to personality theories and its use as an emotional barometer. Additionally, the section discussed the HSQ that was used for this project.

3.3.2 Duchscher’s Transition Shock Model

This section discusses the transition shock model. The reader was introduced to it in the previous two chapters, according to the relevance of the content. However here, it is presented as part of the theoretical foundation of this study and is discussed in appropriate depth.

Transition shock refers to the unsettling period experienced by the newly graduated nurse who has left the safety of the student ‘cocoon’ to begin to ‘fly unaccompanied’ as an RN in a vastly discrepant anticipated reality (Duchscher, 2009). The intense transition period typically lasts from 1 to 4 months and affects GNs on multiple levels—

emotionally, physically, intellectually, socioculturally and developmentally—causing them to feel disoriented, confused, and full of doubts (Duchscher, 2009; see Figure 3.4). Duchscher asserts that an element of surprise is a significant contributing factor to undergoing transition shock.

Figure: Removed due to copyright restrictions

Figure 3.4: Transition Conceptual Framework© (Duchscher, 2009)

Duchscher's (2008) theory also postulates stages experienced by the GN. The new nurse navigates through the stages of 'doing', 'being' and 'knowing' (Figure 3.5), consolidating learning and experiences, leading them to eventually reach the shore of self-assurance. During their first year of practice, they will require from 3 to 5 months to find their feet and move on to the next stage.



Figure 3.5: Stages of Transition (adapted from Boychuk Duchscher, 2008)

The initial stage of **doing** sees the GN engrossed in the task at hand. They are learning about the workplace culture, spending a lot of energy trying to fit in, while managing feelings of insecurity, doubt, and challenged confidence in their skills and adequacy. They usually require 3–4 months within the clinical setting before they progress to the second stage (Duchscher, 2008).

The second stage, that of **being**, sees the new nurse somewhat settled in the professional tasks and now focusing on seeking validation, feedback, and reassurance (Duchscher, 2008). Over a period of 4–5 months, the GNs develop their independence in practice and become more comfortable with, and prefer, minimal supervision. They seek opportunities to increase their skills and exposure and are generally more at ease within their role. The GNs' idealistic views of their profession have been moulded by the reality of day-to-day practice, and the discrepancies this entails shape their career progression (Duchscher, 2008).

The third and final stage, **knowing**, covers a stable period of 3–4 months during which GNs consolidate their skills and confidence, as well as their identity within the profession and the inequalities within the ranks (Duchscher, 2008). Their protected first year of clinical practice will soon come to an end, and they reflect on how they will continue on this journey without their safety net (Duchscher, 2008).

Students embarking on their nursing study journey arrive on their first day with a considerable amount of hope and fear. With feelings ranging from preconceived ideas about the profession to boundless expectations, they soon face their firsts—first academic semester, first time using a stethoscope, first time seeing a naked body (typically elderly) and perhaps even witnessing their first death. Not only do they have to apply knowledge and fumble through practice; they also learn to socialise with peers, mentors, service users and the wider community they serve. It is therefore possible that the new student nurse experiences a similar transition shock during their first year of academic learning, a likelihood discussed by Hartung et al. (2020).

The concept of transition difficulties from educational to clinical practice is not exclusively reserved to nursing. It has been identified and discussed in education (Farrell, 2016), medicine (Sturman et al., 2017), physiotherapy (Forbes et al., 2020), dietetics (Snell, 2021), interpreters of American sign language and English (Meadows, 2013), and in first-year college students (N. S. Thomas et al., 2019). The stages of transition and model developed by Duchscher (2008, 2009) remain mostly applied to the GNs. Despite this, Duchscher's model, which encompasses the development of roles, relationships, responsibility and knowledge, is echoed in Snell's (2021) findings relating the developing professional identity of the dietician. Snell's (2021) findings highlighted the importance of knowledge, professional confidence, workplace

expectations and a sense of belonging to the professional. Sturman et al.'s (2017) study of junior medical doctors also revealed common themes. The theme relating to the steep learning curve highlights the same physical, emotional, intellectual and cognitive challenges described by Duchscher (2009). Their second theme pertaining to relationships and team paralleled the socio-developmental ones by Duchscher. These research findings demonstrate the transferability of the transition shock model across a variety of settings.

The term transition implies the concept of adaptation. The *Collins Dictionary* defines transition as 'the period of time during which something changes from one state or stage to another' (Collins Dictionary, 2021c) and adaptation as 'something that is changed or modified to suit new conditions or needs' (Collins Dictionary, 2021a). Understanding what helps and hinders students to adapt to all facets of their learning journey is vital in assisting academics and clinical staff supporting students on the road to success. The transition stages model serves as guiding signposts in identifying the journey of the FYNS to identify whether the same patterns are applicable in that novice state.

3.4 Reflective Practice

The benefits of RP have long been established, particularly in nursing, education and practice (Barbagallo, 2021; Contreras et al., 2020; Levett-Jones, 2007; Thompson & Pascal, 2012). RP is often imbedded in the nursing curricula as well as forming an integral part of the clinical placement requirements, helping NSs to make connections between theoretical and practical components (Barbagallo, 2019). RP is beneficial in helping NSs develop cultural humility (Sobel, 2020); promote a positive attitude (Trueman, 2017); reduce anxiety and stigma; and improve empathy, compassion and understanding (Contreras et al., 2020; Ross et al., 2014; Webster, 2010). RP has also been demonstrated as a key teaching and learning method in developing resilience in NSs (P. Walsh et al., 2020), while even informal self-reflection has been seen to be beneficial to NSs' emotional management during their clinical placement (McCloughen et al., 2020; Mlinar Reljić et al., 2019) and assist first-semester NSs in transitioning to university (Pryjmachuk et al., 2019).

Students valued being taught RP skills early, namely, in the first year, of their education (McLeod et al., 2020). The efficacy of RP in the context of FYNSs during their first clinical placement has been demonstrated to reduce anxiety experienced in the clinical

setting (J. T. Goodman, 2018). Online completion of RP through journaling during nursing education has been shown to produce positive outcomes (Langley & Brown, 2010); however, to be effective, RP skills must be taught prior to attending the clinical placement (Asselin, 2011).

The process of reflection can require the person to either look back at their actions and learn from them or focus their thoughts on a given subject; reflection is therefore performed *in practice* or through *practical action* (Barbagallo, 2019; Higgins, 2011). NSs are often taught to engage in formal RP by using models such as the Gibbs Reflective Cycle (G. Gibbs, 1988). The cycle requires the person to engage in six different aspects: describing their experience, expressing their thoughts and feelings, providing an evaluation of their experience, making sense of the experience through analysis, drawing conclusions about what they learnt through their experience, and finally formulating an action plan for future occurrences.

However, more recently, Bass et al. (2017) developed the Holistic Reflective Model (HRM) for midwifery students. In developing their model, the authors were heavily influenced by the well-known RP models of G. Gibbs (1988), Cranton (1994) and Johns (2000). Bass et al.'s model is supported by several theoretical and conceptual frameworks—philosophy, transformative learning, ways of knowing, holistic reflection, development of mental process and holistic concepts—which affords it robustness. Despite being developed expressly for midwifery students, the model does not preclude being used in other sectors, including nursing, which is regardless closely related. It was used in this study because it is holistic, as the name suggests, and is inclusive of a variety of models. It is presented in Figure 3.6.

Figure: Removed due to copyright restrictions

Figure 3.6: Holistic Reflective Model (Bass et al., 2017)

3.5 Nursing Students' Wellbeing

The next section of this literature will discuss NSs' wellbeing. Wellbeing, and thereby life satisfaction, is understood in our study to be negatively affected by stressors and improved by stress relievers. The section is divided in those two corresponding sections and presented around known stressors for NSs and stress relievers (Figure 3.7). The

first section will concentrate on stressors identified in nursing, while the second section will discuss the means of re-establishing balance with stress relievers.

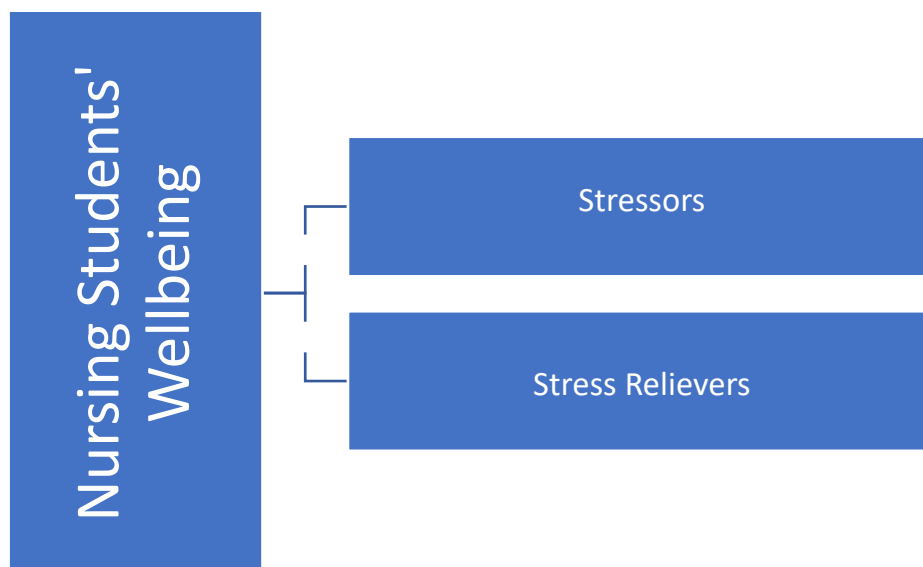


Figure 3.7: Known Stressors and Stress Relievers around Nursing Students' Wellbeing

3.5.1 Stressors in Nursing

The capacity to manage stress effectively will enable a person to deal with situations, adapt, develop resilience, and ultimately steer to a state of wellbeing. Stressors are encountered daily in nursing and are inescapable for NSs. Findings of research conducted by Labrague et al. (2017) examining NSs' sources of stressors identified caring for patients, completing assignments, and managing workloads. They also reported that relationships with others, namely, clinical and academic staff, were other important stressors (Labrague et al., 2017).

NSs experience the reality of nursing early on in their degree. By view of being exposed through their clinical placements, students will see, feel, and perhaps even be subjected to the same conditions faced by practising nurses. The NS, through their academic and clinical placement, experience these stressors intermittently and somewhat unequally due to differences in program delivery, setting and length of their placements. However,

the constant remains that students first acquire theoretical knowledge in the academic setting, and then put this knowledge into practice through clinical placements. These two settings, academic and practical, and the constant flux between the two during their education not only prepare NSs to face the reality of nursing stressors but can help them face the challenges better equipped.

To adequately prepare NSs, educators need to identify elements of concern that will provide part of the blueprint for prevention. It is for this reason that the following section will discuss the main sources of stress and adverse conditions encountered by NSs and present in the nursing profession in general (Figure 3.8).

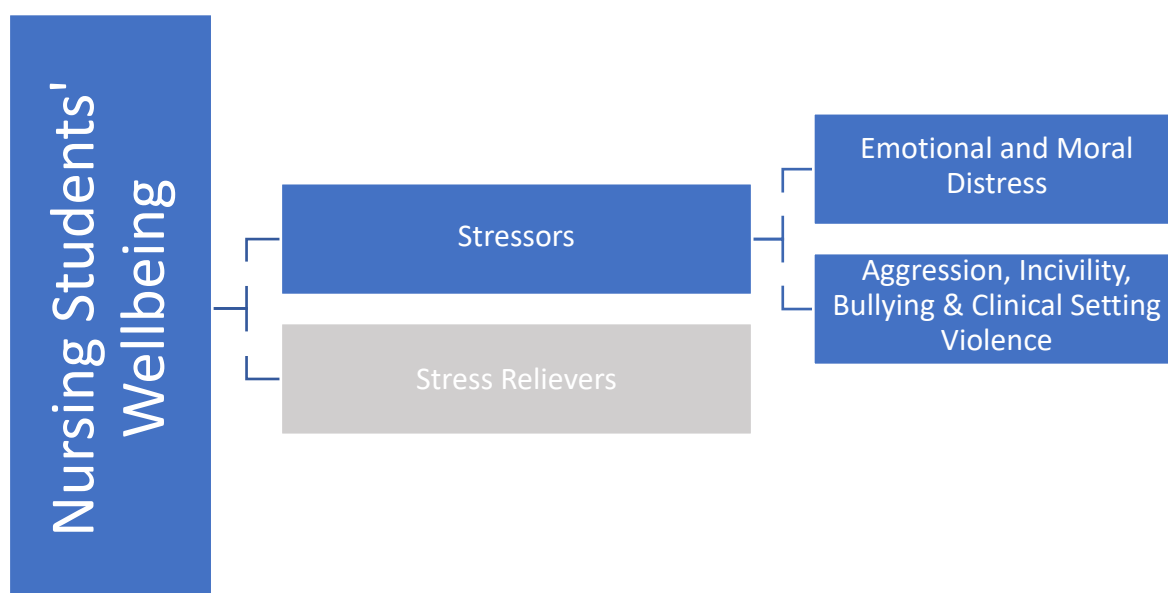


Figure 3.8: Nursing Students' Stressors

3.5.1.1 Emotional and Moral Distress

Emotional distress in nursing relates to the presence of psychiatric symptoms in nursing personnel (Karanikola et al., 2012). When stress is sufficiently severe, it can induce suffering in those experiencing it to a point where normal coping skills are inaccessible (Rus et al., 2019). Emotional distress has been linked to stress and anxiety in nurses (Amin et al., 2018).

Studies have demonstrated the presence of emotional and psychological distress in NSs (Moxham et al., 2018; Salvarani et al., 2020; Treiber & Jones, 2018). A recent study conducted by Salvarani et al. (2020) found that NSs of all years of study, particularly first years, reported high levels of psychological distress; 70% of all respondents scored highly and first years even more so at 73% (Salvarani et al., 2020). Other studies have reported NSs' psychological distress scores as moderate (Moxham et al., 2018; P. Zhang et al., 2016). The presence of emotional distress is therefore prevalent in NSs, and identifying elements of prevention and mitigation would benefit students during their education and into their qualified careers.

Moral distress in nurses is another concept that has been researched (Wilson et al., 2013). It was first described by Jameton (1984) as 'one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action' (p. 6). This definition has been disputed in the nursing context as being too narrow and needing to include the experience of a moral event and psychological distress (Morley et al., 2020).

Educational years influence undergraduate students in nursing studies. Bordignon et al. (2019) showed that moral distress in students increased along their journey, students scoring higher for moral distress towards the end of their studies than at the beginning of their undergraduate course. Almost all students reported multiple moral dilemmas during their clinical practice that were left unresolved (Mehdipour Rabori et al., 2018). Krautscheid et al. (2017) found that students' hierarchical position and degree of role subordination reduced their inclination to act according to their moral compass. This was complicated by their unwillingness to negatively affect relationships, a lack of knowledge and a hesitation in speaking up. Their student status and inexperience was conducive to an unwillingness to challenge those in authority, a finding corroborated by Escolar-Chua (2016); in addition, it was found that students' sensitivity was associated with moral distress (Escolar-Chua, 2016; Ohnishi et al., 2018). However, although undergraduate NSs experienced moral distress, they were not deterred from continuing in the profession (Escolar-Chua, 2016).

Moral distress is experienced not only in the clinical setting but also in nursing academia and teaching. Research has identified that those in teaching roles, such as lecturers and clinical mentors, can be a source of moral distress for students (Rennó et al., 2016).

Events and circumstances, such as some students experiencing discourteous verbal and non-verbal behaviour from their lecturers, including mockery and ridicule (Aliakbari & Hajizadeh, 2018; Rennó et al., 2016), coercion, aggression, and harassment (Masoumpoor et al., 2017), are contributors. Academic impoliteness, including lecturers behaving immorally and unethically, was also identified (Aliakbari & Hajizadeh, 2018). Incivility can lead to moral distress. As they are interrelated, the author will discuss incivility further in this chapter in the broader context of bullying and workplace violence.

3.5.1.2 Aggression, Incivility, Bullying and Clinical Setting Violence

Nurses are exposed to several sources of violence, and this places a taxing emotional burden on them (B. C. Allen et al., 2015). Types of aggressive behaviours include raised voices and threats, aggression in the presence of others, and actual acts of violence (Kowalczyk & Krajewska-Kułak, 2017). Reported sustained physical injuries include scratches, bruises, muscle soreness, fractured bones, whiplash, nerve damage requiring intervention, and needle stick injuries (K. Kerr et al., 2017). Psychological consequences have left healthcare workers wondering if similar events could happen again, with resultant anxiety; feelings of vulnerability, disempowerment, embarrassment, and powerlessness; and decreased self-confidence, which can also be complicated by nurses blaming themselves and feeling guilty (K. Kerr et al., 2017).

NSs are not exempt from being the recipients of aggression in the clinical field (Hopkins et al., 2014, 2018; Shapiro et al., 2018; Tian et al., 2019). Definition of what constitutes aggression, while standardised, has been reported to be both physical and non-physical. A study conducted by Hopkins et al. (2014) found that 34% of second-year NSs and 32.7% of third-year students had experienced physical aggression and violence in the course of their clinical placements in WA. Sources of violence have been identified as other nurses in the workplace, constituting vertical violence (Tian et al., 2019), and patients. In their study, Shapiro et al. (2018) found that despite notifying a co-worker immediately after being subjected to violence, midwifery students on clinical placement did not complete incident forms or receive formal debriefings, calling for more education to be provided to students regarding the urgency and importance of doing so. Students may become intimidated by the potential repercussion of resistance-based behaviour. Paradoxically, a study conducted by Gluyas et al. (2019b) that introduced education strategies to teach situational awareness to third-year NSs resulted in

hypervigilance and non-completion of required tasks. This prompted the authors to suggest that education programs may be more beneficial included early in the curricula and reinforced subsequently to optimise results (Gluyas et al., 2019a, 2019b). In addition, virtual simulation has been shown to develop multiple skills, including communication, teamwork, confidence and vigilance (Peddle, 2019).

Workplace-related violence can be experienced in the form of workplace incivility (Rasool et al., 2021). This term refers to 'low-intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect' (Andersson & Pearson, 1999, p. 457). Workplace incivility differs from bullying in that the uncivil nurse is mean to 'everyone', and the aggressive behaviour is of a low level yet still transgresses workplace expectations of professional behaviour. Job demands have been shown to adversely affect nursing staff behaviour and produce counter-productive work behaviour and aggression (Y. Chen et al., 2017; Enwereuzor et al., 2021).

Workplace bullying and violence, including horizontal and vertical, are also felt within the nursing ranks (Anusiewicz et al., 2020; Granstra, 2015). The once implicitly tolerated nursing culture of intimidation, of 'nurses eating their young', including their students, remains a vocational certainty despite formal no-tolerance policies and implementation measures (L. Anderson, 2015; Iheduru-Anderson, 2014). Several causes of workplace bullying have been identified: nursing hierarchy and seniority, insecurity, abuse of power, intended protection of patients, territorialism, and differences in education (Anusiewicz et al., 2020; Granstra, 2015).

Cultural differences also accounted for the prevalence and tolerance of bullying in some countries with higher power differentials, such as India, Turkey, Nigeria and Singapore (D'Cruz et al., 2016; Salin et al., 2019). Culturally, nurses from Anglo cluster countries, comprising the United States, Australia, Canada, the United Kingdom and Ireland, are less likely to tolerate workplace bullying and incivility than their Asian counterparts, who are more accepting of high power distance (Karatuna et al., 2020; Loh et al., 2021). Australian nurses tend to engage more in resistance-based responses, for example, reporting disrespectful behaviour, confronting the perpetrator, and gaining collective support (Samnani, 2013). Being subjected to and resisting uncivil workplace behaviour can take an emotional toll on those experiencing it, causing distress and negative emotional symptoms (Arnetz et al., 2020; Fida et al., 2018; Loh et al., 2021). Workplace-

related violence is associated with increased burnout (J. Johnson et al., 2019; Leiter et al., 2011), and its repercussions are felt across the workforce (Brunetto et al., 2016; Rasool et al., 2021).

Undergraduate NSs have also been the recipients of bullying, workplace incivility and aggression (Hopkins et al., 2014). A study conducted by Birks et al. (2017) found that half of the NSs surveyed reported being subjected to bullying while on clinical placement and that the main offenders were nurses. Australian NSs reported higher incidences of bullying on clinical placement than their UK counterparts (50.1% versus 35.5%). However, a higher percentage of UK nurses (68%) were the perpetrators compared with Australian nurses (53%) (Birks et al., 2017). Bullying towards inexperienced nurses also included newly graduated nurses and newcomers to a unit (Anusiewicz et al., 2020).

In addition to being bullied themselves by nurses, students observed qualified nurses bullying patients. Unequipped to deal with this negative behaviour, some NSs then internalised this behaviour and shifted from being victims to being perpetrators towards patients (Randle, 2003). This left them with negative feelings of shame, guilt, and lowered self-esteem (Fernández-Gutiérrez & Mosteiro-Díaz, 2021; Randle, 2003; Tee et al., 2016). Bullying can negatively affect mental health (L. Fang et al., 2020). This has the potential to cause moral distress in the student or junior nurse and highlights the pertinent role that RP can play in managing emotions and events.

The repercussions of workplace bullying affect staff and patients equally. Workplace bullying has been demonstrated to impede teamwork and effective communication and to negatively affect patient outcomes (Anusiewicz et al., 2020; Arnetz et al., 2020; Alisha H. Johnson & Benham-Hutchins, 2020). Bullying in nursing can increase the incidence of healthcare-related infections such as central-line-associated bloodstream infections (Arnetz et al., 2020), urinary tract infections, ventilator-associated pneumonia (D. Kelly et al., 2013), falls and medication errors (Van Bogaert et al., 2014). These outcomes can lead to patient death and must be taken seriously.

Being the target of bullying behaviour is not exclusive to students or nurses in care settings. Uncivil behaviour has also been witnessed of students towards their educators (McKay et al., 2008). Meires (2018) discussed how students have been known to bully faculty members by engaging in behaviour including yelling, belittling, complaining, gossip mongering and slandering. Such behaviour could be premeditated, such as to

seek a better grade or secure a desired timetable or assignment, or unintentional, the student simply unaware that such behaviour is improper (Meires, 2018). On the other hand, students may falsely interpret a lecturer providing them with feedback as bullying (Seibel & Fehr, 2018). Respectful behaviour should be promoted and valued by both students and faculty members.

Several study recommendations have been made for inclusion to be made in nursing curricula. Some have called for resilience building, training in situational awareness, aggression training, and disclosure (Gluyas et al., 2019a; Hopkins et al., 2018; Shapiro et al., 2018). In others, humour was found be a powerful strategy to defuse tense situations (Norrick & Spitz, 2008), de-escalating aggression (H. Goodman et al., 2020; Price et al., 2017); cope with difficult work settings (Beryl et al., 2018) or manage incivility (Munro & Phillips, 2020); and foster positive relationships (Chiew et al., 2019), leading to calls for its usefulness in applied clinical settings. The positive effects of these strategies and purposely designed interventions, have contributed to improvements in work engagement, retention, resilience, health outcomes and general wellbeing of employees (A. L. Cooper et al., 2020; León-Pérez et al., 2021). Imbedding humour and resilience development strategies in the nursing curricula would serve as preventative measures to cope with the demands of training and the profession.

This section highlighted the prevalence of aggression and incivility in nursing and how these can in turn affect NSs and practising nurses without differentiation.

3.5.2 Stress Relievers

To maintain or restore a sense of balance, NSs and their educators are urged to explore effective strategies for stress management and the maintenance of good general health (Labrague et al., 2018). This section discusses helpful concepts and strategies enabling the effective management of stressors (Figure 3.9). They will be discussed in relation to nursing and how they can benefit NSs' wellbeing. These are presented under the headings of positive psychology; humour; EI; and social interactions, relationships and culture.

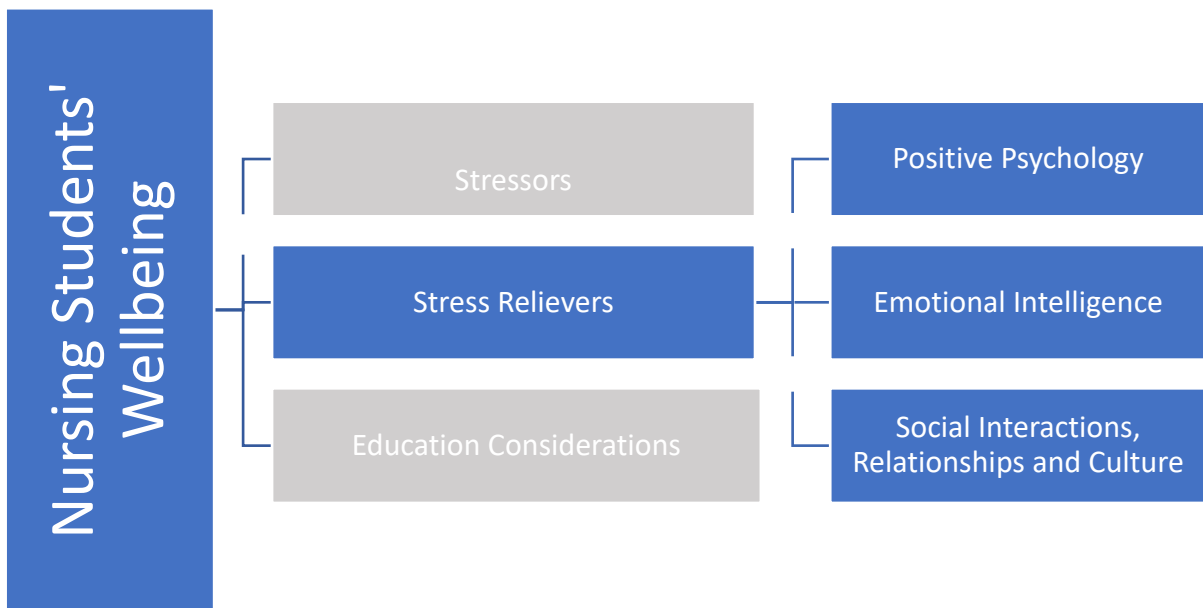


Figure 3.9: Nursing Students' Stress Relievers

3.5.2.1 Positive Psychology

In the wake of the new millennium, the field of psychology has extended from the study of mental *illness* to enquiry into a more holistic approach to positive human behaviour inclusive of wellbeing, happiness, gratitude, character strengths and contentment. Gable and Haidt (2005) describe it as 'the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions' (p. 103). This is referred to as positive psychology. Positive psychology is no longer restricted to the field of psychology and has been applied to others, including criminology, design economics, education, engineering, fine arts, law, linguistics, the military, philosophy, political science, public policy, religion, social work, sociology, and technology (Campbell et al., 2021; Crespo & Mesurado, 2015; Delany et al., 2015; Ronel & Elisha, 2011; M. A. Warren & Donaldson, 2017). In health, notable fields to utilise positive psychology are epidemiology, medicine, oncology, psychiatry and nursing (M. A. Warren & Donaldson, 2017), and its popularity is shared between Western and non-Western countries (Hendriks et al., 2019; Macaskill, 2016).

Happiness and wellbeing at work have been linked to several positive outcomes. Employees' happiness and wellbeing lead to organisational wellbeing (Page & Vella-

Brodrick, 2009), productivity (Robertson & Cooper, 2018) and employee retention (Harter et al., 2003; Sears et al., 2013; Singh et al., 2016), and can predict job performance (Edgar et al., 2015; Voorde et al., 2012). Devoting adequate attention to employees' happiness and wellbeing is therefore an investment in capital, not simply a feel-good exercise.

The use of positive psychology strategies has been proved to improve NSs' wellbeing. In the development of a toolbox to deal with stress encountered during nursing education, appropriate strategies have been identified in the forms of meditation, mindfulness, breathing, humour, gratitude, personal character strengths, acts of kindness, hope and wellbeing therapies, and positive psychotherapy (Alsaraireh & Aloush, 2017; Guillaumie et al., 2017; Hossain & Clatty, 2021; S. L. Kerr et al., 2015; Macaskill, 2016; Maiolino & Kuiper, 2016; White et al., 2019). These interventions have proved beneficial to students in reducing anxiety, depressive symptoms and stress, and improving general wellbeing (He et al., 2018; Song & Lindquist, 2015; Stinson et al., 2020). Some of these have previously been discussed in Chapter 2.

3.5.2.2 Emotional Intelligence

The concept of EI became widespread in the early 1990s and has been attracting considerable academic research ever since. According to Zeidner and Matthews (2018), EI refers 'to a generic competence in perceiving, understanding, and the regulation of emotions (both in oneself and in others)' (p. 1). EI includes two types of intelligence: intrapersonal and interpersonal. Intrapersonal intelligence refers to a person's ability to be aware of and discern their feelings, goals and intentions, and have an accurate representation of their strengths and limitations, while interpersonal intelligence refers to the ability to understand others' feelings, emotions and motivations (Gardner, 2011; Zeidner & Matthews, 2018). EI relates to a person's ability to recognise the presence and role of emotions in a personal and social context and their effective regulation. Jain (2018) simplified various definitions of EI and presented a framework of the 20 competencies it encompasses (Table 3.1).

Table 3.1: Emotional Competencies

	Self	Other
	Personal competence	Social competence
Recognition	Self-awareness Emotional self-awareness Accurate self-assessment Self-confidence	Social awareness Empathy Service orientation Organisational awareness
Regulation	Self-management Self-control Trustworthiness Conscientiousness Adaptability Achievement drive Initiation	Relationship management Developing others Influence Communication Conflict management Leadership Change catalyst Building bonds Teamwork and collaboration

Source: Jain (2018, p. 155).

EI is strongly linked to general happiness. In their study, Huang and Lee (2019) demonstrated that EI was positively correlated with satisfaction with life, while humour styles had mediating effects on both EI and satisfaction with life. They concluded that a strong ability for emotional self-regulation through positive humour styles, especially the self-enhancing style, had a beneficial impact on overall life satisfaction (Huang & Lee, 2019). M. Wang et al. (2019) also examined EI in relation to satisfaction with life, positive and negative affect, and humour, and reported similar results. They found that self-enhancing humour played a role in the association between EI and satisfaction with life and positive affect, while self-defeating humour had the opposite effect. These results demonstrate that the influence of humour is frequently found embedded among wellbeing outcomes and can positively or negatively influence these outcomes, depending on the style used. It is therefore possible that paying attention to and developing interventions that consider humour styles can greatly improve general happiness and contentment in several measures (Giapraki et al., 2020).

The ability to interpret emotional context can assist nurses in all aspects of their work and has been shown to influence clinical decision-making (Kozlowski et al., 2017). EI has been demonstrated to positively affect the performance of health managers and executives, increasing motivation, commitment and job satisfaction, and decreasing stress and exhaustion in the people they manage (Hur et al., 2011; Rinfret et al., 2020). Additional positive impacts of EI are lowered stress (Malinauskas & Malinauskiene,

2020; Por et al., 2011) and improvements in occupational wellbeing (Nel et al., 2013), engagement (Pérez-Fuentes et al., 2018), retention in higher education (Alsharari & Alshurideh, 2021) and nursing (L. Wang et al., 2018), effective collaboration in multidisciplinary teams (Cox, 2018), clinical performance (M. S. Kim & Sohn, 2019; S.-H. Park & Park, 2018), and clinical teaching (D. E. Allen et al., 2012). The influence of IE in nursing is pervasive.

The effect of EI is also encountered in education. Research has shown that EI can be taught in higher education (Gilar-Corbí et al., 2018) and has been demonstrated to naturally increase over the course of the undergraduate nursing degree (E. Foster et al., 2017). Exposure to the first clinical placements in the first two semesters was shown to produce the most significant improvement on the EI scale (E. Foster et al., 2017). Reduced capacity for EI can decrease a student's ability for intrapersonal intelligence, contributing significantly to career confusion (Shearer, 2009), whereas increased EI capacity can enable students to improve their social supports and manage their stress (Malinauskas & Malinauskiene, 2020). Therefore, assisting students with EI within the first year of education may assist in improving program completion and maximise learning opportunities.

EI is encountered in all areas of nursing, from higher education to clinical practice, and there is a strong association between EI and effective leadership styles (Carragher & Gormley, 2017; Spano-Szekely et al., 2016). Adequate attention, resources and strategies concerning EI, humour and wellbeing can not only improve the quality of GNs entering the profession but also serve as building blocks for producing effective transformational leaders in later years (Carragher & Gormley, 2017). In the long term, as well as benefiting students on a personal level, addressing NSs' EI ability can assist patients and consumers by improving clinical decision-making and care outcomes (Kozlowski et al., 2017).

3.5.2.3 Social Interactions, Relationships and Culture

Humans are beings who thrive on social connections. We form bonds and relationships with those we work with. These can develop in cultures and subcultures; for example, a healthcare facility will have its own organisational culture, while doctors, nurses and allied health practitioners may form their own subcultures (Traczyńska & Kunecka, 2018). Workplace culture can have a considerable effect on work performance, such as

the implementation of evidence-based practice (Henderson & Fletcher, 2015). Health organisations with positive work cultures experienced less staff turnover, and rated high on employee engagement, patient experience and overall performance health outcomes (Owens et al., 2017).

Social support in the work setting has been proved beneficial on several levels. It can predict job satisfaction (Orgambídez-Ramos & de Almeida, 2017) and work engagement (Nappo, 2020; Strömberg et al., 2016), and mediate the link between burnout and workload (Vander Elst et al., 2016). Its effect on work environment also improved the experience of GNs and was beneficial to their learning process (Rodríguez-García et al., 2020). Further, the quality of working relationships and social support is a strong predictor of the utilisation of effective coping strategies (Karaca et al., 2019).

The quality of relationships developed and maintained in the academic and clinical spheres plays an important role in the wellbeing of students and nurses, including those in the academic setting (Rawlins, 2017). Students' acculturation commences in the classroom, where nurses-to-be meet like-minded peers and mentors and clinical staff (Mitchell et al., 2017). Additionally, those formed relationships have been shown to facilitate peer learning collaboration and can prepare NSs for transition to registered practice (Christiansen & Bell, 2010). Forming effective and helpful relationships therefore not only serves in the educational space in terms of wellbeing but also assists in learning, teamwork and adaptation.

Educational institutions with strong organisational culture perform better than those lacking such culture. In these institutions, relationships between instructor and student are viewed more positively and students are generally more satisfied (Kantek et al., 2015). Their professional social network expands when they reach the clinical setting for their practical placement and clinical instructor approaches affect students' learning experiences (Arkan et al., 2018). Encountering negative people and being subjected to incivilities has been shown to cause negative emotions such as anxiety and distress, eroding NSs' confidence and sense of competence (Birks, Budden et al., 2018; Courtney-Pratt et al., 2018). Bullying negatively affects not only the NS as an individual but also the professional reputation (Hartin et al., 2018). Bullying was also shown to reduce the quality of learning experience and contributed to NSs to consider or choose

to leave the profession (Minton & Birks, 2019). Students expressed that being ignored by nurse mentors in clinical practice had a negative effect on them and contributed to a reduction in self-confidence (Arkan et al., 2018). The quality of social interaction, whether positive or negative, will serve to build the foundation of the future nursing culture. Being exposed to disrespectful interactions may falsely inform a student that this behaviour is acceptable in the field, perpetuating its negativity. Targeted education to counter this can help students find a voice in the workplace (Baik et al., 2017).

Relationships are the glue of our human experience; we affiliate, interact and create congenial relationships with others through non-verbal behaviour and by copying others' behaviours (Lakin et al., 2003). Nursing is not merely a task to be performed, but a therapeutic role that is potently enhanced by the positive nature of the personal relationships, whether within oneself or with others. The health of these relationships affects not only oneself but the people with whom we live, work and socialise (Murray et al., 2021). J. Stewart et al. (2015) discussed how nurses developed their deep sense of collegiality in the 1970s and 1980s through shared living arrangements, playing practical jokes on each other and having fun on the ward. In its application, their display of humour was not always perceived as being affiliative (for example, in playing pranks), but it had a strengthening power in maintaining those relationships.

NSs' belongingness has been studied in the context of their clinical placement (King et al., 2017) and is considered a prerequisite for effective learning in the clinical setting (Levett-Jones & Lathlean, 2008). Belongingness strongly influences the development of learning identity and student motivation (Vivekananda-Schmidt & Sandars, 2018). Research conducted by Liljedahl et al. (2016) has shown that students were welcome in the clinical setting, but they showed hesitancy regarding their wish to be included in its community, particularly when their personal values were challenged and not aligned with those of the workplace. Their study identified that the most pressing need was for students to maintain their critical and reflective abilities, and not to prioritise improving belongingness (Liljedahl et al., 2016).

Despite this, belongingness is an important aspect of the clinical experience. Short clinical placements are challenging for students as they spend most of their time trying to adjust to their surroundings and trying to fit in, which reduces their capacity to practise their clinical skills. Students attempt to solve relationship difficulties encountered with

their mentor by trying to rebuild the relationship (taking steps aimed at improving the relationship, such as persisting and being agreeable), by redirecting their efforts for help (for example, seeking help from a peer), by retreating (for example, by accepting circumstances or practising avoidance), or by reframing (engaging in RP to extricate meaning) (O'Mara et al., 2014).

The quality of relationships students form in the academic or clinical setting is therefore vital to their learning journey (Jack et al., 2017). Students completing their first placement have been shown to utilise all clinical, peer and personal relationships to positively cope with the experience (Alshahrani et al., 2018). Helping students to develop healthy relationships and to learn to interact with others positively can assist in improving self-confidence, foster positive learning outcomes and facilitate the growth of a positive nursing culture (Arkan et al., 2018; Owens et al., 2017).

3.6 Theoretical Underpinnings of this Study

The study was informed by the combination of elements and specific theories discussed in the previous sections. The primary aim was to investigate the role played by humour in coping and resilience in FYNSs via a process of exploring the general wellbeing of FYNS during their first year of study and determining elements conducive to their successful adaptation. This study therefore used instruments to quantify students' beginnings of their journey regarding humour, coping and general wellbeing. The transition shock model was used as a reference to all aspects of adaptation to the new role and reality experienced by FYNSs. The model was used to investigate the totality of this experience and to observe whether FYNSs exhibit similar aspects of transition shock documented in NSs towards the end of their degree and during their graduate year.

3.7 Gaps this Study is Aiming to Address

This study seeks to provide specific data concerning the FYNS population's coping strategies and predisposition for resilience and wellbeing. The role of humour has been demonstrated to be a coping mechanism yet also affects relationships and wellbeing. This research seeks to analyse the complex ways in which humour infiltrates the FYNSs' experience.

First, there exists a gap in quantitative data relating to humour styles exhibited by NSs. This gap is particularly evident in their first year prior to the activity of nursing having a potentially altering effect on humour styles resorted to to cope with stressors. This dearth of quantitative data also extends to resilience and general wellbeing of FYNSs. There are minimal initial data enabling researchers to follow the trajectory of NSs along their educational journey, that available either ignoring FYNS or amalgamating all years in one cohort.

Second, no other study has directly combined the role of humour in FYNSs and its overall effect on coping, resilience, and their general experience throughout the foundational first year of study. This study seeks to connect these elements with the goal of obtaining a well-rounded view of FYNSs' experience.

Finally, this study aims to examine how students depart on their journey and what elements have significance in either helping or hindering their first year of study. Previous research studies have focused on specific parameters, for example, examining students' life satisfaction during their study without comparison to their status prior to experiencing the full force of that first year of study or clinical placement. Data collected during this project sought to provide a departing point and to then follow students along their first-year journey, and in doing so identifying both pre-existing coping mechanisms and those the students develop along their journey.

3.8 Chapter Summary

This chapter began by discussing the theoretical approaches that were used to build the research project, namely, the humour and transition shock theories. The intention of this project is to examine the elements conducive to NSs' wellbeing and zone in on one particular coping strategy—humour. Students, as future nurses, and their wellbeing are influenced by several factors, some of which can assist or hinder in maintaining personal balance during the formative educational years.

In the second instance, the chapter examined personal wellbeing by addressing its psychological aspects; the numerous stressors experienced in nursing; and what is currently known to alleviate the burden and relieve such stress, and how these relate to students. Nurses, whether in their educational or practising years, do not simply 'do' nursing, they 'are' nurses first. In considering what is required in becoming a nurse, this

chapter explored the educational considerations surrounding future nurses and what is required to maintain a healthy self that enables the student nurse to cope during their studies and to develop resilience—all aspects also being required of them during their future practising years. The role of humour was included within all these aspects.

In the next chapter, Chapter 4, the author will discuss the research project methodology in detail, including the framework it was built upon. Elements relevant to the research design, data collection methods and analysis, and ethical considerations will be described.

In subsequent chapters, the researcher will present the results of the data collection and provide an analysis, namely, in Chapters 5 and 6. In Chapter 7, the quantitative and qualitative results will be combined and compared with the literature. Finally, Chapter 8 will present the implications of findings and the subsequent recommendations derived from these findings.

Chapter 4: Methodology

4.1 Introduction

The first chapters provided background information on the project as a whole. Chapter 2 offered a comprehensive review of the current published literature around humour, coping, resilience, and the transition shock in the nursing context, centring specifically on FYNSs where possible, and Chapter 3 presented the theoretical framework used to develop the study.

This current chapter will describe the research methodology. It will first describe the methodological approach utilised to undertake the study. Second, it will present a description of the data collection methods, followed by details of the data analysis.

4.2 Methodological Approach

This sub-section will discuss the approach utilised to develop the research project. It will first discuss the research design, including its methodology, and provide details regarding the various research phases, the imbedding of triangulation, and the time frame of each of those phases. The reader will then be provided with details pertaining to the ethical considerations for this study. Finally, this section will conclude by discussing the characteristics of the population from which the study participants were recruited and how informed consent was achieved, including details regarding the sample of participants, and presenting all bias identified.

The research methodology follows the pragmatic worldview, a philosophical movement dating back to the 1870s that follows the work of C. S. Peirce (1839–1914), a researcher who endeavoured to link thought and action (Frey, 2018). Pragmatism is centred on real-world problems needing practical solutions and where the quest for answers is open to any means of data collection and analysis that will achieve the result (Creswell & Creswell, 2018). The emphasis is on the question posed rather than the methods used to answer it. Therefore, pragmatist researchers usually select a mixed methods design, combining quantitative and qualitative types of data to enable complete problematic exploration (Creswell & Plano Clark, 2011). The collection of information from multiple sources allows the researcher to utilise data triangulation to reduce 'bias and find convergence on a single reality' (Tracy, 2019, p. 276) and seek convergence

across qualitative and quantitative sources, which in turn leads to increased credibility and reliability (Creswell & Creswell, 2018).

The principal research question attempts to acquire knowledge about NSs without the restrictions imposed by set boundaries that would be delimited by bounded relativism. Bounded relativism refers to the mental concepts of reality that are identical in space and time within set boundaries such as moral and cultural (Moon & Blackman, 2014). Despite the research taking place in the set space offered by the commencement of their nursing degree, it could not be assured that participants' construct of reality was equal to all. As many elements were likely to influence participants, the wider range offered by the pragmatism ontological perspective was more appropriate than that of bounded relativism as it is typically person-centred (Moon & Blackman, 2014).

Further, in considering the principal research question, the researcher could not be certain both subject and object were independent of each other. Is it the participant's humour style that influences their ability to adapt to their nursing studies or is it the activity of nursing, whether theoretical or practical, together with the people encountered in the process that imposes its meaning on the other? Constructionists believe that humans construct their knowledge and meaning by their interactions with the world in a two-way fashion (Denzin & Lincoln, 2018). Choosing a constructivist epistemological stance would have accounted for the possible existence of multiple realities experienced by participants, but the limited research available around humour and the NS population would have limited the means of enquiry.

Prior to the selection of pragmatism, other worldviews were considered but did not fit the intent of the study. For example, post-positivism seeks to test or verify a theory (Creswell & Plano Clark, 2018), which could have been beneficial in validating the transition shock theory in FYNSs; however, this would not have captured the entirety of the main research question, particularly around the influence of humour. On the other hand, the constructivist worldview would have been beneficial around understanding the social construct (Creswell & Plano Clark, 2018), but the researcher did not seek to develop a theory. Morgan (2019) states that a crucial element is that pragmatism distinguishes between post-positivism and constructivism without depending on set ontological and epistemological assumptions and offers a new way for social researchers.

In seeking to uncover the influence of humour in NSs' wellbeing and as a coping strategy, a quantitative design was favourable but not sufficient. For example, the researcher first deliberated about an ethnography design. Ethnography is often used in health research and is valuable in studying social interactions, behaviour patterns, language and perceptions that occur within groups, teams, organisations and communities within their natural setting (Creswell & Creswell, 2018; Reeves et al., 2008). It would have been useful in providing insight into FYNSs' views and practices; however, it was discarded on the basis that FYNSs, particularly in their first semester, have not yet developed their own culture and are confronted with more than one culture—that of the academic and clinical settings. Perhaps this type of methodology would have been more appropriate if the population chosen had targeted final-year students rather than first.

Additionally, the principal research question could not be answered using only quantitative or qualitative methods alone. Using only quantitative methods, such as the three instruments selected for the study, would have permitted answering three out of the four research questions that directed the study—those relating to the humour styles score pre first clinical placement and their relationship with coping and satisfaction with life. To provide the abundant information required to delve into NSs' experience, a combination of both quantitative and qualitative methods was necessary, resulting in a mixed methods design methodology.

The popularity of mixed methods research (MMR) in the nursing field has grown in the past decade despite challenges, especially during data collection, analysis and reporting (Younas et al., 2019). Researchers must pay particular attention to considering and identifying adequately the role, impact and weight that their study's qualitative and quantitative arms have (Plano Clark & Ivankova, 2016). The researcher will discuss each of these aspects further in this chapter in relation to the current research by first discussing the research design. Other aspects, such as data collection methods and their analysis, are detailed according to each type of data, namely, quantitative and qualitative, and will be presented in following sub-sections.

4.2.1 Research Design

This study was based on an explanatory sequential design using quantitative and qualitative methods of enquiry to inform the problem (Figure 4.1). The explanatory

sequential design described by Creswell and Creswell (2018) states that ‘the key idea is that the qualitative data collection builds directly on the quantitative results’ (p. 222). The researcher sought to capture cross-sectional baseline measures prior to the activity of nursing, whether academic, practical or social. This was to permit the collection of data, such as humour styles and resilience score, that could offer a picture of NSs prior to the ‘effect of nursing’. With the subsequent collection of qualitative data longitudinally, the researcher would be better equipped to identify influential elements enabling NSs to cope with their nursing studies, including humour. Additionally, the researcher had not located any published research that could offer this dataset. Therefore, the collection of quantitative data in the first instance could not only assist the researcher in the identification of coping mechanisms—particularly that offered by humour—and their presence prior to, development during or influential impact overall during the timespan, but also offer a comparison of results for future research projects.

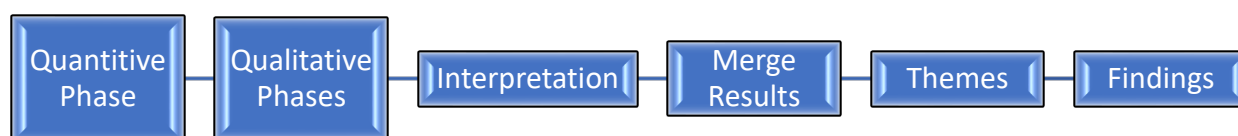


Figure 4.1: Explanatory Sequential Design

Creswell and Creswell further explained that an explanatory sequential mixed methods design is the reverse of an exploratory sequential design, which would commence with qualitative data rather than quantitative (2018). The qualitative and quantitative arms of the current design were not conducted entirely separately from each other and therefore did not fit the description of a convergent design (Creswell & Plano Clark, 2018). Additionally, the study does not depart from the explanatory design that could match the description of a complex mixed methods design described by Plano Clark and Ivankova (2016), which would have combined two or more sequential or concurrent designs.

The following sections will provide details regarding the application of MMR in the context of this project. Additionally, information regarding the research phases of the project and the integration of triangulation to the design will be presented, together with the time frame for each of the phases. The modifications that were necessary during the course of the project have already been discussed in Chapter 1; the reader can refer back to section 1.4.6 for specific details.

4.2.1.1 Mixed Methods Research

MMR is appropriate when analysis of only qualitative or quantitative data is statistically insufficient, and a higher degree of understanding is obtained by combining both datasets (Creswell & Creswell, 2018). Combining the two methods can enable researchers to answer multiple research questions simultaneously (R. B. Johnson & Onwuegbuzie, 2004). Bressan et al. (2017) discussed gaps in knowledge and the understanding of mixed methods, which have resulted in inconsistencies of application and reporting, highlighting the need for clear guidelines in nursing to enable the translation of research findings into practice. Nonetheless, MMR has been perceived as being contemporary and providing different depths of understanding of the concepts examined (McKim, 2015), and is recognised as a promising approach to addressing multifactorial questions encountered in nursing and healthcare in general.

While two means to answer research questions through various research methods can broaden a researcher's enquiry, the type of method combination is critical to achieving an optimal outcome. This practice is called triangulation, which facilitates the ability to compare and contrast findings through different perspectives (Bressan et al., 2017), improving the credibility of research studies (Salkind, 2010), and its use was first discussed by Denzin (1978). Triangulation was therefore applied to this research to ensure comprehensive data examination and enrichment of findings and will be discussed further in this sub-section.

4.2.1.2 Research Phases

The research was conducted following a series of three phases, and within each phase, there were two waves of data collection; the three main phases are illustrated in Figure 4.2. The first phase was concerned with collecting quantitative data, while Phases 2 and 3 were focused on qualitative data. The quantitative dataset was initially collected and

analysed on its own. These analyses, together with the findings, are presented in Chapter 5. Similar to the quantitative data, the qualitative phases' data were analysed, and findings will be reported in Chapter 6. Following this, both quantitative and qualitative results were combined and a comparison of findings with the literature was made; their discussion and conclusions will be presented in Chapter 7.

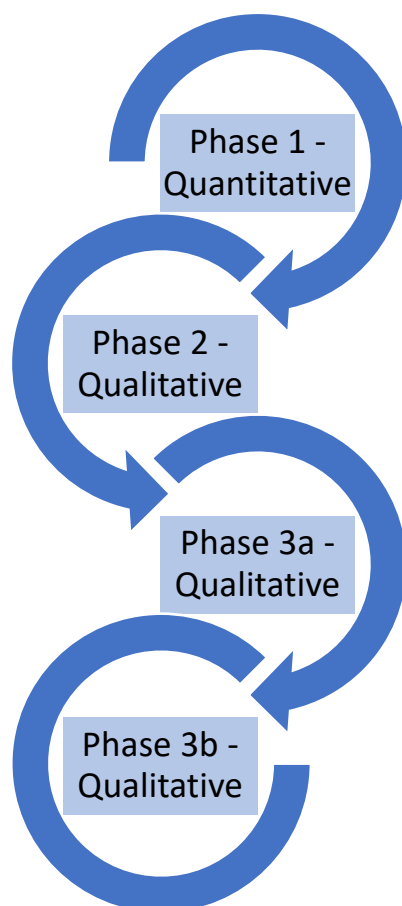


Figure 4.2: Research Design Phases

In Phase 1, participants were invited to complete an electronic survey through SurveyMonkey© containing demographic questions (Appendix A) and three validated instruments during their first semester of study before attending their first practicum. A paper-based version was also available as mentioned on the (Appendix J). All completed hard-copy survey answers were entered into the database without delay. All results were stored in one location and saved on a computer and file-protected by a password. Participants who answered surveys online could not skip a question and were required to provide an answer prior to the next question being displayed. The researcher keyed in all hard-copy answers into SurveyMonkey© to ensure that the

complete quantitative dataset was situated in one location as early as possible. All hard-copy documents were destroyed

The three instruments chosen for this research project are presented and described in further detail in section 4.3.1.2. They were selected to assess participants' baseline at the commencement of their learning journey. The first instrument (Appendix B) sought to identify the preferred humour style utilised by students before engaging actively with the activity of nursing. Humour can assist relationships with self and others or, conversely, can negatively influence them (R. A. Martin, 2007), and therefore potentially affect a student's first practical experience. The other two tools measured their level of coping and resilience (Appendix C) and overall satisfaction with life (Appendix D). The quantitative portion of this research was undertaken in Phase 1. The data were collected, interpreted, analysed and examined by standalone measures.

Humour styles results were further compared against levels of coping and resilience. The researcher scrutinised the data in search of associations. All data, its interpretations and findings are presented and discussed in Chapter 5. Humour, coping and resilience were further examined in combination and along the first year of the students' learning journey through qualitative methods, and are presented and discussed in Chapter 6.

Humour data were further collected and explored across the complete spectrum of the students' first year of nursing study. The type of humour displayed by undergraduate NSs at the commencement of their first semester was compared with information gathered from reflective journals and interviews conducted with students during and post clinical placements. All other relevant humour data collected extended to Phases 2 and 3 (including Phase 3a and Phase 3b) and are discussed below.

Phase 2 consisted of participants completing a reflective journal during their first practicum. Bass et al. (2017) stated that RP is particularly useful in promoting personal and professional development, and the structure of the reflective journal was therefore based on the Holistic Reflection Model (Appendix E) that was explained in detail in section 3.4 in the previous chapter. It was expected that students would return at least one journal during their clinical practicum but could complete as many as they wanted on a weekly basis. They were encouraged to do this by receiving weekly emails, including an electronic link, to complete the journal.

The reflective journals sought to capture information relevant to the first nursing exposure experienced by participants. In addition to humour, students' accounts of their first clinical exposure were examined to discern the possible presence of transition shock and elements conducive to adaptation, coping and resilience at the point of commencement in their clinical practice and exposure to the profession. The data collected through the reflective journals were explored, analysed, coded and themed. This is discussed further in this chapter in section 4.4.4. The researcher then referred to these personal reflective journals to draw more information or seek clarification with students who subsequently participated in the interview phases.

In Phase 3 (a and b), students were invited to participate in individual interviews. Interviews were designed to expand on the information that students had provided in their reflection and extrapolate additional data regarding humour, and their general experience combining education with the lived experience of nursing practice. The guiding questions can be found in Appendix M. The first interview was conducted following the completion of the student's first practicum (Phase 3a). The same students were invited to be interviewed again following their second practicum (Phase 3b).

Initially, the researcher had planned to obtain post-practicum test results from the three validated instruments. Because of a combination of low response rate and difficulty in accessing the students as a whole cohort, the researcher obtained permission to abandon this portion of the data collection and a second interview with students was favoured in lieu. The rationale for the second interview was to capture information-rich data to inform the research about the students' entire first year of nursing studies. Post-test results were not expected to provide sufficient data to detail the students' experience. They would not have captured the same level of information-rich data afforded by semi-structured interviews. As the study design and ethics application already included the collection of data through interviews, it was deemed by the Research Coordinator Professor of Nursing and the University Ethics Officer that formal amendment to the ethics approval was not necessary but noted by both.

Halfway through data collection, the worldwide COVID-19 pandemic presented the researcher with significant difficulties. Because of this unique situation, students from W1 who had already completed their two interviews were invited for a third interview to provide their perspective on the impact of COVID-19 on their nursing studies. This would

assist to alleviate the identified element that both group sets would be influenced unequally in their interview responses; the impact of COVID-19 would be present in all of W2 participants, but the same input would not be captured by all those of W1 who had already completed their second and final interview. To mitigate this impact, permission was again obtained to invite all W1 participants to a third interview, which posed the same questions as those of W2. Here again, amendment to the secured ethics approval was not deemed necessary by the Research Coordinator Professor of Nursing and the University Ethics Officer as the addition did not significantly depart from the original intention of the study or data collection. The continuity offered by following students along their whole first year enriched the data and provided a snapshot of their academic and burgeoning nursing experience. The qualitative arm of this research project is explained in more detail in section 4.3.2.

These changes enabled the study to maintain its explanatory sequential mixed methods design and its original intention. Specific explanations on how the data were collected will be explained for each phase in section 4.3 and their analysis in section 4.4.

4.2.1.3 Triangulation

A research project requiring two or more different perspectives to answer the research question needs to maximise the value of the data it collects. This can be achieved through the process of triangulation (Flick, 2018b). The definition of triangulation has been outlined in many ways. Some associate it with the combination of two methodologies, qualitative and quantitative, such as in MMR (Renz et al., 2018; Turner et al., 2017), while others more broadly associate it with examining a particular event or concept from multiple angles (Denzin, 2012; Kern, 2018). Consideration for triangulation enables researchers to adequately select and plan their data collection (Flick, 2018b). The following paragraphs will first define and explain the triangulation concept. The researcher will discuss how the process was applied to this research more specifically in section 4.4.2.

Triangulation is a highly valuable research method for enriching data analysis by enabling multiple viewpoints (Denzin, 2012; Moon, 2019). For meaning to be derived from the collected data, it must be examined and scrutinised. The combination of each arm of collected data (observation of an event or concept) produces a third (or more, depending on how many were initially collected) level of information, offering a

supplementary level of evidence. It can additionally reduce potential biases inherent in a single method (H. Noble & Heale, 2019) by covering more perspectives and reducing blind spots. The process enables the researcher to draw additional conclusions that otherwise would not have been possible, or it can highlight areas requiring further research (Moon, 2019).

Flick (2018b) stated that triangulation makes its appearance at the end of the study during the validation process. It is a means of verifying the integrity and validity of conclusions by employing various data sources, investigators, methods, or theoretical perspectives by combining different angles and viewpoints (Kern, 2018; Koro-Ljungberg, 2015).

Recent technological advances offering novel approaches to collecting data are opening possibilities for researchers. Triangulation is of particular merit in the context of social media platforms, audio diaries and photovoice, which can all enrich data collection and offer added standpoints (Carr et al., 2019). Triangulation enhances the researcher's reasoning process, maximising the utilisation of such multiple and inherently varied perspectives (Flick, 2018b).

Researchers have discussed several types of triangulation (Moon, 2019; H. Noble & Heale, 2019; Patton, 2015; K. Walsh, 2013). Their specific application will be discussed in more detail in section 4.4.2 but are briefly described below:

- Data triangulation: Data are collected at different locations (space), at various times (same data collected at other points in time), with different people (e.g. patients and nurses), from multiple sources (obtaining data from several sources with the same data collection method to obtain a complete picture) and using methodological triangulation (including multiple research methods for the data collection). For example, during this study, data pertaining to humour were collected pre and post clinical placement through different methods, namely, quantitative and qualitative, and using more than one means, for example, reflective journals and interviews.
- Theory (or theoretical) triangulation refers to different theories to explain a phenomenon. It also helps to guide the entirety of the research by shaping its design, its implementation, and the interpretation of the data. This study included

two main theories, namely, humour styles and transition shock. The data were matched to each theory then compared.

- Investigator triangulation means using more than one researcher to collect or analyse the data. This research included the research student and her two supervisors, one of whom is an Associate Professor.
- Combined levels of triangulation: Data are triangulated more than once and then combined. In this project, that data were analysed as standalone components and then combined and analysed in its entirety.

In MMR, Creswell and Plano Clark (2018) stated that triangulation compares qualitative data findings to quantitative data, seeking to achieve convergence and validation by the process. This process is supported by Morgan (2019), who specified that through triangulation, the comparison of qualitative and quantitative results seeks to answer the same question and may lead to a convergent, complementary, or divergent outcome. However, Flick (2011, 2018b) discussed the difference between 'weak' and 'strong' programs of triangulation, stating that a weak program is when triangulation is used as a measure of assessment of qualitative data, or applied as a pragmatic mix of methods. He further specified that a strong program recognises triangulation as providing an additional source of knowledge about the phenomenon studied and thereby extending the research; it is not just a process of mere confirmation of results already achieved by a previous method (for example, through convergence of findings) (Flick, 2018b). In this study, the combination offered a means of further insight into a theory.

Research studies must be able to withstand scrutiny, and this can be achieved by several means. Examples of such means are peer examination, triangulation, involving participants in evaluating pattern descriptions, and counterbalancing (which involves investigating for invalidating evidence and opposing interpretations) (Denzin, 2009; Kyngäs et al., 2019). Scrutiny improves a study by adding validity and reliability, dependability, conformability and transferability (Denzin, 2012; Moon, 2019; H. Noble & Heale, 2019). However, triangulation as a means is not fool proof; it will not rectify errors made in data collection, just as findings from triangulation can be wrong for a variety of reasons (Moon, 2019; K. Walsh, 2013). Triangulation is a means to achieve validity and credibility; it does not necessarily ensure it (Flick, 2017).

4.2.1.4 Time Frame

The data collection was conducted over a number of phases. Encompassing all phases, the data collection commenced in February 2019 and was completed in May 2020, and is represented in Figure 4.3. These phases have already been discussed in section 4.2.1.2.



Figure 4.3: Study Time Frame and its Phases

4.2.2 Ethical Considerations

The current research upheld the principles of integrity, respect, honesty, and ethical behaviour in its design, as directed by the Australian Code for Responsible Conduct of Research (National Health and Medical Research Council [NHMRC], 2018) and the National Statement (NHMRC, 2015). It respected participants' right to self-determination regarding participation, withdrawal, and the safeguarding of their wellbeing. This project generated new knowledge and understanding of the experience of the student nurse at the onset of their education and provided valuable insight in shaping education programs tailored to foster the retention of students and their wellbeing and adaptation. The project abided by the guidelines and measured the development of an accountable and conscientious researcher, the ethical context of each element having been examined judiciously (NHMRC, 2018).

The following section will discuss all matters pertaining to the specific ethical considerations involved in this project. The section will explain how ethical approval was obtained and how confidentiality and data security were maintained. It will provide information on how consent was obtained from participants and how their welfare was addressed and supported. It discusses how participants were able to withdraw at various stages of the project. Finally, it informs the reader of the risks and benefits of the research and discloses any conflict of interest.

4.2.2.1 Ethical Approval

To ensure the safety of the participants, the researcher sought and obtained ethics committee approval (NHMRC, 2018). The application and proposal to undertake research with human subjects was submitted to the university's Human Research Ethics Committee (HREC). Ethical consideration for this proposed research was demonstrated in the informed consent forms (Appendices F and G) and participant information sheets (Appendices H and I), which included voluntary participation, study process, withdrawal process and data storage information. Formal ethics approval 018164F (Appendix N) (Phase 1) and 019062F (Appendix O) (subsequent Phases 2 and 3) were received by the university's Research Office.

4.2.2.2 Confidentiality

Particular attention was devoted to maintaining participants' anonymity and confidentiality at all levels of data collection. As soon as practical at the conclusion of each data collection, data were matched with previously collected items to maintain continuity of collection and then re-classified by allocating a non-identifiable code by the researcher. This ensured confidentiality while maintaining the ability to analyse the results. Where an identifier was required, such as to a person or place, a generic number and letter replaced it, such as 'Participant (R2)'. With a view to anonymous accuracy of information control, participants were invited to review any information or transcripts pertaining to their journal entries and invited to provide clarifications and corrections before submission of the thesis.

4.2.2.3 Data Security

Data security rests with the researcher as outlined in the Australian Code for the Responsible Conduct of Research (NHMRC, 2018). All data were transferred into digital format; digital copies of instruments, reflective journals and data analysis were kept on a university password-protected computer that was stored within the School of Nursing and Midwifery. All paper-based and digital records of this study will be destroyed and erased at the 5-year anniversary of the conclusion of this study, as per the expressed guidelines.

4.2.2.4 Participants' Welfare

The welfare of participants throughout this research was paramount. The appropriate contact numbers for the university counselling service were provided on the participant information sheet for participants who might have experienced any emotional or psychological discomfort and wanted to seek help.

4.2.2.5 Right to Withdraw

All participants were able to withdraw their consent following the return of the questionnaires in Phase 1 by expressing their wish to the researcher and providing their student identification number. All reflective journal participants retained the right to withdraw from the study throughout the data collection period by not submitting any further entries. Participants were able to advise of their wish to withdraw by email. In such instances, participants were removed from the contact list. Once the data collection was complete and de-identified, participants were no longer eligible to withdraw their contribution. Participants who expressed their wish to withdraw did so by email. Once their communication was received, the researcher sent an acknowledgement, thanked them for their participation so far, and then removed them from the contact list.

4.2.2.6 Risks and Benefits

Research projects must assess and address any potential risk for harm, discomfort or inconvenience to participants (NHMRC, 2015). The current research project was a natural extension of the current course requirements. The only foreseen harm was the possible discomfort participants might have experienced while completing their journal

entries or during their interview. It required students to discuss personal issues such as feelings towards a situation and personal values. However, it was probable that the reflective writing and journaling benefited rather than harmed participants (Bulman & Schutz, 2013). If a participant experienced discomfort of any description, either directly related to this project or during the natural course of their clinical practicum, pastoral care was offered together with encouragement to seek free counselling sessions at the university's student counselling services. No participants expressed any discomfort or sought assistance because of experiencing discomfort. No risk of harm or discomfort has been identified regarding the completion of the instruments in Phase 1. The only inconvenience might have been the time required to complete the instruments; however, participants retained the right to refuse participation, therefore voiding this potential risk. No students contacted the researcher, or the research team, to advise that they were experiencing any distress.

Overall, the research project was more likely to generate a positive outcome than be detrimental to participants. For example, engaging in RP could help participants identify personal difficulties likely to lead them to address their issue(s) and potentially completing their practicum rather than storing their negative experience and potentially performing below standards or leaving the program.

4.2.2.7 Conflict of Interest

Within the research domain, conflict of interest is defined as an individual or institution's interests or responsibilities potentially influencing the course of research through their professional role or obligations (NHMRC, 2015). The researcher held a formal role within the university where this research took place during the data collection, which could have produced actual or perceived abuse of power related to her position. The researcher having no duties or other direct contact relevant to the FYNSs reduced this as her academic contacts were with second-year NSs, thus negating any potential abuse of power. However, to further decrease any potential or perceived abuse of power, the researcher removed herself before distributing paper-based questionnaires. A third party did this once the researcher had left the room. Students could also access all documentation and questionnaires through their learning platform Blackboard® at their leisure, without any potential to create a desire to please bias.

4.2.3 Site/Population Selection

The following sub-section focuses on how participation in the study was achieved. It begins by detailing the setting where the research took place, and then provides details on how participants were recruited, how their consent was obtained, and how samples were obtained for each phase of the research.

4.2.3.1 Setting and Population

In WA where this study was conducted, students' first clinical placement is typically held in an aged care setting (Kelly et al., 2020). Such placement generally lasts for 5 weeks, and all rotations are completed over a 12-week period (The University of Notre Dame Australia, 2017, 2020a, 2021). Other local universities similarly place students in an aged care setting; however, the number of weeks for this first practicum may vary in length and may be undertaken in the second semester, although usually completed in the first year of study (Curtin University, 2018, 2021; Edith Cowan University, n.d., 2021; Murdoch University, n.d.-a, 2021).

The study was conducted at a private Catholic university in WA, Australia, and was completed in two waves, which followed two cohorts of NSs at the commencement of their nursing education in their first semester. The research naturally excluded any ENs completing the bachelor conversion program to become an RN. These students enter the nursing bachelor's program in the second year, not the first.

4.2.3.2 Recruitment

Prospective participants were informed of the research project during their first week of study. An announcement was placed on the students' learning platform, Blackboard®. This announcement introduced the project and the researcher to the students and disclosed the possibility of the researcher having future academic contact with them in their second year (third semester) of study. The announcement pointed to the inclusion of the study information sheet, the upcoming face-to-face information sessions, and options on how to participate. A copy of these announcements is presented in Appendices J, K and L.

4.2.3.2.1 Phase 1—Wave 1

The researcher addressed the students during a compulsory lecture in Week 1 of their semester. This compulsory lecture captures all students of the cohort and takes place prior to them attending their first practical placement. The researcher introduced herself, and verbally discussed the nature of the research, its aim, and its multiple phases. She provided prospective participants with the opportunity to ask clarifying questions. The survey was provided in the form of hard-copy material at the end of the lecture. Students were reminded that the survey was also made available by electronic means to capture those preferring to answer at a later date. The electronic version was also available for any students who were absent from the lecture.

As mentioned, the first recruitment opportunity was conducted alongside the pre-clinical compulsory lecture. This lecture is traditionally heavy in information but appeals to students as it directly relates to their upcoming 'real-life' nursing experience. The time allocated for the lecture and its content can present time challenges, especially when students ask numerous questions. Following unforeseen time constraints during the first recruitment attempt, the researcher secured permission from the unit coordinator to address students in a different lecture for a second recruitment opportunity.

During the first contact, students were given an electronic link through SurveyMonkey© to complete the survey. As the lecture was already heavy in content, it was agreed with the unit coordinator for this course that the researcher could address the cohort verbally but could not expect to distribute a paper copy to all students. However, the coordinator agreed for these to be made available at the end of the lecture. The participant's information sheet (Appendix H) and link to the SurveyMonkey© online survey were also placed on the student's learning management system, Blackboard©, and could be accessed throughout the semester without restrictions. Students were sent reminders via Blackboard's electronic communication system every 2 weeks to encourage them to complete the survey during the semester if they had not done so already.

The researcher addressed the same students face-to-face a second time at the end of the semester. This was again during the progression of the same compulsory course and lecture. This time, a third party to all those present in the room handed out a hard copy of the survey. During this final face-to-face encounter with participants of Wave 1 (W1), the researcher provided details regarding voluntary participation in Phase 2, a

participation sheet was available (Appendix I), and the researcher answered any questions. As the researcher's allocated time with students had been scheduled to be at the end of the lecture, which by then had already run overtime, several students had to leave because of other commitments. Those still present were invited to stay after the end of the lecture and complete the survey, or to return the completed survey by electronic means by scanning and emailing it directly to the researcher, or to complete the online SurveyMonkey®.

4.2.3.2.2 Phase 1—Wave 2

As discussed above, the researcher sought to adjust the recruitment process to capture a maximum of participants during the second attempt. Comparable with W1, Wave 2 (W2) students were sent an electronic announcement through their learning platform (Appendix K). The announcement not only informed them of the research project but also provided a link to the electronic survey through SurveyMonkey®.

The prospective participants were addressed at the beginning of their lecture in Week 1. Minor modifications meant that this time all students were handed a hard copy of the survey before the commencement of the lecture. Students were invited to complete the survey during the lecture time and break. The researcher placed an identified box next to the exit door and left the room during the lecture. As the hard copy of all surveys were physically distributed and collected on one occasion, participants were not provided with sealed envelopes, only an identified box near the exit door where participants could leave the survey as they exited the room. The researcher returned at the end of the two-hour lecture to collect the surveys and the box. Hence, the strategy for distributing and collecting the survey was slightly modified between the two recruitment opportunities but remained intentionally the same. The commonality between the two recruitment occasions was that:

- Participants were addressed through an announcement on their learning platform prior to attending the lecture.
- A dedicated page for the research opportunity was made available on the learning platform. It contained an introduction, the participant information sheet, and the option to download a hard copy of the survey. A link to the electronic version of the survey was also made available to participants.
- The researcher's details were available.

- The information was available during the entirety of the semester.
- Students were addressed in person in the first week of the semester and again at the end of the semester, prior both to their examination period and to attending their first clinical practicum.
- Reminder announcements were posted regularly on the learning platform throughout the semester, automatically emailing all students.

Details for each recruitment opportunity will be discussed in further depth according to each cohort in the following paragraphs. A visual representation of how participants were addressed is displayed in Figure 4.4.

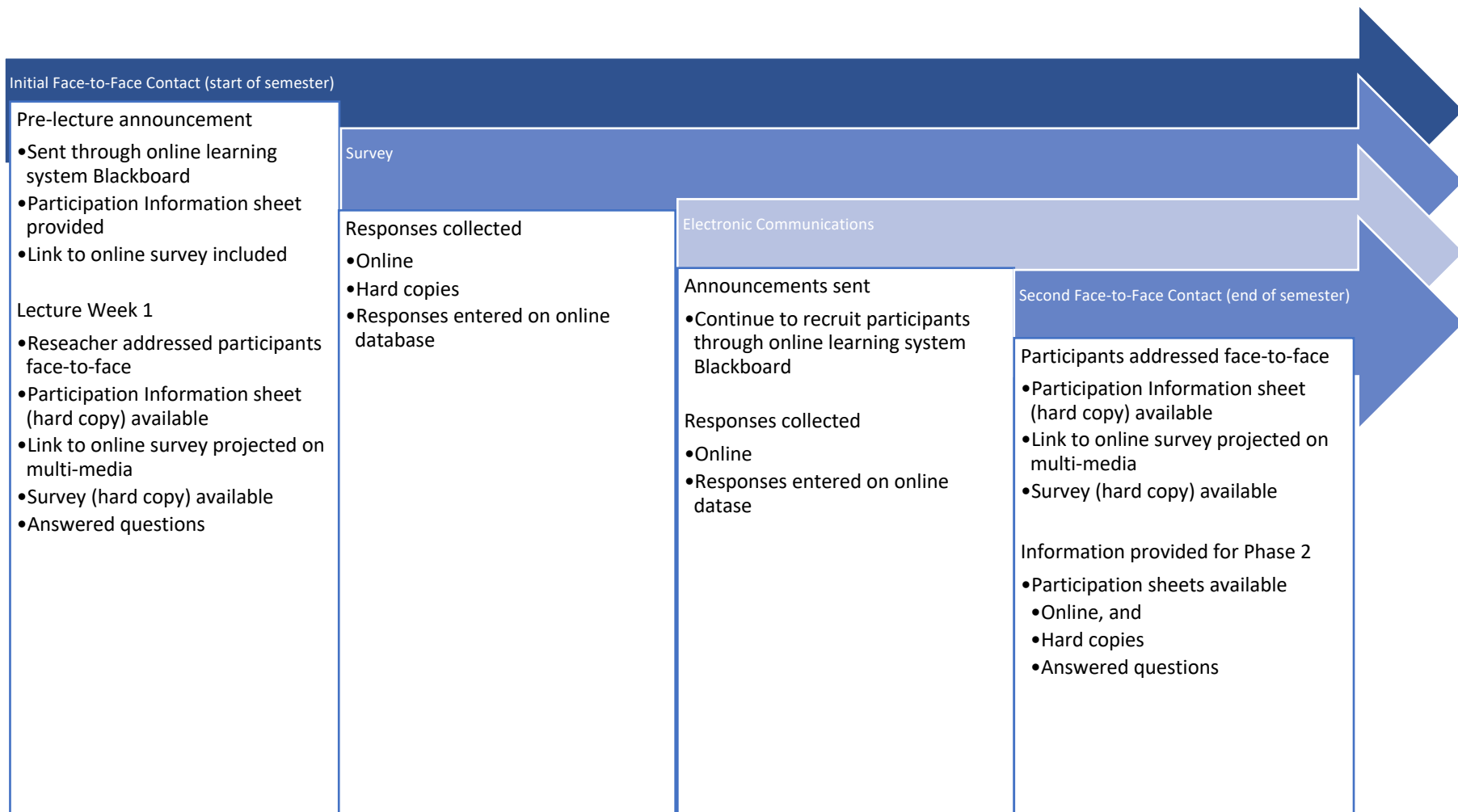


Figure 4.4: Address to Participants

4.2.3.2.3 Phases 2 and 3

Participation for Phases 2 and 3 was also on a voluntary basis. Participants of Phase 1 had the opportunity to express their wish to be contacted to continue their participation during their first practicum, corresponding to Phase 2. All those who participated in Phase 2 were contacted by electronic communication again and invited to participate in Phase 3. Participants maintained the right to withdraw at all stages by not returning the RP journal, declining to respond to the invite to attend an interview, or advising that they wished to withdraw. Some students participated in all stages, while others participated in only some. Participants were contacted by electronic communication, and examples can be found in Appendices J, K and L.

4.2.4 Informed Consent

This research respected the requirement for participants to provide valid and informed consent, free of coercion and pressure, as outlined in the National Statement by the NHMRC (2015). This specifically meant that participation was on a voluntary basis. This voluntary choice was made following the adequate and sufficient disclosure of written information pertaining to the nature and implication of the research in an accessible language and format to each participant (Appendices F and G). The information was also outlined verbally during the compulsory lecture to assist participants in understanding all participatory elements and requirements of this research project. Prospective participants were able to ask questions and receive immediate answers to their queries during the lecture time.

In Phase 1, participants' consent was voluntarily obtained by completing and returning the questionnaires presented in Appendices A, B, C and D.

In Phase 2, recruited participants from Phase 1 were sent an informed consent form (Appendix F) together with a participation sheet (Appendix I). All relevant elements regarding the purpose, method, demands, risks, and potential benefits of the research were outlined (NHMRC, 2015). Consent was given by return of the completed consent form to the researcher.

Participants were also able to access participation sheets and informed consent forms through their online learning management system (Blackboard®). Should they have

wished to complete participation documents later, but before data collection, they were able to do so by accessing the documentation through that means.

Consent from participants who agreed to be interviewed was also sought prior to commencing the interview (Appendix G). Participants maintained the right to withdraw from the study at any time by declining to participate, or expressing their wish to cease participation or to no longer be contacted by the researcher.

4.2.5 Sample

All phases were conducted over two semesters of study to capture the highest number of possible participants. This was also to account for non-participation and subsequent withdrawals. It was estimated to capture a high number of students.

Phase 1, the quantitative portion of the study, utilised a nonprobability sampling method. Participants for Phase 1 were recruited through convenience opportunistic means. The convenience opportunistic sample was obtained from volunteer first-year undergraduate NSs attending a compulsory lecture. The sampling procedure was expected to achieve a participation rate close to 80%.

In Phase 2, recruitment was achieved from contacting the pre-existing sample who had expressed their willingness to participate further. According to the Institute for Health Research senior biostatistician, a meaningful sample size for this phase was approximated as eight participants. The researcher however aimed to recruit a sample of 35 participants to ensure sufficient data were collected and to sufficiently inform the quantitative results. This number was also thought to compensate for any participants who may choose to withdraw.

In Phase 3a, the researcher again contacted all participants from the pre-existing sample who had participated in Phases 1 and 2 and who had indicated their willingness to be contacted for individual interviews. Those who agreed to be interviewed were again contacted following the completion of semester two for a follow-up interview. The researcher aimed for a sample size of eight participants, with corresponding interviews. This number considered participants who might have taken leave of absence or terminated their nursing program; however, in the event of such event occurring, their participation was not excluded on the grounds that information pertaining to their reason

to take leave or withdraw could further inform the study. The interviews were to be held at a time and place convenient to the participant.

Because of alterations made in the context of COVID-19, a second portion was added to Phase 3 and referred to as Phase 3b. Interview questions of Phase 3b related to seeking data concerning COVID-19 and its effect on participants' learning journey. Participants from Wave 1 were then invited to return for a third interview to answer questions relating to COVID-19. Here again, participation was voluntary.

4.2.6 Bias

Research projects can be subject to bias, which the researcher must minimise. Such bias can affect study design; participant selection; and how data are collected, measured, analysed or published (J. Smith & Noble, 2014). Potential bias during this study and its management will now be presented and reviewed.

The selection of an ideal data collection method is driven by the research question and the constraints of restrictions in the study (de Leeuw, 2005). The selection of a mixed-mode approach including email reminders has been shown to improve response rates in nursing-related surveys (Guise et al., 2010). Respondents to this research could self-select a paper or online form of the survey. Online reminders through their learning platform were also used throughout the survey collection period to encourage participation.

Selection bias was reduced by providing all potential participants with an equal right to either participate in or abstain from the study. Participants were addressed as a group with no expectations for them to enrol. They were given reasonable time to decide whether or not to enrol, and reasonable time and both available modalities (paper and online) to choose to complete the survey. The mixed-mode survey format was chosen for its capacity to capture larger samples and its ability to navigate modest resources (Bethlehem, 2010). There were no means for the researcher or academic staff present to identify non-participants, thereby eliminating the potential for fear of reprisal for non-enrolment as a confounding bias.

The researcher disclosed the potential to be the participants' future lecturer in their second year of study. As this possibility was 1 year distant, it was considered that bias

related to wishing to please or social desirability was absent. The researcher was unknown to participants and would not have direct academic contact with them until the collection period had been completed.

Question-order bias can exist when the order of the questions presented may lead or influence the respondent's answers to subsequent questions (Dillman et al., 2014; Lewis-Beck et al., 2004). Items the researcher deems critical are often placed at the start to improve the chance of critical information being captured should the respondent not complete the survey (Dillman et al., 2014). The need to order multiple questions also requires thoughtful consideration and scaffolding, much like the logical sequencing of the conversation aspect of research centred around humour, thereby justifying presenting the HSQ first in the series of instruments. Additionally, use of well-known instruments that have been assessed, validated, utilised, and presented in published literature offers an added degree of assurance in their use.

Further, Galesic et al. (2008) have demonstrated that respondents of online surveys concentrate more on the first few options offered as possible answers rather than the last few. All three instruments contained in our survey required answers on a given Likert scale. The first two instruments, the HSQ and the CD-RISC-25, have five possible choices, but these were termed differently; for example, the HSQ's first possible answer was '*strongly disagree*', while the first option for the CD-RISC-25 was '*not true at all*'. This required the participants to read the new choices prior to answering and reduced potential confusion that a differently ordered Likert scale could have presented. The continuity offered across the two instruments, together with being presented to participants one after the other, reduced possible confusion between answers and avoided unintended responses. The first two instruments also contained the most items across all three.

Bias can exist in data analysis (Bauce & Fitzpatrick, 2018). It can present in reporting on multiple analyses of demographic variables. For this research, the researcher controlled for reporting bias by setting the significance level of the results at $p < .01$.

A bias relating to the single site and non-random sampling was introduced. Because of this, results from subsequent studies may vary in other settings or samples (Bauce & Fitzpatrick, 2018). However, because of the explanatory design of this research and the lack of published literature, particularly concerning the use of humour in FYNSs, the

results from this research can provide insight into a whole cohort and guide future research that may benefit by utilising larger or multi-site samples.

In summary, this sub-section sought to detail the research project methodological approach. It discussed the research design and ethical considerations, and provided details around the chosen site, population, and how informed consent was achieved. Finally, it discussed how the sample of participants across the multiple phases was obtained and any bias identified. The following section will provide the reader with information pertaining to the data collection methods used in this project.

4.3 Data Collection Methods

The data collection utilised both quantitative and qualitative methods. Data were collected along a series of three phases that built on each other. They are synthesised in Figure 4.5. The following sub-sections will provide details of each collection method and will discuss how they were achieved according to each phase of the study.

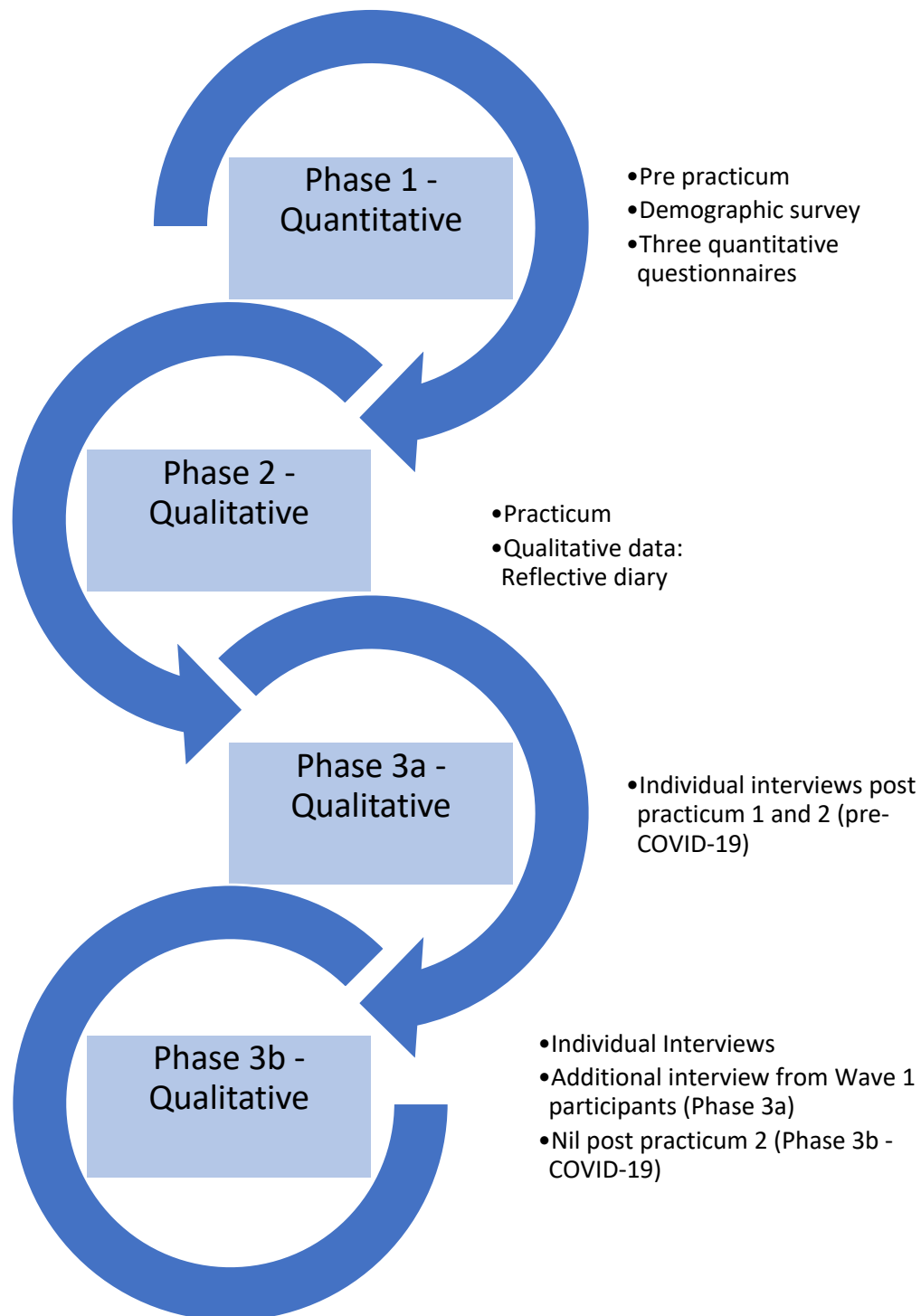


Figure 4.5: Data Collection According to Phases

4.3.1 Quantitative Data Collection—Phase 1

Phase 1 pertained to the quantitative portion of this study and was composed of short demographic questions and three validated instruments. This first phase was performed to obtain a baseline description of the population prior to exposure to the activity of

nursing. The data were collected at the commencement of the first semester of study, during the formative relationship-building period at the commencement of the nursing degree.

The results of the quantitative data collected during this phase were used to inform the elements of the qualitative portion of the research, which forms part of subsequent phases. The researcher will discuss these in the following sub-sections.

4.3.1.1 Variables

The demographic survey collected information on age, prior education, and exposure to health education and employment. The collection of these data was to enable the researcher to account for confounding variables including age and prior exposure to a health-related work setting, both of which might influence humour style.

All other variables directly related to the three guiding research questions. The first variable focused on humour styles for each participant, while the others addressed coping, resilience, and satisfaction with life. These will be paired with the measures used to obtain the variables in the following section.

4.3.1.2 Measures

This section presents the reader with the instruments used to gather the quantitative data for this research. The complete survey was presented to participants in the same order whether online or through paper form. It contained the demographic questionnaire, the HSQ, the CD-RISC-25 and the SWLS. The last three instruments are well known, have been utilised in several research projects, and are popular in the published literature.

The first three guiding research questions for this study sought to obtain data on participants' use of humour, their level of coping and resilience, and their satisfaction with life, as presented in Table 4.1.

Table 4.1: Quantitative Variables and Measures

Variable	Measure
Demographics	Demographic Questionnaire
Humour	Humor Styles Questionnaire (HSQ)
Coping and resilience	Connor–Davidson Resilience Scale 25 (CD-RISC-25)
Life satisfaction	Satisfaction with Life Scale (SWLS)

The one-time survey included all measures. First, participants were asked to answer demographic questions, followed by the HSQ, CD-RISC-25 and SWLS. All questions contained in each instrument were presented in the same order as intended by their author(s). While the questions might have had a flow-on effect from one instrument to the next, the order of presentation was consistent across all surveys to ensure consistency among participants. They are visually represented in Figure 4.6. The questions naturally flowed from personal identifying details to the use of humour, life experience in terms of how a participant manages around life’s challenges, and finally how they rated their overall life experience up to the time of answering the survey.

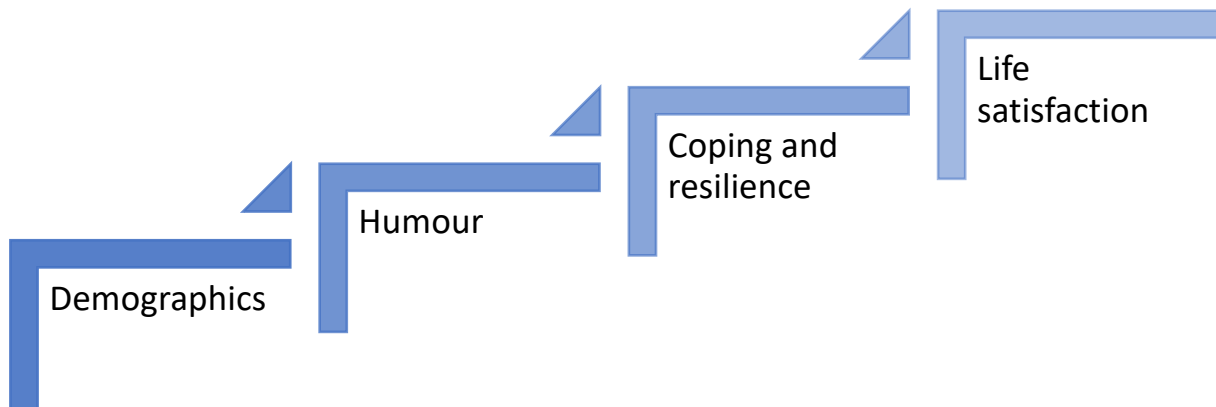


Figure 4.6: Order of Survey Questions

4.3.1.2.1 Demographic Questions

The first part of the survey required participants to answer demographic questions. The data collected from the answers to these questions enabled the researcher to correlate information obtained from the three quantitative instruments along with the following

qualitative data and to draw conclusions from them. In the first seven questions, participants were asked questions about their gender, age, prior studies, current healthcare occupational experience, and willingness to participate in a future phase of the research project. A complete list of these questions can be found in Appendix A. The time to complete the demographic questions was less than 1 minute.

4.3.1.2.2 Humor Styles Questionnaire

The HSQ is a 32-item questionnaire developed by R. A. Martin et al. (2003). It is used to assess individual differences in uses of humour across four dimensions. These four humour dimensions are represented in the instrument's four sub-scales and are identified and defined as:

- affiliative humour: promoting relationships with others
- self-enhancing humour: the gentle use of humour to improve the self
- aggressive humour: the use of humour that will benefit the self at the expense of relationships with others
- self-defeating humour: the use of humour that will benefit the relationships but will be at the detriment of the self.

The HSQ is a widely used instrument for measuring the use of humour and a person's predominant style. It is commonly used in student- and health-related research (Salavera et al., 2020; Schneider et al., 2018). The complete HSQ can be found in Appendix B.

Responses are ranked on a 7-point Likert scale from 1 (*totally disagree*) to 7 (*totally agree*). An item example for each humour sub-scale is presented below:

- Affiliative humour: I laugh and joke a lot with my closest friends.
- Self-enhancing humour: If I am feeling upset or unhappy, I usually try to think of something funny about the situation to make myself feel better.
- Aggressive humour: If someone makes a mistake, I will often tease them about it.
- Self-defeating humour: I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults.

Each of the four sub-scales contains eight items. Individual item scores are added together to obtain the subfactor score, which ranges from 8 to 56. A higher score in any dimension signals a person's tendency to favour this type of humour. The authors of this instrument completed scale reliabilities and intercorrelations tests (R. A. Martin et al., 2003). Their results demonstrated adequate internal consistencies with Cronbach alphas between .77 and .81 for all four scales. Their principal components analysis using varimax rotation returned eigenvalues of 4.7, 3.9, 2.7 and 2.0 on the first four factors and accounted for 41.6% of the variance. The authors' results of their confirmatory factor analysis indicated appropriate matches between the data and the expected factor structure (CMIN/DF = 3.37, GFI = .91, AGFI = .90, RMSEA = .048). The regression weight for each sub-scale with their corresponding eight items from the complete 32-item set ranged between .57 and 1.27 and returned an average of .93 (R. A. Martin et al., 2003).

Permission to use the instrument was granted by the primary author, Dr R. Martin, on 23 August 2018. The time to complete this questionnaire was less than 5 minutes.

4.3.1.2.3 Connor–Davidson Resilience Scale 25

The second instrument of the survey was the CD-RISC-25 (Connor & Davidson, 2003) comprising 25 questions. Each statement is scored on a 5-point Likert scale ranging from 0 (*not true at all*) to 4 (*true nearly all of the time*). The CD-RISC-25 (as well as versions with fewer items) is a widely used instrument for measuring coping and resilience. It is frequently used in student- and nursing-related research (Fowler et al., 2020; Torgheh et al., 2015). The complete CD-RISC-25 can be found in Appendix C.

Scores are added to give a score between 0 and 100. High scores correspond to higher degrees of resilience. Examples of items are:

- Past successes give me confidence in dealing with new challenges and difficulties.
- I tend to bounce back after illness, injury, or other hardships.

The reliability and validity of the instrument have been demonstrated by its authors (Connor & Davidson, 2003). Internal consistency was established with a Cronbach alpha of .89 for the full scale. Factor analysis generated five factors with eigenvalues of

7.47, 1.56, 1.38, 1.38, 1.13 and 1.07. Application of the scale has been identified as compatible with studies that seek to identify adaptive and maladaptive strategies in managing stress, and resilient characteristics (Connor & Davidson, 2003).

Other shorter versions of the scale have also been developed. The CD-RISC-10 comprises 10 questions, totals ranging between 0 and 40, and the CD-RISC-2 contains two questions, with totals ranging between 0 to 8. Only the full 25-item version was used for this study; however, during comparison of results with other published results, the researcher adjusted the score accordingly (Connor & Davidson, 2003).

The prevalent use of the 25-item CD-RISC-25 in numerous studies, including undergraduate nursing populations, confirms its credibility and value. Its test–retest reliability has been established at $r = 0.87$ for the full version; consistency and validity have also been well documented in many research projects (Connor & Davidson, 2003). Permission to use the instrument was granted by the primary author, Dr J. Davidson, on 30 May 2018. The time to complete the test was less than 4 minutes.

4.3.1.2.4 Satisfaction with Life Scale

The third instrument, the SWLS, was developed by Diener et al. (1985) and consists of five questions scored by respondents on a 7-point Likert scale from 1 (*strongly disagree*) to 7 (*strongly agree*). The SWLS is a widely used instrument for measuring global life satisfaction, particularly in student populations, including those in health-related fields such as nursing (Aslan et al., 2020; Chattu et al., 2020).

All five questions' scores are totalled to return a result out of 35. The score interpretation is as follows: 5–9, extremely dissatisfied; 10–14, dissatisfied; 15–19, slightly dissatisfied; 20, neutral; 21–25, slightly satisfied; 26–30, satisfied; 31–35, extremely satisfied.

Examples of items are:

- In most ways, my life is close to my ideal.
- If I could live my life over, I would change almost nothing.

The reliability and validity of the instrument have been demonstrated by its authors (Diener et al., 1985; Pavot & Diener, 2009). Their factor analysis produced a single

factor that accounted for 66% of the variance. The internal consistency coefficient was reported as .87. Scale reliability was also noted to increase with a corresponding larger female population (Vassar, 2008), adding pertinence to its selection in this study. The complete SWLS can be found in Appendix D.

The instrument has been extensively used in research. The scale has been demonstrated to have good stability over time, with reliability above 0.8 and good consistency (Diener et al., 1985). It has been examined in a meta-analysis composed of more than 60 studies (Pavot & Diener, 2008). Its main advantage is its reliance on the respondent's answers based on their own interpretation of a meaningful life, thus avoiding delving into subjective definitions, which may be unequal among participants (Cooke et al., 2016). As per their statement, the use of this instrument was permitted, providing that the authors and the source are acknowledged (Diener et al., 1985). The time to complete the test was less than 1 minute.

4.3.1.3 Quantitative Data Collection Waves

All data were collected in two waves. These waves represent the cohorts of students that were addressed. To improve recruitment of participants and data collection yield, the researcher slightly modified her approach during the second wave. These were previously discussed in 4.2.3.2 and are only briefly mentioned below for continuity.

4.3.1.3.1 Wave 1

During the first contact, students were addressed during a compulsory pre-clinical placement lecture in the first week of the semester. The reader can refer to previous section 4.2.3.2.1 for specific details. No surveys were directly collected during this first contact. During the second face-to-face contact at the end of the semester, a few more students took the opportunity to complete a hard-copy version of the survey while none used their device to complete the electronic version.

4.3.1.3.2 Wave 2

As discussed above and in previous section 4.2.3.2.2, the researcher adjusted the recruitment process to capture a maximum of participants during the second attempt and to circumvent time and restrictions encountered during the first attempt. These

modifications proved successful in achieving a higher response rate. Factual details regarding response rate will be provided in Chapter 5.

4.3.2 Qualitative Data Collection

The qualitative data were collected along two separate phases. Phase 2 pertained to the collection of data through reflective journals. Phase 3 data were collected through individual interviews. These are described separately below.

4.3.2.1 Reflective Journal—Phase 2

The qualitative data were first generated through completion of an online reflective journal. A standard template (Appendix E) was provided to students, with headings that directly followed the format of the HRM (Bass et al., 2017) (Figure 4.7). According to the authors, their model is heavily influenced by other well-known RP models, namely, G. Gibbs (1988), Cranton (1994) and Johns (2000), and is supported by several theoretical and conceptual frameworks—philosophy, transformative learning, ways of knowing, holistic reflection, development of mental process, and holistic concepts—which affords it robustness (Bass et al., 2017).

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Figure 4.7: Holistic Reflective Model (Bass et al., 2017)

This current research's specific reflective questions were adapted from Bass's model and were guided by the population of novice NSs with no prior experience. Each online reflective journal entry required between 15 and 30 minutes to complete, there were no hard copies available. It was anonymous to other participants and structured to promote the recognition of self-perceived behaviours (Hendrix et al., 2012). The weekly journal entries were made available to students on the Friday of each week through a SurveyMonkey© link sent by email. It was easily accessible and user-friendly through a portable device, such as a smartphone, which most students carry daily. Students were then able to complete their entries quickly and easily. Students' online entries were kept confidential on a university password-protected computer. The format is presented in Appendix E.

4.3.2.2 *Individual Interviews—Phase 3*

Phase 3 is further divided to account for slight modifications due to COVID-19. Phase 3a refers to the interviews conducted with participants of W1 and W2 pre-COVID-19, while Phase 3b refers to all second interviews of W2 and the inclusion of a third, extra, interview for participants of W1. In essence, Phase 3a refers to pre-COVID-19 interviews while 3b refers to data affected by the pandemic. Means of data collection across Phases 3a and 3b remained the same. These will now be presented in more detail.

Qualitative interviews were designed to extract further information from participants. All reflective journal entry participants were contacted by email and invited for an interview. Additionally, all initial survey responders who had expressed willingness to be contacted to participate in further phases were contacted by email and encouraged to share their perspectives. Once a participant had responded affirmatively to the invitation, a suitable time and location were set between the researcher and the participant.

Interviews were audio-recorded, and then transcribed verbatim. After the first interview, participants were asked to state whether they were willing to participate in a second interview after their second placement, and their intent was recorded at the time. Participants were contacted by the same method for the second interview.

Repeat emails were sent to participants who did not reply. Participants who responded that they no longer wished to participate were thanked and removed from the list and no longer contacted. After three unanswered emails, the participants were deemed to have withdrawn from the study and were no longer contacted.

Questions for the first interview were formulated after reading participants' reflections and designed to elicit further information centred on the research questions. They are presented in Appendix M. The questions for the second interview were similar to the first, while also including the opportunity for the student to reflect on their entire first year of studies, combining both academic and practical components of that first year. The interview questions were trialled with a NS who could not participate in this study. The questions were refined to ensure understanding.

The research interviewer utilised eliciting and clarifying questions to ensure that the participant's intention and experience were appropriately understood and conveyed in the data. Reflective journals completed by the participants in Phase 2 were used to address the last interview question, including clarifying questions pertaining to better understand answers provided by participants in their reflective journal.

Interview time slightly varied between participants. They lasted between 10:43 and 44.42 minutes each. The average time was 24:41 minutes.

Recorded interviews, once transcribed verbatim, were then de-identified and kept on a password-protected computer. Once this process was completed, the audio recordings were deleted.

Because of COVID-19 and all clinical placements being cancelled, participants from the second wave could not attend their second practicum and had only attended their first practicum. This meant that the second interview questions had to be slightly modified; clarifying questions about their clinical rotation and reflection following the second practicum had become impractical. As the original question was reflective in nature around their 'experience', the interviewer permitted participants to free talk around this during the interview, using minimal use of encouragers and reflection of content to encourage participants to continue talking. For example, with the first wave of students, the question 'Thinking back of your last clinical placement, do you remember if humour was ever present at any time during that practicum?', followed by an encourager to offer examples, was re-formulated as 'Looking back at that first year of study, can you tell me anything about humour in that year?' for the second wave of participants. In respect to the fourth research question, the interviewer asked a general question to encourage participants to reflect on their first year, encompassing their academic and practicum (or lack therefore), which also indirectly addressed the impact of COVID-19 without influencing their answer, for example: 'What has helped you get through that year of study and practicum?' The first group of participants were invited to participate in a third interview to answer similarly broad questions that had been asked of the second wave of participants (for example, 'What has helped you through this semester?') that could also capture the impact of COVID-19 on their semester and first year of study without directly influencing them. The researcher sought advice from the school's Research Coordinator and Ethics Officer at the institution as to whether a formal ethics

amendment was required for a very minor change to the interview questions and to the number of interviews. Given that the changes did not deviate from the main intention of the interviews, an amendment to ethics was not deemed to be required. These interviews are identified along the phases as Phase 3b.

In summary, this section examined the types of data the research sought to obtain during the research project and how this was achieved. It provided details regarding the demographic survey, instruments, and other qualitative information the researcher used. The following section will discuss how the data were analysed.

4.4 Data Analysis

The current section discusses the datasets generated by the research phases together with their combination (Figure 4.8). Each dataset is examined and related to the research question(s) it sought to answer. They are presented below, together with the principal research question and the questions that guided the enquiry. Finally, the researcher will discuss how data triangulation was applied to the research design to increase trustworthiness in the data analysis phase.

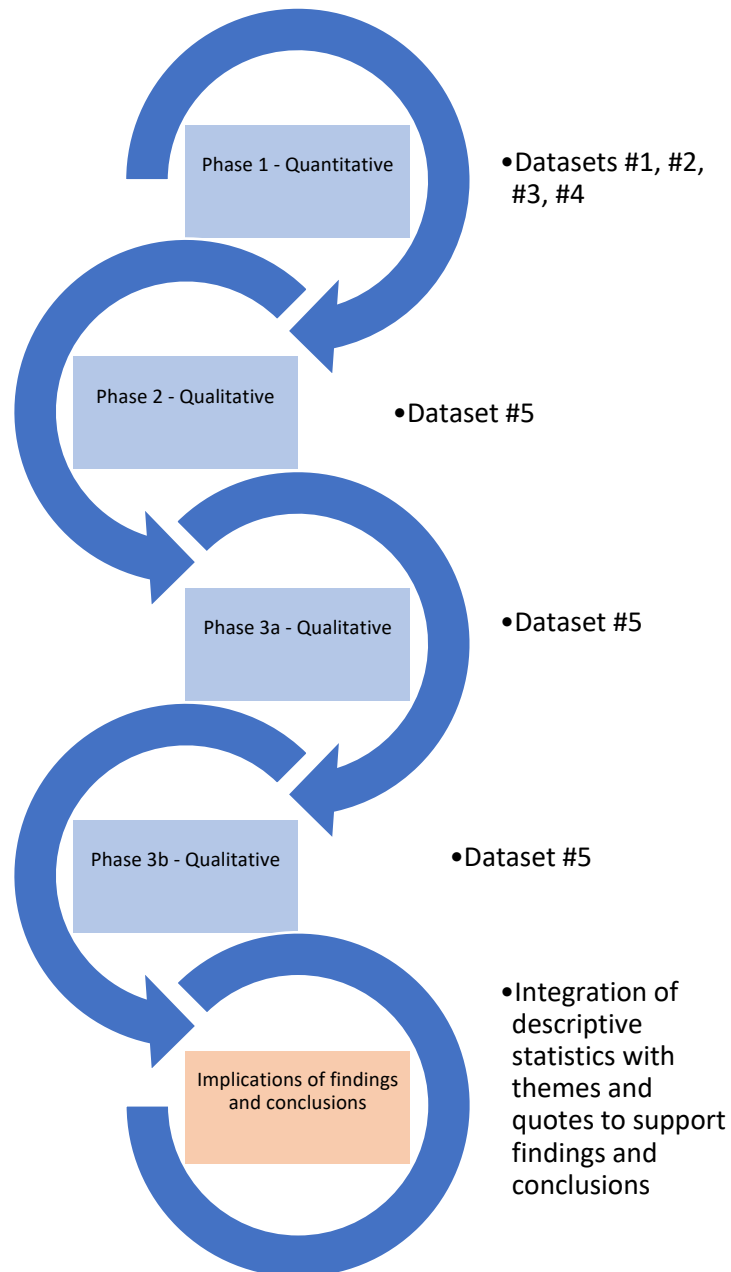


Figure 4.8: Data Analysis According to Research Phases

4.4.1 Datasets

The five datasets were:

- Dataset #1: The quantitative data acquired regarding student demographics reported using descriptive statistics.
- Dataset #2: Results of the HSQ instrument entered in SPSS and reported using descriptive statistics.

- Dataset #3: Results of the CD-RISC instrument entered in SPSS and reported using descriptive statistics.
- Dataset #4: Results of the SWLS instrument entered in SPSS and reported using descriptive statistics.
- Dataset #5: Reflective journals and semi-structured interviews provided by NSs, transcribed for thematic analysis.

As discussed in Chapter 1, the principal research question was: How does humour influence a NS's wellbeing and coping mechanisms at the onset of their undergraduate degree?

This primary research question was to be answered using the following guiding questions and served to direct the study:

1. What is the humour style score of NSs pre first practicum?
2. What is the relationship between NSs' humour style and their overall resilience score pre first practicum?
3. What is the relationship between NSs' humour style and their satisfaction with life?
4. How do NSs perceive their engagement with the activity of nursing studies (both academically and during practicum), how it impacts on personal wellness, and contribute to their coping strategies?

Specific quantitative and qualitative data analysis details are provided below and matched according to the guiding research question they sought to answer:

- Information gathered in datasets one and two was used to answer research question one, which sought to answer which humour style was preferred by the student at the commencement of their study in semester one.
- Datasets one, two and three were utilised to answer research question two regarding the influence humour has on resilience. It also sought to establish whether there was a meaningful relationship between the two.
- Datasets one, two and four were utilised to answer research question three regarding the influence humour has on a student's overall satisfaction with life. It also sought to establish whether there was a meaningful relationship between the two.

- Datasets one, two, three and four were also examined in combination to identify whether meaningful relationships were present between humour, resilience, satisfaction with life, and participants' demographics. Information and results gathered here were used to inform further results obtained in research question four.
- Dataset five was used against research question four, which sought to identify the contributing factors to students' wellness during their first year of nursing studies, including any clinical placements, and the coping strategies influential to these.
- Finally, all results and findings gathered from the above datasets were examined in combination. They sought to explain the overall findings of the study further and to identify major themes. Their combination provided the researcher with sufficient depth of data to enable the main research question to be answered satisfactorily.

4.4.2 Application of Triangulation to this Research

In deciding how to answer a research question, the researcher must consider several aspects to establish the research design and select the appropriate methods of data collection. Flick (2018a) warned that the quality criteria applied in one study method are not necessarily applicable to another. The study should be considered in its entirety rather than being dominated by only one of its arms. As this research aimed to understand how humour influences an NS's wellbeing and coping mechanisms at the onset of their degree, it was broken down into various parts that could cover all aspects of their first year.

The study sought to initially obtain a picture of participants at the onset of their nursing studies by obtaining baseline measures through quantitative data. By utilising various methods, the study then collected information on how participants developed and progressed during their first year of study and how the experience affected them. The quantitative data gathered at the onset of the observational period set the baseline to which further depth was provided by the qualitative data collected throughout that first year. This was completed to provide an initial departing point and to create scope to examine whether the presence of humour and its effects could be detected further along the year, together with any other means for coping and resilience. Four triangulation

methods were used in this study, namely, data triangulation, investigator triangulation, theory triangulation, and methods triangulation, and are depicted in Figure 4.9.

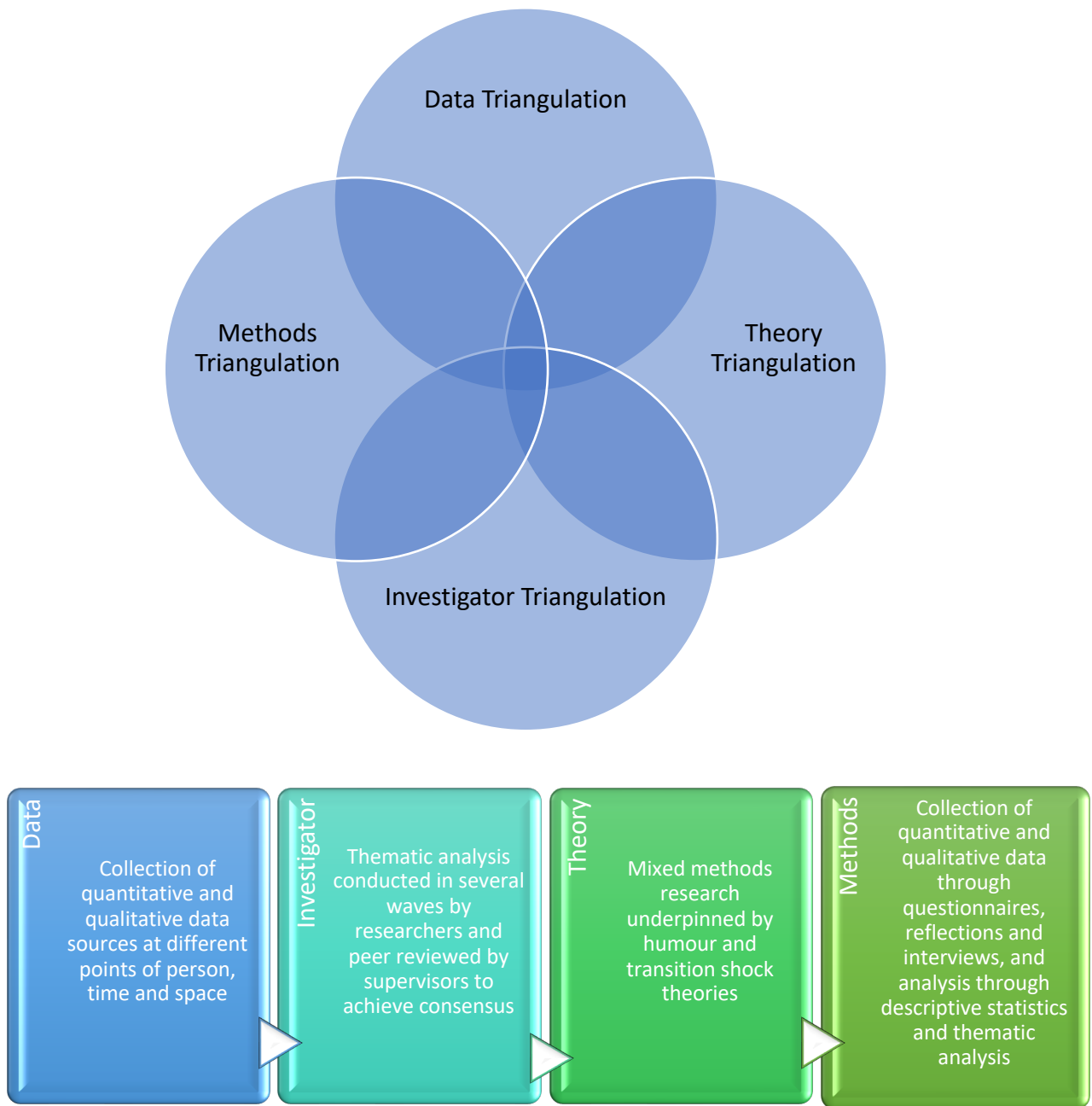


Figure 4.9: Application of Triangulation Methods to this Research Project

The following section will examine how the researcher applied each triangulation method across the span of the study. It will first discuss the reasons for selecting each type of triangulation, and then discuss their application and outcomes. The section will conclude by discussing trustworthiness in relation to investigator triangulation.

4.4.2.1.1 Data Triangulation

Triangulation of data can be achieved by incorporating multiple methods (Moon, 2019). However, Fusch et al. (2018) stated that it is not to be confused with methodological triangulation and asserts that this is one of the most common mistakes made by students when discussing triangulation. Consistent with Denzin (2017), data triangulation occurs at three data points, which are interrelated and enduring, each representing different data regarding the same event. These data points are those of time, space and person.

The researcher sought to observe a particular event along a given continuum. The event was the students' adaptation to their nursing journey along their first year of study (continuum). The elements that served as the guideposts were (1) humour, (2) coping and resilience, and (3) wellbeing across the span of that first year. The researcher observed these elements across time and space. However, the data point of people, which is usually understood as being 'different people' (such as a patient, nurse or doctor) was not applicable per se as only students were observed. However, the researcher sought to observe the 'person' from three different perspectives: a formal questionnaire perspective (initial quantitative measures), a personal introspection perspective (reflection journal) and a two-person dialogue perspective (interview). Thus, three sides of the same person are expressed under the label of data source—person as the term is more appropriate and closely related to the intention of the researcher.

The study commenced with baseline measures of humour styles, coping, resilience, and general wellbeing. As these measures were broad, they provided room for the researcher to observe what features were conducive to coping and wellbeing. Humour was postulated as a potential factor for coping; however, whether this was the case was yet to be identified. Additionally, to be determined was whether other coping factors were present or meaningful. Triangulation can assist in identifying unexpected findings (Moon, 2019) and was, therefore, an informed method to include. Thus, time, space and source were the types of data triangulation utilised in this study (Figure 4.10). They will each be discussed in more detail in the following paragraphs.

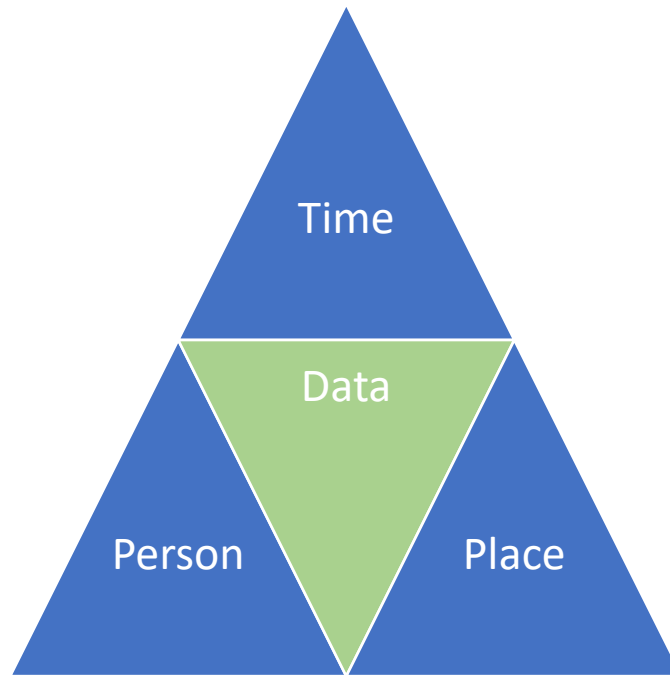


Figure 4.10: Application of Triangulation Across the Span of the Study

The first type of data triangulation integrated into the study design was that of time. The researcher sought to observe participants for specific elements of humour, coping and resilience, and collect data at given points in time. These times were (1) at the start of their learning journey before engaging in clinical practice, (2) during the first practicum, and (3) after completion of semesters one and two (Figure 4.11). Quantitative data in the form of questionnaires were collected at the start of the journey. At all other times, the researcher recorded and collected qualitative data in the form of reflective journals and semi-structured interviews.

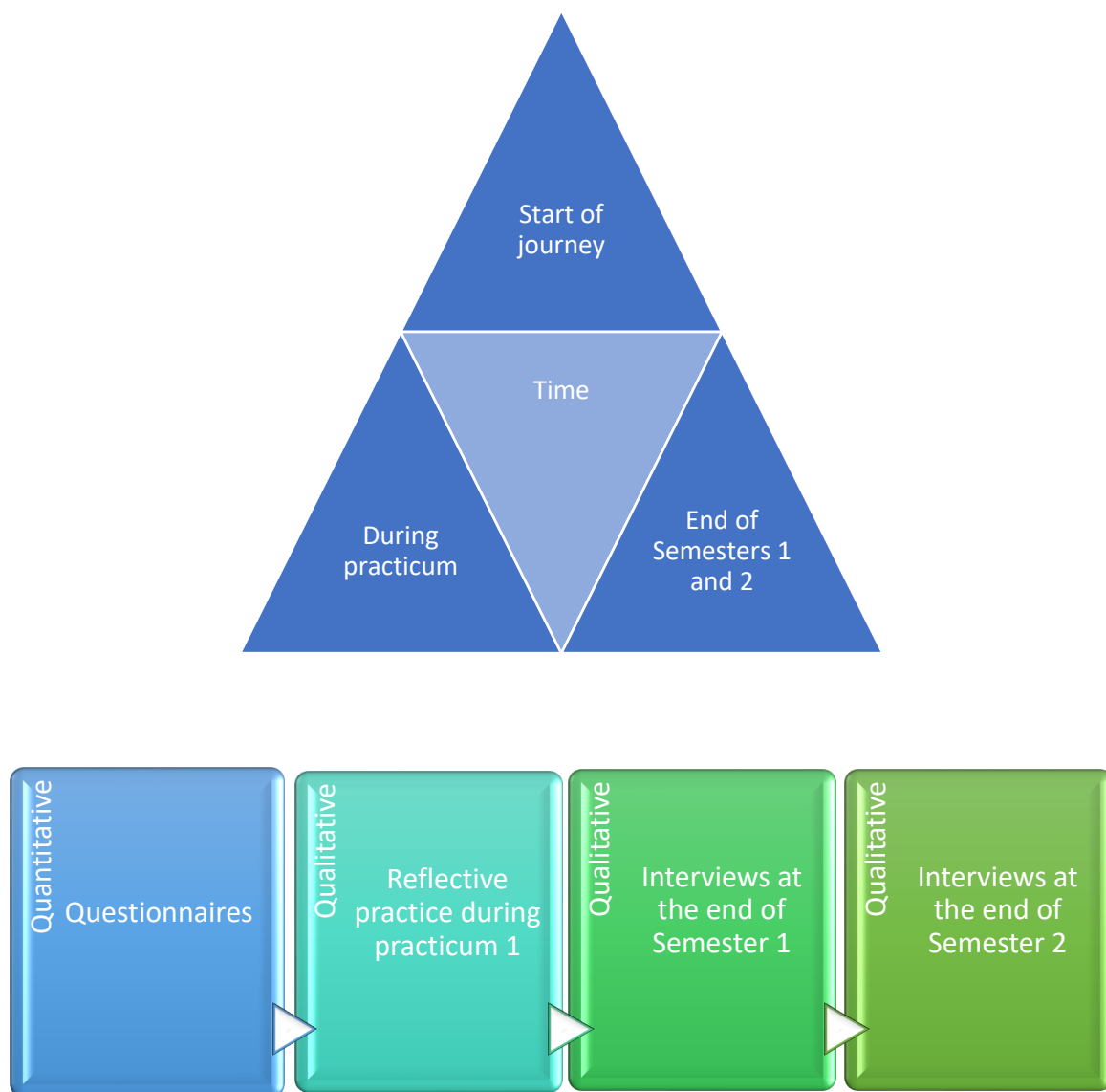


Figure 4.11: Application of Data (Time) Triangulation to this Research

The combination of surveys and interviews is the most common type of data source in mixed methods design (Bryman, 2006; Fielding, 2012). As discussed previously, triangulation of data is not to be confused with methodological triangulation (Denzin, 2017; Fusch et al., 2018). However, in the context of this research, the data ‘source’ offers a different perspective of the same person (people) during the continuum of the study. As the student develops along this continuum, the researcher sought to capture a snapshot of the student at four significant time points and affected by four different moments of significance: (1) the person at the commencement of their study journey, (2) the person during their first clinical practicum, (3) the person after their first practicum

and (4) the person after their second practicum. These were captured through three different sources of data at the four times mentioned previously: (1) the survey and questionnaires, (2) the guided reflections, and (3) the semi-structured interviews, and are represented in Figure 4.12.

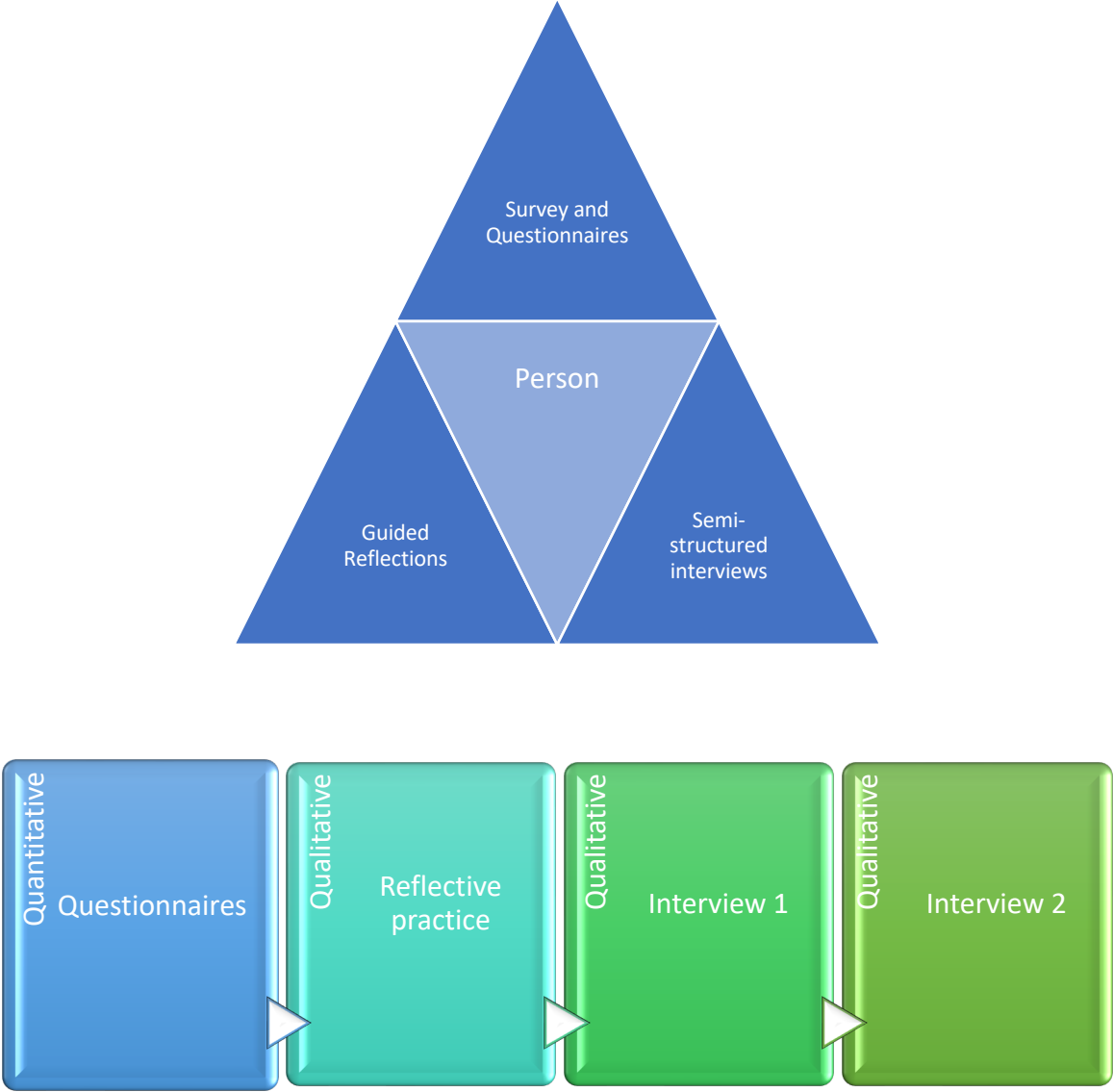


Figure 4.12: Application of Data (Person) Triangulation to this Research

The areas and means of data collection offered to researchers are continuously evolving, the increased use of technology and mobile methods being prime examples. The internet can be seen as a *tool* to study people, as a *place* or, as a *way of being* (Flick, 2018b; Markham, 2018). In attempts to capture various angles of a subject’s experience, the researcher may choose to collect data where the subject is placed in a

'different place' or a 'different space'. The choice of which data to use, alone or in combination, must be driven by the research question(s) and design of the study (Moon, 2019). Because the researcher's aim for this study was to uncover the influential role of humour on the NS's wellbeing, together with other possible coping mechanisms, along the student's evolution at the onset of their nursing study, it was warranted to examine the effect of every setting, or place, the participant found themselves in.

In this current research, data pertaining to the participants' experience were collected in a variety of places, which offered insight into their experience within that space (Figure 4.13). The first place was that of the participant completing a questionnaire within the physical environment of the academic world. The second was that of the clinical setting and was captured through participants completing personal reflections online. The final place was that of the relational space offered by the face-to-face semi-structured interviews. Participants were thought to be equally affected by the passage of time (discussed earlier), the activity they engaged in (different person), and the space they found themselves at the time of these (place).

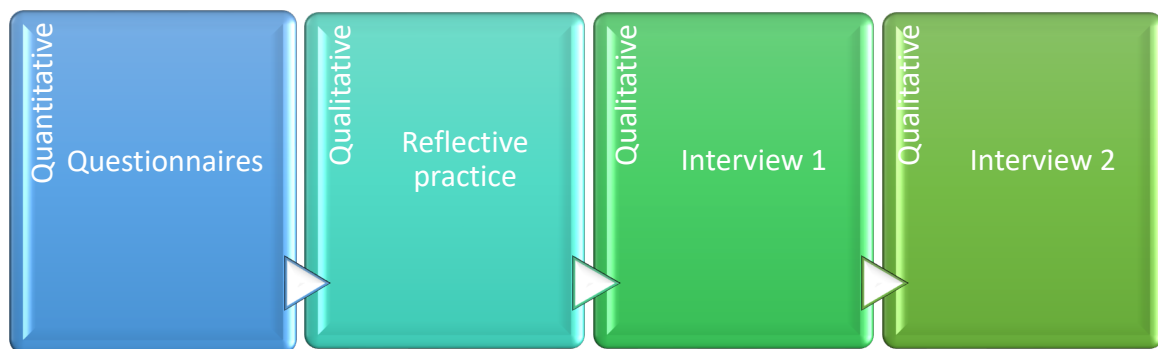
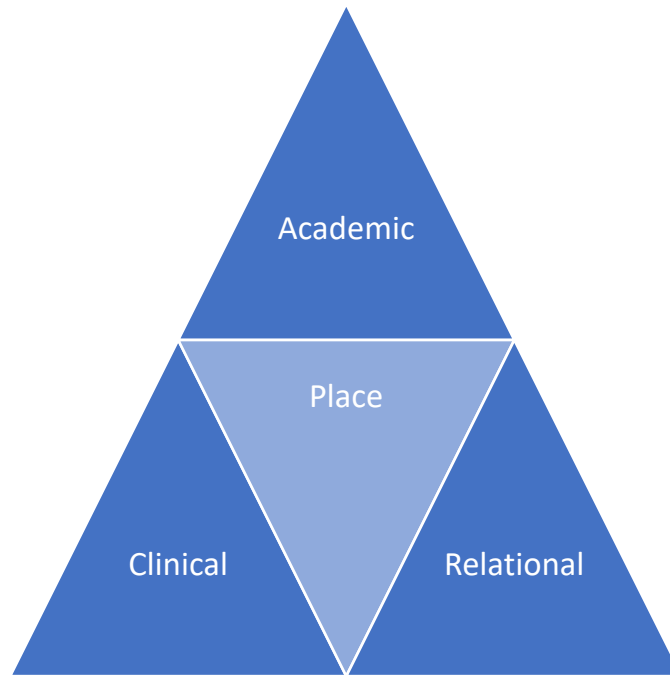


Figure 4.13: Application of Data (Place) Triangulation to this Research

4.4.2.1.2 Theory Triangulation

Theory triangulation refers to the application of different theories to the dataset to guide design, implementation, and the interpretation of data (Moon, 2019). In discussing various strategic approaches to theory triangulation, Fusch et al. (2018) stated that the data can be viewed through one theoretical lens, and then contrasted with a contradictory one. For this study, the researcher used two different theories, which to some degree have some common features (Figure 4.14). Transition shock theory centres around the adjustment period of the new GN and its effect on self and others, as well as its effects on relationships, roles, responsibilities and learning. It was

contrasted with humour styles theory, which pertains to the role of humour and its adaptive and maladaptive consequences for self and others. Despite their commonalities around relationships, both theories come from different perspectives and can help elicit influential or ineffective elements of adaptation on a student's learning journey.

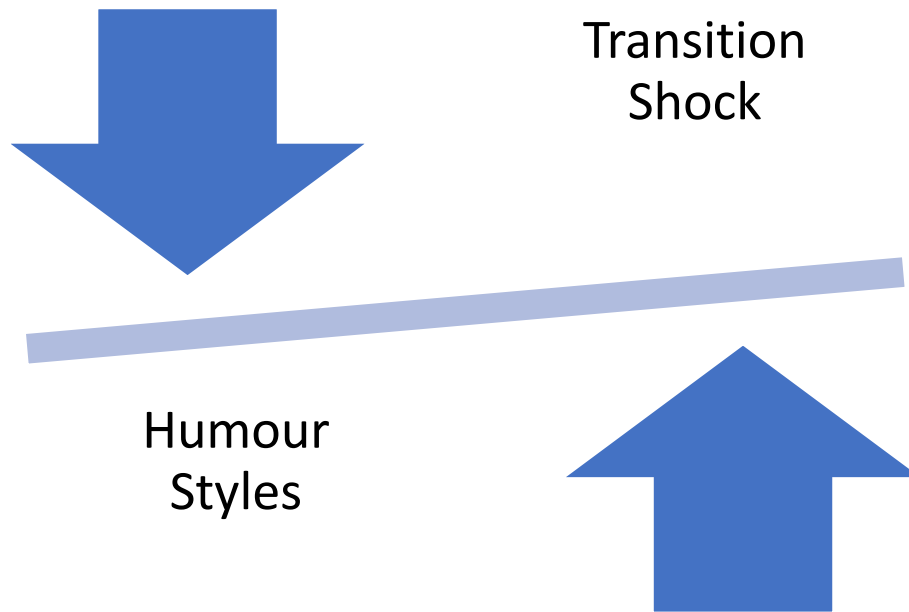


Figure 4.14: Application of Theory Triangulation to this Research

4.4.2.1.3 Investigator Triangulation

Investigator triangulation refers to more than one researcher collecting and analysing the data; however, an additional researcher must be more than simply a coder, an assistant, or a data analyst (Denzin, 2017). This study, being in the context of doctoral research, only had one researcher collecting the data, not two. From this perspective, investigator triangulation does not fully apply to this project. Nonetheless, the doctoral project was overseen by two university supervisors, one being an associate professor and one an academic doctor, both taking an active part in the thematic analysis part of the qualitative data analysis. The university biostatistician was also consulted during the project.

As outlined by Flick (2011), a study requiring several approaches may benefit from the input of more than one researcher. One of the most challenging dilemmas faced by a

researcher is ensuring that they hear and consider other people's perspectives during the research process (Fusch et al., 2018). This demands that the researcher recognise their personal views and other factors that could distort their analysis and findings (Fusch et al., 2018).

Bias is alleviated by having different investigators examining the same data with the potential for interpretive differences (Fusch et al., 2018). The present study benefited by including the two supervisors and their impartial perspectives; they were a degree removed from the data collected, which reduced the risk of confirmation or analysis bias. These types of biases may occur organically during the analysis process; the researcher may look for information to support their personal view and overlook data that may be contrary to their existing belief or expected hypothesis confirmation (J. Smith & Noble, 2014). Both supervisors participated in the development, review and acceptance of codes and themes during the qualitative data analysis. A second layer of scrutiny of the data by another researcher also constitutes investigator triangulation as it offers a different researcher's influence over the study and its results (Flick, 2018a; Moon, 2019). This provides external validity by that researcher's involvement during the results stage; having another member or expert checking is an analytical technique for demonstrating validity (Whittemore et al., 2001). In this respect, the researcher deems that the input of the supervisors and the other researcher provided an added layer of scrutiny of the project, derived from their respective professional expertise; therefore, these individuals fit the notional understanding of 'investigator' as it is understood in the context of investigator triangulation.

4.4.3 Quantitative Data Analysis

The results obtained from the three instruments (HSQ, CD-RISC and SWLS) were first imported into Microsoft Excel to clean the data. The data were then imported into SPSS (SPSS Statistics, n.d.), statistical analysis software used by students and professionals (Creswell & Creswell, 2018). In SPSS, the data were analysed using descriptive statistics, including frequencies, means and standard deviations. This enabled a general analytical overview, including identification of correlations between each measure and against other measures. These results will be presented in Chapter 5.

The three instruments completed by participants all provided a score with which to interpret and analyse the results as standalone measures. The three instruments have

been utilised extensively in previous research, including similar nursing and undergraduate populations, thereby facilitating data comparison between this research and other published studies. This enabled the researcher to substantiate the results of this study against others. This is discussed in depth in Chapter 7—Merging of Results and Discussion.

The determination of rigour in quantitative research is achieved by examining the quality of the research (Claydon, 2015). Rigour of the quantitative portion of this study was therefore achieved by consulting external parties to the main research group of the author and the two supervisors. First, the researcher keyed in all the data in SPSS and performed statistical tests such as correlations. A de-identified Excel data file was shared with a third party who performed the same tests. The researcher then compared with her results to ensure that she achieved the same. Second, once the data analysis had been performed and written up, the researcher enlisted the help of a colleague outside of her research team, who is an academic researcher of predominantly quantitative research, who reviewed the results and interpretations to ensure readability, meaningfulness of statistical tests, and their correlation with the findings. The independent input from these two external parties means that the reader can be confident the results are sound and withstand external scrutiny.

4.4.4 Qualitative Data Analysis

The complete verbatim transcript of reflective journals and interviews were de-identified and printed. The entirety of the qualitative data was read several times by the researcher and two supervisors individually, and then as a group.

The coding of qualitative data was completed through two coding cycles. Braun and Clarke (2006) explained that data extracts can be uncoded or coded once or as often as deemed relevant, and can fit into many different themes. For this research, the researcher and supervisors conducted an initial round of coding individually. All three members then subsequently met as a group to complete a second round of coding. They compared and discussed their individual coding until consensus was reached. Together, they formulated categories, which grouped the identified codes. With these categories, emerging themes were identified, which enabled the formulation of findings (Figure 4.15).

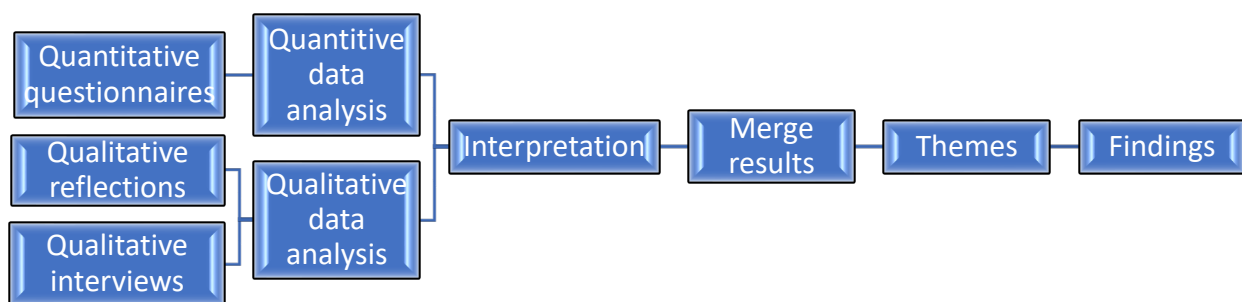


Figure 4.15: Explanatory Sequential Design—Data Analysis

The research team utilised Clarke and Braun’s thematic analysis method, which provided a flexible approach for identifying, analysing, and reporting patterns of meaning (or themes) within the qualitative data, well suited to most studies (Braun & Clarke, 2006). The qualitative data were examined as a standalone measure and were used to describe any changes in the pre- and post-quantitative results. The data collection sequence was driven by two theoretical perspectives: transition shock and humour theories. They were chosen as both provide insight into a person’s behaviour concerning coping and adaptation. Their use sought to analyse the effect of nursing on the student nurse while also potentially denoting any initial personal characteristics that could account for the change.

The rigour and trustworthiness for this research was achieved through several means. Barbour (2001) warned against simply resorting to the use of checklists to confer rigour, rather calling on adequate inserting of these in the research design and data analysis. First, the imbedding of multiple triangulations within the study design meant that data were collected and scrutinised from several angles. This was to maximise the uncovering of meaningful data and to reduce blind spots. Second, as discussed above, the qualitative data were coded multiple times and involved more than one person to reduce the risk of researcher’s bias and subjectivity. Multiple rounds of coding and the cross referencing of coding are effective strategies to ensure trustworthiness (Barbour, 2001).

Additionally, the researcher and the supervisory team used reflexivity during supervisory meetings during all research phases. Reflexive thinking is particularly

effective in ensuring good quality in qualitative research projects (Newton et al., 2012, Rettke et al., 2018). The team met usually monthly and more frequently as required, for example, when the researcher was experiencing difficulties due to COVID requiring multiple modifications, meaning that reflexivity was entwined in the whole research process.

During specific phases of the project, the three members of the team had the opportunity to debate their point and question others over their rationale until mutual agreement was achieved. The scrutiny of others alleviated the potential for the researcher's bias. Additionally, the supervisory team was composed of two researchers with different research experience that enriched the debate among team members and provided additional and valuable input.

This section informed the reader of the multiple datasets obtained and how they were utilised to answer the main research question and its guiding four sub-questions. It also provided the reader with specific information regarding how trustworthiness and rigour were established, particularly with the use of triangulation, and how they were imbedded in the research design and applied to the data analysis.

Specific details regarding data analysis and results will be presented in subsequent chapters of this thesis. Chapter 5 will present the reader with results of the quantitative data, while Chapter 6 will present the results of the qualitative data. Further, the quantitative and qualitative results are merged in Chapter 7, together with a discussion.

4.5 Chapter Summary

This chapter described how the research project was planned and conducted. It discussed the methodological approach that was followed. It described the research design used to build the phases of the research, explained how they related to each other, and discussed the ethical considerations and the measures utilised to address them. It also discussed the site and sample of the population captured. Following this, this chapter provided extensive details regarding both the quantitative and the qualitative arms of the research, including data collection and analysis. Finally, the researcher detailed how rigour and trustworthiness were applied to the project.

The researcher's goal was to conduct a research project that would identify and respect the strengths observed and honoured in the student nurse. The researcher was motivated to find out whether NSs possessed these individual strengths and coping skills prior to embarking on their nursing journey and to what extent nursing itself as an activity affected these elements. The researcher sought to answer whether NSs start their journey 'strong' or whether they 'strengthen up' along the journey.

Chapter 5: Quantitative Data Results, Analysis and Findings

5.1 Introduction

While Chapter 1 introduced the reader to the research project and its origin, Chapter 2 presented the supporting literature and Chapter 3 the theoretical foundations of the study. In Chapter 4, the researcher described the framework used to shape the project, including its methodology and multiple phases of quantitative and qualitative data expected from an MMR project.

This chapter will provide participants with details for the quantitative phase. It will describe the analytical strategy used together with the results for each measure while the next chapter, Chapter 6, will do the same in respect to the qualitative component. In Chapter 7, the researcher will combine the quantitative and qualitative results and will present a comparison of findings.

Nursing has a culture of its own, multifaceted, subject to varying interpretations and meanings, and at times contradictory in nature; nurses can be described as being both caring and unkind towards the novice nurse (Strouse & Nickerson, 2016). It is distinct from other health professions, such as medical practitioners (Degeling et al., 2001; Anya Johnson et al., 2018), and differs across ethnic backgrounds (Jose, 2008; Pung & Goh, 2017). In acculturating into this profession, NSs will be affected by the group as much as by their individual experiences. The researcher sought to obtain a clear picture of a cohort of students embarking on their nursing journey and the details for each individual participant prior to being affected by the reality of the nursing culture encountered in the clinical field.

This chapter is centred around the first three guiding questions used to answer the principal research question for this study. The three questions are repeated here to assist the reader and are:

1. What is the humour style score of NSs pre first practicum?
2. What is the relationship between NSs' humour style and their overall resilience score pre first practicum?
3. What is the relationship between NSs' humour style and their satisfaction with life?

The following sections in this chapter will provide information regarding the data collected, the analytical strategy that was used and the results obtained. Following this, a discussion will be presented in relation to the findings.

5.2 Participation Quantitative Results – Phase 1

Specifically, the population chosen for this study was FYNSs at the commencement of their nursing degree. The sample was selected from one university in WA. The recruitment exposure lasted for a whole academic semester for each cohort, spanning across 11 weeks and including the exam period, equating to approximately 22 weeks in total for the complete quantitative data collection.

The quantitative data collection period was from the February to September 2019 academic year, between February and May for Wave 1 (W1) and July and October for Wave 2 (W2). The enrolment rate for each into of their academic units pertinent to data collection is itemised in Table 5.1. The figures are presented according to each of the two semesters and include students' non-enrolment rate (continuation rate) between theoretical and practicum courses. This information is important in accounting for a reduction in sample size further along this study.

Table 5.1: Description of Cohorts Waves Based on Academic Enrolment

	Semester	Students	Continuation rate ^a	Continuation rate ^b
Wave 1				
Course—Nursing Care	1	250		
Practicum	1	204	18%	
Course—Nursing Care	2	209		16%
Practicum	2	192	8%	
Wave 2				
Course—Nursing Care	1	212		
Practicum	1	195	8%	
Course—Nursing Care	2	175		17%
Practicum	2	185	-6% ^c	

Note: ^a Academic dropout rate before attending a practicum; ^b Academic dropout rate between semesters; ^c Positive academic dropout rate due to some students catching up from a previous semester.

The sample is appropriate for the intent of the study because one of the goals at the beginning of the research project was to obtain a well-rounded assessment of NSs prior to being influenced by activity nursing the encountered during their practicum.

W1 had 250 students enrolled (Table 5.2 below), of whom 52 participants (20.8%) commenced the survey and 38 completed it. All recruitment attempts discussed above for W1 resulted in a 15.2% completion rate. There were 212 student enrolments in W2. Of those, 117 (55.1%) commenced the survey and 110 (51.8%) completed it. Most of the surveys were completed during the first lecture, and a few were returned later during the semester following electronic email reminder communications through their online learning platform Blackboard®.

Table 5.2: Initial Survey Response Rate

	Wave 1	Wave 2	Total
Students enrolled	250	212	462
Survey—commenced	52 (20.8%)	117 (55.1%)	169 (36.6%)
Survey—completed	38	110	148
Response rate	15.2%	51.8%	32%

All recruitment efforts resulted in 148 total participants. An adequate sample size to achieve a confidence interval of 95% would have required 210 participants (Australian Bureau of Statistics, n.d.). Our sample size was however higher than those of several published papers examining a NS population. This is particularly relevant to published results for the CD-RISC and SWLS measures used for this research. Several publications using the HSQ measure had larger general student samples, but our study was the only one with a population of FYNSs. Additionally, our response rate was similar to those in research conducted with FYNSs in Australia (Alshahrani et al., 2018). The quantitative results achieved in this study provide information in their own right and were used to further inform the qualitative arm of the project to enrich the findings.

The combination of all recruitment attempts produced a 15.2% response rate for W1. This improved strategy for W2 produced a 51.8% response rate. The recruitment strategy modifications applied to W2 proved effective; the higher response rate obtained from W2 was achieved by providing more time during the initial face-to-face meeting

and the opportunity to complete the survey without delay. There are several factors affecting response rate, including the lack of prior involvement with the target population (Groves & Peytcheva, 2008).

5.3 Analytical Strategy

All data were transferred and manipulated through Microsoft Excel and SPSS (V.28) databases (SPSS Statistics, n.d.). The initial data captured in SurveyMonkey© were extracted in an Excel format, where the data were then cleaned. This was done by removing any duplicate and unwanted information such as time, and start and end date, of collection. All questions were answered by participants, apart from one participant who omitted to answer questions in the last instrument (SWLS) (five items). This participant's answers for the other instruments were kept. This accounts for the discrepancy of frequency in respondents, which is usually stated as 148, and will appear as 147 for questions pertaining to the SWLS.

Once in Excel, the data were transformed into numerical data. For example, answers to demographic questions, such as 'Please specify which would best describe the type of studies that you have previously enrolled in or completed', were given a numerical code. Answers to instruments were all recorded according to a Likert scale; however, the HSQ instrument contains 11 statements that are reversed-keyed. These were manually adjusted.

Visual validation of the data was done by scanning through the Excel document. The researcher looked for data that appeared to be incongruent with the rest of the set, missing or duplicated. Once the researcher was satisfied the data had been cleaned, they were transferred into SPSS V.28 (SPSS Statistics, n.d.) for further statistical manipulation.

The use of both programs enabled the production of tables and graphs to better understand the composition of the population group in terms of age, previous studies, and occupational roles, and provided the ability to perform statistical tests. Additionally, various statistical tests were performed to identify relationships between scales' scores.

Demographic variables were used to develop groupings. Participants' age was grouped by decades, with the first commencing with the youngest age of participants: 17–19,

20–29, 30–39, 40–49 and ≥50 years of age. In descriptive analyses, the two age groups utilised were group one, 17–19 years of age, and group two, 20 years and above. Gender was classified as female or male.

Confounding variables were identified as prior exposure to education and employment, and whether either of these were health-related or not. Data concerning these were collected in the demographic survey and utilised in inferential tests including correlations.

Each measure was analysed using descriptive statistics. Descriptive statistics are utilised to provide a general summary and overview to describe a given sample through totals, means, frequencies and percentages. This information is presented succinctly in tables and other visual summaries easily accessible to the reader (Kaliyadan & Kulkarni, 2019). Additionally, regression analysis and Pearson correlation tests were performed to identify relationships between scales' scores. For example, the researcher attempted to determine whether there were meaningful relationships between students' sub-type humour score, CD-RISC score and SWLS score. These results will be discussed in more detail according to each questionnaire or scale further in this chapter.

5.4 Results

The following section will present the results obtained from the analysis of data. These results will first be presented according to demographics, followed by each measure used, namely, humour styles, coping and resilience, and life satisfaction. Finally, results of comparisons between instruments will be presented.

5.4.1 Demographics

Of 148 FYNSSs, 87.2% were female and 12.8% were male. W1 had 38 participants, of which 94.7% were female ($n = 36$) and 5.3% male ($n = 2$) (Table 5.3). W2 had more male participants ($n = 17$) than W1, representing 15.5% of the cohort, while female participants comprised 84.5% of W2 ($n = 93$). The gender distribution of participants in this study sample is consistent with the nursing population registered to practice in Australia in 2019. Currently, the nursing workforce includes 88% females and 12% males (NMBA, 2020). The consistency in gender distribution in this research compared to the nursing workforce points to the relevance of results across the nursing population.

Table 5.3: Wave Participants by Gender

Baseline characteristic	Wave 1		Wave 2		Full sample	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender						
Female	36	94.7	93	84.5	129	87.2
Male	2	5.3	17	15.5	19	12.8
Full sample cohort	38	100.0	110	100.0	148	100.0

The majority of participants were young adults, with a mean age of 20.74 years ($SD = 5.56$). Participants' age was later placed in categories according to decades, the first beginning with the youngest age of participant (17 years). Those above 50 years of age were placed in a single category because of their low number (Table 5.4). These categories were self-made and used to examine the data with a view to maximise the availability of statistically significant results and conclusions. In some statistical tests, such as analysis of variance (ANOVA), the only participant above 50 years of age was included in the 40–49 years group, therefore forming a >40 years group category to enable the completion of the test.

Table 5.4: Participant Demographics by Gender and Age Distribution

Baseline characteristic	Female		Male		Full sample	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Age						
17–19	87	91.6	8	8.4	95	64.2
20–29	35	79.5	9	20.5	44	29.7
30–39	5	83.3	1	16.7	6	4.1
40–49	2	100.0	0	0.0	2	1.4
≥50	0	0.0	1	100.0	1	0.6
Full sample cohort	129	87.2	19	12.8	148	100.0

A total of 63 participants (42.6%) stated having commenced or completed other studies prior to enrolling in their nursing degree. The majority of them had done so in the previous 12 months ($n = 40$). A small number of participants ($n = 26$, 17.6%) responded 'yes' to currently working in the healthcare industry. Roles varied but were predominantly as assistant in nursing (AIN), medical/dental receptionist ($n = 4$ for each),

pharmacy assistant ($n = 3$), care worker, clinical trial assistant and support worker ($n = 2$ for each). A complete table can be found in Appendix P.

5.4.2 Humor Styles Questionnaire

The following sub-sections will provide the results around the HSQ. Results will be presented around demographics of age and gender. Additionally, results pertaining to each of the four humour styles will also be provided.

5.4.2.1 Humour Styles by Age

In terms of humour styles, affiliative humour was the most frequent type of self-identified use of humour by participants of all ages. A total of 82.4% ($n = 122$) of participants scored higher on this humour scale than on any other sub-scale (Table 5.5). This result was also consistent across age brackets, with the slight exception of the 30–39 age group ($n = 6$), where affiliative humour was rated a close second to self-enhancing humour.

Table 5.5: Humour Style by Age

Humour style	Age bracket										Full sample	
	17–19		20–29		30–39		40–49		≥50			
	<i>n</i>	% ^a	<i>n</i>	% ^a	<i>n</i>	% ^a	<i>n</i>	% ^a	<i>n</i>	% ^a	<i>n</i>	% ^b
Affiliative	79	64.8	38	31.1	2	1.6	2	1.6	1	0.8	122	82.4
Self-enhancing	13	61.9	4	19.0	4	19.0	0	0.0	0	0.0	21	14.2
Aggressive	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	1	0.7
Self-defeating	3	75.0	1	25.0	0	0.0	0	0.0	0	0.0	4	2.7
Total	95		44		6		2		1		148	100.0

Note: ^a Percentage across all age brackets; ^b Percentage across all participants.

One supposition was that the use of humour was affected by age. Our sample comprised a majority of young participants aged 19 years or less. We tested this assumption by using each humour style mean with age, grouped as those aged 17–19 years (group 1) and ≥20 years (group 2). An independent samples *t*-test, presented in Table 5.6, returned Cohen effect sizes ranging between -.06 and -.28 for all humour styles. Cohen effect sizes of .2 and below are considered small (Cohen, 1977); thus, age did not have an effect on humour.

Table 5.6: Effect of Age on Humour Styles

Humour style	17–19 years		≥20 years		<i>t</i> (146)	<i>p</i>	Cohen's <i>d</i>	CI	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>					
Affiliative	46.35	5.51	46.68	6.99	-.32	.75	-.06	-2.39	1.73
Self-enhancing	38.75	7.78	40.83	8.00	-1.55	.12	-.27	-4.75	.58
Aggressive	22.24	7.29	24.53	9.60	-1.63	.11	-.28	-5.06	.49
Self-defeating	31.76	8.16	29.42	10.25	1.52	.13	.26	-.70	5.38

5.4.2.2 Humour Styles by Gender

A second possibility was that the use of humour was affected by gender. Our sample comprised a majority of females. We tested each humour style mean with gender, grouped as female (group 1) and male (group 2).

A series of independent samples *t*-tests were performed to ascertain whether humour styles were affected by gender. Results were that two of the humour styles were affected by gender. For affiliative humour, the two gender groups differed significantly ($t(146) = 2.0$, $p = .05$, $d = .49$, 95% CI [.03, 5.87]). The mean for the female group ($M = 46.84$, $SD = 5.85$) was significantly different from that of the male group ($M = 43.89$, $SD = 6.99$). Similarly, the two gender groups differed significantly regarding aggressive humour, ($t(146) = -5.17$, $p = <0.001$, $d = -1.27$, 95% CI [-13.34, -5.96]). The mean for the female group ($M = 21.82$, $SD = 7.39$) was significantly different from that of the male group ($M = 31.47$, $SD = 8.94$). These findings support the idea that there is a moderate difference in affiliative humour score between genders, with females scoring higher than males, while there was a large difference in aggressive humour scores between them, being more favoured by males.

The other two humour styles were not affected by gender. In self-enhancing humour, the two gender groups did not differ significantly ($t(146) = .78$, $p = .45$, $d = .19$, 95% CI [-2.37, 5.31]). The mean for the female group ($M = 39.68$, $SD = 7.86$) was not significantly different from that of the male group ($M = 38.21$, $SD = 8.23$). In self-defeating humour, the two gender groups also did not differ significantly ($t(146) = -.48$, $p = .63$, $d = -.12$, 95% CI [-5.45, 3.33]). The mean for the female group ($M = 30.78$, $SD = 9.18$) was not significantly different from that of the male group ($M = 31.84$,

$SD = 7.89$). The findings do not support the assertion that there is a difference in self-enhancing or self-defeating humour score between genders in first-semester NSs.

Regardless of gender, the affiliative humour style was the most preferred humour style by the majority of participants in this study (Figure 5.1). The second highest was the self-enhancing style. As discussed previously, both of these styles promote positive relationships and outlook on life and have a beneficial effect on self and others (R. A. Martin & Ford, 2018). Humour styles with the potential to lower a person’s self-esteem (self-defeating) and negatively affect interpersonal relationships (aggressive humour) were the lowest ranking of the four. This shows that the majority of young female participants significantly favoured a positive use of humour, although a gender difference existed with the aggressive style.

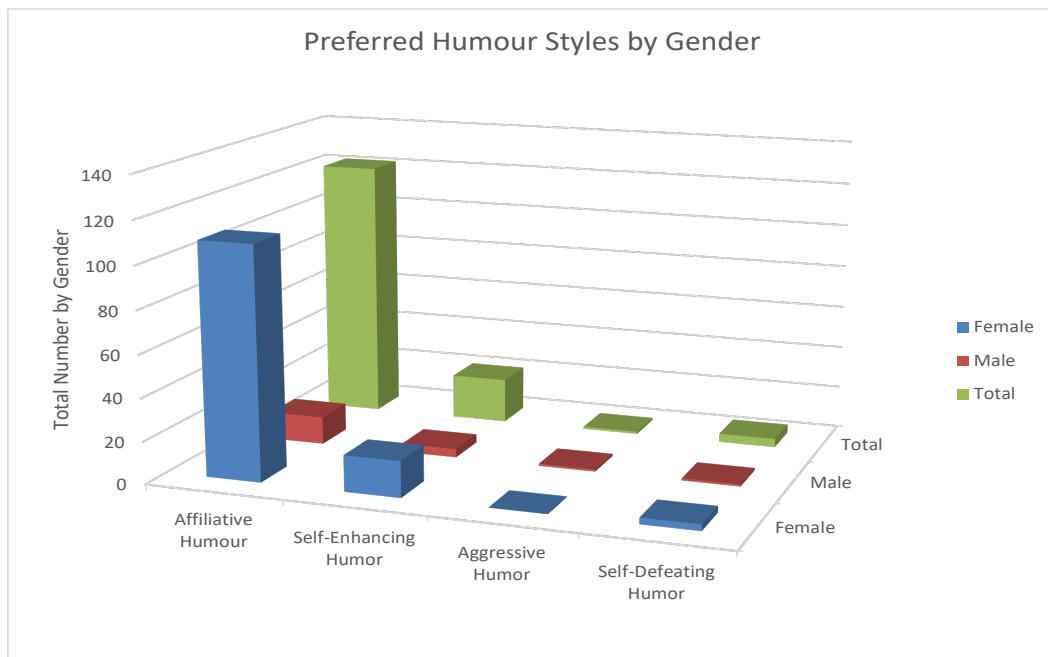


Figure 5.1: Humour Style by Gender

Across gender, humour styles facilitating positive relationships ranked the highest, with 143 participants (Table 5.7). Affiliative and self-enhancing styles consistently returned higher means regardless of gender (Affiliative: females: $M = 46.84$, $SD = 5.85$; males: $M = 43.89$, $SD = 6.99$; Self-enhancing: females: $M = 39.68$, $SD = 7.86$; males: $M = 38.21$, $SD = 8.23$). Aggressive humour was the least preferred across gender, being predominantly favoured by only one participant, who scored highest on the aggressive scale.

Table 5.7: Humour Style Results by Gender

Humour style	Female				Male				Full sample					
	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	<i>n</i>	%
Affiliative	22	55	46.84	5.85	31	55	43.89	6.99	22	55	46.47	6.06	122	82.43
Self-enhancing	9	56	39.68	7.86	20	53	38.21	8.23	9	56	39.49	7.89	21	14.19
Aggressive	8	43	21.82	7.38	22	56	31.47	8.94	8	56	23.06	8.23	1	0.68
Self-defeating	9	48	30.78	9.18	19	47	31.84	7.89	9	48	30.92	9.00	4	2.70

5.4.2.3 Affiliative Humour

Among all participants, affiliative humour was the most preferred and widely used humour style ($M = 46.47$, $SD = 6.06$; $n = 122$, 82.43%) (Table 5.7); 84.50% ($n = 109$) of females recognised it as their style of choice (Table 5.8), and male participants ($n = 13$, 68.42%) scored higher in this humour style than in any other. This trend persisted across age brackets, with affiliative humour also being the most preferred with 95.90% ($n = 117$) of participants aged 17–29 (Table 5.8).

Table 5.8: Affiliative Humour Style by Gender and Age

	Female			Male			Full sample		
	<i>n</i>	%	%	<i>n</i>	%	%	<i>n</i>	%	%
Total	109	84.50	89.34	13	68.42	10.66	122	82.43	100.00
Age bracket									
17–19	75	68.81	94.94	4	30.77	5.06	79	64.75	100.00
20–29	30	27.52	78.95	8	61.54	21.05	38	31.15	100.00
30–39	2	1.83	100.00	0	0.00	0.00	2	1.64	100.00
40–49	2	1.83	100.00	0	0.00	0.00	2	1.64	100.00
≥50	0	0.00	0.00	1	7.69	100.00	1	0.82	100.00

5.4.2.4 Self-Enhancing Humour

Among all participants, self-enhancing humour was the second most used humour style ($M = 39.49$, $SD = 7.89$). A total of 21 participants (14.19%) recognised resorting to it in most instances (Table 5.9). Participants moderately self-reported it to be a form of humour that enabled them to cope with stress, maintain a generally positive outlook on life and possibly ‘raise their spirits’. Participants who reported predominantly using self-enhancing humour were mostly between 17 and 19 years of age ($n = 13$, 61.90%).

Table 5.9: Self-Enhancing Style by Gender and Age

	Female			Male			Full sample		
	<i>n</i>	%	%	<i>n</i>	%	%	<i>n</i>	%	%
Total	17	13.8	80.95	4	21.05	19.05	21	14.19	100.00
Age bracket									
17–19	10	58.82	76.92	3	75.00	23.08	13	61.90	100.00
20–29	4	23.53	100.00	0	0.00	0.00	4	19.05	100.00
30–39	3	17.65	75.00	1	25.00	25.00	4	19.05	100.00
40–49	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
≥50	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00

5.4.2.5 Aggressive Humour

Interestingly, only one participant, a male in his twenties, scored aggressive humour as their most widely used form of humour (Table 5.10). The maximum score of 56, attributed to him, indicates that they answered the highest possible option, *totally agree*, to all items pertinent to this sub-scale. This result should be considered with caution. This participant identified with using humour to make fun or ridicule others, and with a reduced ability to control themselves to use humour in inappropriate instances. However, overall, the mean score of all other participants across all ages and genders ($M = 23.06$, $SD = 8.23$) indicated that they strongly disagreed that aggressive humour was their commonly used style. Aggressive humour was ranked by all other participants as the lowest used style of humour in all age categories.

Table 5.10: Aggressive Style by Gender and Age

	Female			Male			Full sample		
	<i>n</i>	%	%	<i>n</i>	%	%	<i>n</i>	%	%
Total	0	0.00	0.00	1	5.26	100.0	1	0.68	100.00
Age bracket									
17–19	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
20–29	0	0.00	0.00	1	100.00	100.00	1	100.00	100.00
30–39	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
40–49	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
≥50	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00

5.4.2.6 Self-Defeating Humour

Self-defeating humour was the second lowest scoring humour style. The overall mean score of 30.92 ($SD = 9.00$) (refer back to Table 5.7) indicates that participants either slightly disagreed or did not particularly recognise that they use this style of humour in most situations. As a consequence, participants did not self-report as hiding behind humour to conceal their true feelings or as using themselves as a vehicle by which they, or others, can make fun of them. No participant 30 years of age or older reported a predominant use of self-defeating humour (Table 5.11). Out of the four participants who scored highest for this style, three were aged between 17 and 19, and one between 20 and 29.

Table 5.11: Self-Defeating Style by Gender and Age

	Female			Male			Full sample		
	<i>n</i>	%	%	<i>n</i>	%	%	<i>n</i>	%	%
Total	3	2.33	75.00	1	5.26	25.00	4	2.70	100.00
Age bracket									
7–19	2	66.67	66.67	1	100.00	33.33	3	75.00	100.00
20–29	1	33.33	100.0	0	0.00	0.00	1	25.00	100.00
30–39	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
40–49	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
≥50	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00

5.4.3 Connor–Davidson Resilience Scale 25

The scale produces an overall result ranging from 0 to 100, with higher overall scores corresponding to higher degrees of resilience (Connor & Davidson, 2003). An independent samples *t*-test demonstrated that the two gender groups did not differ significantly ($t(146) = 1.59$, $p = .72$, $d = .08$, 95% CI [-4.16, 5.97]). The mean for the female group ($M = 76.17$, $SD = 10.20$) was not significantly different from that of the male group ($M = 75.26$, $SD = 11.89$). These findings do not support the idea that there is a difference in resilience score between genders.

The high resilience score trend was maintained across age and gender (Table 5.12). Noticeably, females' scores increased with each age bracket; the 17–19 group reported a mean of 75.34 ($SD = 9.57$), and this increased to 76.71 ($SD = 10.20$) for the 20–29

group, 83.40 ($SD = 9.63$) for the 30–39 group, and 84.50 ($SD = 10.61$) for those aged 40–49. No meaningful comparison could be extracted from these results due to the low number of participants in the older age brackets.

Table 5.12: CD-RISC-25 Gender Mean Score

	Female			Male			Full sample		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Total	129	76.17	10.20	19	75.26	11.89	148	76.05	10.39
Age bracket									
17–19	87	75.34	9.57	8	78.00	11.92	95	75.57	9.74
20–29	35	76.71	11.49	9	71.22	12.25	44	75.59	11.72
30–39	5	83.40	9.63	1	78.00	-	6	82.50	8.89
40–49	2	84.50	10.61	0	-	-	2	84.50	10.61
≥50	0	-	-	1	87.00	-	1	87.00	-

Note: CD-RISC-25 = Connor–Davidson Resilience Scale 25; Score interpretation: mean >75 is considered high.

5.4.4 Satisfaction with Life Scale

The scoring of the SWLS produces a result ranging between 5 and 35, with higher scores correspond to a higher degree of life satisfaction. Most participants were found to be satisfied with life at the onset of their nursing journey (Table 5.13); 145 participants reported generally being satisfied. Two were extremely satisfied, while only one participant scored as slightly dissatisfied with their life at the present time. The total overall mean score of 26.5 ($SD = 4.62$) suggests that the majority of all 148 participants (1 missing value = 1 female) were satisfied with life.

Across age and gender, females were generally satisfied with life, with scores between 26.06 ($SD = 4.86$) and 30.50 ($SD = .71$). Those aged between 40 and 49 rated themselves as extremely satisfied with life, with a mean score of 30.50 ($SD = .71$). On the other hand, males reported being less satisfied than women across all age brackets, with means ranging between 18.00 ($SD = .00$) and 30.50 ($SD = .71$). One male participant between 30 and 39 years of age reported being neutral on the topic ($M = 20$, $SD = .00$), while another male in the category of over 50 years of age reported a mean score of 18 ($SD = .00$) (slightly dissatisfied). The low number of male participants only offer partial insight, preventing the formation of meaningful conclusions.

An independent samples *t*-test demonstrated that the two gender groups differed significantly ($t(145) = 2.86$, $p = .01$, $d = .70$, 95% CI [.98, 5.37]). The mean for the female group ($M = 26.91$, $SD = 4.34$) was significantly higher than that of the male group ($M = 23.74$, $SD = 5.59$). These findings support the idea that there is a difference in life satisfaction score between genders, with females being generally more satisfied with their life than males.

Table 5.13: Satisfaction with Life Scale (SWLS) Gender Mean Score

	Female ^a			Male			Full sample			Interpretation
	<i>n</i>	M	<i>SD</i>	<i>n</i>	M	<i>SD</i>	<i>n</i>	M	<i>SD</i>	
Total	129	26.91	4.34	19	23.74	5.59	148	26.50	4.62	Satisfied
Age bracket										
17–19	87	27.09	4.14	8	27.25	5.01	95	27.11	4.19	Satisfied
20–29	35	26.06	4.86	9	21.67	5.02	44	25.14	5.16	Satisfied
30–39	5	28.20	4.27	1	20.00	-	6	26.83	5.08	Satisfied
40–49	2	30.50	.71	0	-	-	2	30.50	.71	Extremely satisfied
≥50	0	-	-	1	18.00	-	1	18.00	-	Slightly dissatisfied

Note: ^a Missing value.

5.4.5 Comparison between Instruments

The researcher examined the data for meaningful relationships between instruments results and demographic details. To achieve this, a Pearson product-moment correlation coefficient was conducted to identify relationships between the variables age, gender, previous studies, healthcare industry experience, the four humour styles, resilience, and satisfaction with life. Correlations were significant at $p < .01$.

There was a moderately positive correlation between affiliative humour and self-enhancing humour ($r = .47$). The correlations between resilience ($r = 0.28$) and satisfaction with life ($r = .29$), indicated that the more a person resorted to adaptive humour styles, the more resilient and satisfied with their life they were; however, this association was considered weak. There was also a moderately positive correlation between self-enhancing humour and resilience ($r = .44$) and a weaker correlation with satisfaction with life ($r = .32$). There was a negative relationship between aggressive humour, self-defeating humour ($r = -.34$) and satisfaction with life ($r = -.26$), although these were also considered weak. This means that the more participants favoured an aggressive humour style, the more their use of self-defeating humour decreased, and participants were less likely to be satisfied with their life. Generally, there was a moderate, positive correlation between participants who were satisfied with their life and their resilience ($r = .35$).

Several statistically significant correlations, mostly weak, were identified between variables. These are summarised in Table 4.14. Although weak, age was associated with a number of variables—positively with gender ($r = .18$), previous studies ($r = .23$) and working within the healthcare industry ($r = .18$) (Table 5.14). There was a weak negative correlation between age and self-defeating humour ($r = -.24$), meaning that the older a person was, the less likely they were to use self-defeating humour.

As participants' age distribution was heavily skewed towards the 17–29 age group, it was not possible to draw any other age-related conclusions from this study sample. These results offer insights into this age group, but comparison of age cohorts groups would require larger older sample sizes, not necessarily an easy undertaking given the predominance of youth in nursing courses.

Gender was positively associated with the tendency to use humour in a ridiculing, manipulative, or inappropriate manner, with males being more likely to engage in aggressive humour ($r = .39$) (Table 5.14). As the population sample predominantly comprised young females, it was not unexpected that a moderate, negative correlation between age and gender ($r = -.16$) was found. Because of the uneven distribution of age and gender in this sample and the weak correlations shown, it was again not possible to draw meaningful conclusions from these results.

Table 5.14: Descriptive Statistics and Correlations for Study Variables

Variables ^a	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10
1. Age	20.74	5.57	—									
2. Gender ^b	1.13	.34	.18*	—								
3. Previous studies ^c	.43	.50	.23**	.12	—							
4. Currently working in healthcare industry ^d	.18	.38	.18*	0.88	.29**	—						
5. HSQ ^e - Affiliative	46.47	6.07	.01	-.16*	.02	-.06	—					
6. HSQ - Self-enhancing	39.49	7.90	.05	-.06	-.09	.00	.47**	—				
7. HSQ - Aggressive	23.06	8.24	-.01	.39**	.04	.05	-.03	.09	—			
8. HSQ - Self-defeating	30.92	9.01	-.24**	.04	.02	-.03	.11	.03	-.34**	—		
9. CD-RISC-25 ^f	76.05	10.39	.16	-.03	.03	.06	.28**	.44**	-.13	-.29**	—	
10. SWLS ^g	26.50	4.62	-.07	-.23**	.04	.05	.29**	.32**	-.26**	-.12	.36**	—

Note: ^a $n = 148$ for all variables unless specified; ^b 1 = female and 2 = male; ^c 0 = no and 1 = yes; ^d 0 = no and 1 = yes; ^e Humor Styles Questionnaire; ^f Connor–Davidson Resilience Scale 25; ^g Satisfaction with Life Scale, $n = 147$.

* $p < .05$. ** $p < .01$.

5.4.5.1 Connor–Davidson Resilience Scale 25

As discussed in previous sections, resilience score increased with age. However, correlations between resilience score, age ($r = .16$) and gender ($r = -.03$) were not statistically significant. In addition to being associated with the positive use of humour (affiliative: $r = .44$; self-enhancing: $r = .44$), greater resilience was also paired with a lesser use of humour designed to amuse others at a person's own expense (self-defeating: $r = .29$) (Table 5.14).

5.4.5.2 Satisfaction with Life Scale

Participants increased satisfaction with their life was positively correlated with an adaptive use of humour (affiliative and self-enhancing) (Table 5.14). As these humour styles contribute to the development and maintenance of effective personal and interpersonal relationships, it was predictable that they would be strongly associated with life satisfaction.

The results also highlighted that maladaptive humour styles significantly decreased life satisfaction and resilience. Both the resilience and the satisfaction with life scales were strongly correlated with all but one humour style; for resilience, this was aggressive humour, and for life satisfaction ($r = -.13$); this was the self-defeating humour style ($r = -.12$). This suggests that resilience will be more affected by negative humour towards the self, while satisfaction with life is more likely to be affected by the maladaptive style, which affects interpersonal relationships.

5.5 Interpretation

The quantitative findings contained in this chapter were formulated from the HSQ (R. A. Martin et al., 2003), the CD-RISC-25 (Connor & Davidson, 2003) and the SWLS (Diener et al., 1985). Participants completed the survey, which included demographics questions and three instruments, at the commencement of their nursing degree course, before attending their first practical placement.

The purpose of this survey was to capture a picture of the participants at the beginning of their learning journey. The cohort was examined for various qualities: their level of coping, resilience, contentment with life, and the manifestations of humour in their

personal and interpersonal relationships. This portrait captured their sense of self before the activity of nursing could potentially modify it. The results obtained from these instruments were used to inform the qualitative data collected once the participants entered the clinical world during their first practicum.

Our sample contained a majority of young females ($n = 129$, $M = 20.36$, $SD = 4.91$). Samples of predominantly young NSs were also reported in other Australian studies (Alshahrani et al., 2018; Birks, Budden, et al., 2018; Blackman et al., 2007). The consistency of such predominant demographic details of young female undergraduate NSs in other studies indicates that the sample obtained in this research points towards the applicability of its findings (Blackman et al., 2007; Bulfone et al., 2020; Demir Gökmen & Firat, 2020).

Several of the participants ($n = 63$, 42.6%) stated having commenced or completed previous studies prior to enrolling in their nursing degree. Other published research has reported lower prior education rates between 19% and 28% (Birks, Smithson, et al., 2018; Blackman et al., 2007). Previous academic success has been linked to course completion (Robert, 2018). In this study, 41 participants (28%) had commenced or completed studies in a health-related discipline and 15% ($n = 22$) in a non-health-related one. Previous education in a healthcare-related field can influence socialisation during nursing studies (Houghton, 2014) and successful course completion (Snowden et al., 2018).

The desire for career progression has been demonstrated in AIN graduates who continue on to become ENs or RNs (Faithfull-Byrne et al., 2017). A small proportion of our participants (17.6%) were found to be working in the healthcare industry however our study naturally excluded ENs as previously discussed in Chapter 4. This complements Wray et al. (2017) and F. Murphy et al. (2009) who reported that previous care experience has been shown to affect general caring capacity in nursing, encouraging the desire for future work and success in the field.

The following section will discuss the current findings for each quantitative instrument. It will then compare them against what has been published in the literature thus far.

5.5.1 Humour Styles

The findings of this study demonstrating participants' higher scores in positive humour types (96.6%) are contrary to those obtained by Stanley et al. (2014), who found that younger adult (aged between 18 and 30) undergraduate psychology students were more likely to resort to an aggressive style of humour compared with middle-aged and older adults. However, the negative correlation in our findings between age and self-defeating use of humour ($M = 30.95$, $SD = 9.01$) are comparable with those of Falanga et al. (2020), who surveyed a group of 311 university students with a mean age of 21.34; they also reported lower scores in both aggressive ($M = 25.60$, $SD = 7.12$) and self-defeating ($M = 29.63$, $SD = 7.77$) humour styles. Maladaptive humour styles, namely aggressive and self-defeating styles, have been demonstrated to be the least utilised by women and to have socially undesirable consequences (Cann et al., 2016). Participants in our study did not choose to use humour in ways that would be disrespectful towards others. This is consistent with the literature in which aggressive humour is generally reported as lower ranking, although men are reported to use it more often than women (Falanga et al., 2020; Menéndez-Aller et al., 2020).

The mean score of 46 for the use of affiliative humour found in this study demonstrates that participants strongly agree that they engage in affiliative humour most of the time. Numerous studies have reported similar findings, identifying affiliative humour as being the most popular humour style, scoring the highest against the other three styles (Arkan et al., 2018; Falanga et al., 2020; Hampes, 2005; Mendiburo-Seguel et al., 2015; Salavera et al., 2020; Schermer et al., 2019). The results of the present study are in line with those of Schermer et al. (2019), who surveyed a large sample of 8,361 participants and reported that self-enhancing humour was the second highest scoring of all the humour styles. Despite being conducted across 28 countries, their study did not include an Australian sample. Nonetheless, their overall results also demonstrated that affiliative and self-enhancing humour styles were the uppermost two, while the aggressive style was the lowest across both genders (Schermer et al., 2019). Our results are therefore in line with the current literature.

5.5.1.1 Comparison of HSQ Results of with the Literature

Chapter 5 presented the results of the HSQ in a population of first-year, first-semester NSs. The results revealed that most students scored highest in affiliative humour,

followed by the second adaptive style of humour, the self-enhancing humour style. Humour styles deemed to produce more maladaptive responses and have negative consequences for relationships were the least favoured by students, particularly the aggressive style. This indicates that NSs starting on their education journey and acculturation to the nursing world start off using humour in productive ways. This adaptive use of humour has benefits for self and in interactions with others, as well as coping with life's challenges (R. A. Martin & Ford, 2018). Users of adaptive humour also tend to refrain from making fun of others, preferring rather to laugh at themselves. Overall, adaptive humour styles contribute positively to adjustment to most situations and relationships.

An extensive literature search located only one study involving exclusively FYNSs and the HSQ—Demir Gökmen and Firat (2020) surveying 212 NSs from all years. Ten additional studies of general student populations were also identified (Table 5.15). All student populations studied, except one, were mostly female. A majority of studies reported similar results: students rated higher in adaptive humour styles, particularly the affiliative one, and usually lower in both maladaptive styles (aggressive and self-defeating).

Table 5.15: Details on Included Humour Studies for Comparison

Authors (year)	<i>n</i>	nf	%f	nm	%m	Location	Area of study	Aff		S-E		Agg		S-D	
								Score	<i>SD</i>	Score	<i>SD</i>	Score	<i>SD</i>	Score	<i>SD</i>
This research	148	129	87	19	13	Australia	Nsg Stds, 1 st yr	46.47	6.07	39.49	7.90	23.06	8.24	30.92	9.01
Demir Gökmen & Firat (2020)	212	134	63.2	78	36.8	Turkey	Nsg Stds, College	39.26	8.69	36.02	8.74	22.05	8.18	25.97	8.32
Gignac et al. (2014)	309	201	65	108	35	Australia	University Stds	46.34	6.93	38.08	7.87	29.41	7.68	31.07	8.59
Cann & Collette (2014)	120	93	78	27	23	N/A	Psychology Stds	46.48	6.80	36.48	8.96	27.12	7.68	23.84	8.24
Huang & Lee (2019)	260	168	64.6	92	35.4	China	Education Stds	38.16	5.68	38.80	6.80	27.08	6.56	25.12	7.20
Hiranandani & Yue (2014)	101	76	75	25	25	China	University Stds	36.91	6.75	32.89	6.8	29.74	4.93	32.08	5.49
Hiranandani & Yue (2014)	102	41	40	61	60	India	University Stds	39.75	8.92	36.54	7.99	28.91	6.83	30.52	7.43
Zhao et al. (2014)	477	274	57	203	43	China	College Stds	38.6	8.03	22.43	6.08	15.58	6.53	12.42	5.26
G.-H. Chen & Martin (2007)	354	230	65	124	35	China	University Stds	43.55	7.79	35.18	8.26	23.36	6.45	22.68	7.59
Martin ^a	388	213	55	175	45	Canada	University Stds	46.4	7.17	37.3	8.33	28.5	8.79	25.9	9.22
Zhao et al. (2012)	525	292	56	233	44	China	College Stds	38.7	N/A	22.49	N/A	15.53	N/A	12.46	N/A
Kazarian & Martin (2004)	401	221	55	180	45	Beirut	University Stds	43.2	7.74	35.1	8.45	28.7	7.45	25.5	8.05

Note: *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg Stds = nursing students; Aff = affiliative humour style; S-E = self-enhancing humour style; Agg = aggressive humour style; S-D = self-deprecating humour style.

^a Unpublished results, included in G.-H. Chen and Martin (2007).

Huang and Lee (2019) found that participants' adaptive humour styles positively affected, and maladaptive styles negatively affected, EI and satisfaction with life. They also identified that self-enhancing humour had a stronger influence on both EI and satisfaction with life than any other styles. They reasoned that this was due to self-enhancing humour being the most closely related to the traditional understanding of what a sense of humour is, and how one uses it to cope with adversity and stress in daily life. Their research highlighted that self-enhancing humour was also a positive strategy for emotional regulation (Huang & Lee, 2019). This finding is corroborated by our research, as evidenced by the meaningful correlation between self-enhancing humour and SWLS results ($r = .32$) (Table 5.14).

Examining humour style and EI, Gignac et al. (2014) investigated their association by controlling for personality and socially desirable reactions. They showed a positive correlation between adaptive humour styles and EI, and that EI may be directly linked to how an individual uses humour and appreciates it. This information may be particularly useful in future strategy development for education or wellness interventions to improve coping and resilience.

This research project's results compared closely to those of Gignac et al. (2014), which included 309 university students from WA. The authors did not specify whether the students were from one or multiple faculties or the type of degree students were pursuing. However, their results were closely related to this current research on the following points:

- a majority of female participants—87% (this research) vs. 65%
- predominant humour style—affiliative
- second preferred style—self-enhancing
- third utilised style—self-defeating
- least utilised—aggressive.

The results of this study compared closely to others of students' preferred humour styles (Cann & Collette, 2014; G.-H. Chen & Martin, 2007; Gignac et al., 2014). This supports the contention that students' humour styles are conducive to maintaining effective relationships with others and themselves. Students are also not averse to making fun of themselves, yet report having fun with others without being unnecessarily belligerent

towards them. These results appear unaffected by the type of study a person is enrolled in. Further study is warranted to make more statistically robust conclusions than those possible from studies of relatively small populations.

Because of the relative paucity of literature concerning nurses or NSs and humour, the researcher was unable to identify minimal points of difference in their research results compared with only one other study. The sample of Demir Gökmen and Firat (2020) included NSs of all years. Their sample also scored each humour sub-scale in the same order as this current study—the first being the affiliative style, followed by self-enhancing, self-defeating and the aggressive style as the least scoring. Their gender distribution however included a higher proportion of males. Gender effect on humour styles, particularly that of the aggressive humour, has been reported in the literature (Torres-Marín et al., 2018). This however did not translate into the two studies, only that the affiliative overall score was lower than ours though remained the most recognised styles used by participants. Overall, the general consistency of results, namely the preferred humour styles, suggests probable comparability and validity of generalisation.

Nursing as a profession is dependent on both the nurse and the team they work with. It is rare for nurses to provide care single-handedly; the nurse may execute tasks independently, yet generally tends to relay information and results to a team with which they work in close collaboration. The team typically includes other nurses as well as other health professionals including doctors. Our research results indicate that upon commencing their degree, NSs exhibit a strong preference for utilising humour that will be beneficial not only in maintaining positive relationships but also in navigating the challenging dynamics of professional requirements.

This study therefore adds value to the global literature concerning the use of humour and opens a window in the world of nursing. No literature evidence was evident as to whether a nurse's sense of humour changes over time with exposure to the activity of nursing, and no data were located as to the degree to which a nurse's humour style aids in coping and building resilience while caring for others and being exposed to confronting situations. This research provides a departing point.

The majority of NSs examined exhibited a tendency to use humour in productive, adaptive ways to benefit themselves and to promote positive relationships with all others they encountered.

5.5.2 Connor–Davidson Resilience Scale 25

The results for this study against the CD-RISC-25 are comparable to other studies of the undergraduate population. For example, Hartley (2011) surveyed 605 undergraduate students and reported a similar mean of 75.7 ($SD = 11.9$), while Stephens (2012), who surveyed 70 NSs, reported a mean result of 75.2 for the pre-treatment group. The consistency of the results achieved in the present research compared to others indicates that overall, undergraduate students, including NSs, report a reasonably high resilience score.

The results achieved in this study demonstrated that mean scores in resilience increased with age. As the relationship was only weakly established in our sample, the tentative explanation is that resilience in FYNSs may increase with life experience. The researcher was unable to locate other published results on CD-RISC scores reporting on age brackets, a conclusion also reached by Pulido-Martos et al. (2020). Nonetheless, the results returned of this study are similar to those of Lekan et al. (2018). Their NSs' sample, also predominantly female with the majority below the age of 30, reported a high CD-RISC mean score of 73.26 ($SD = 10.7$).

5.5.2.1 Comparison of Resilience Results with the Literature

Several research projects have investigated how nurses cope with the demands of their profession and how this translates into resilience (Eslami Akbar et al., 2015; Gillman et al., 2012; Labrague et al., 2018). Enquiries have also considered NSs (Klainin-Yobas et al., 2014; Labrague et al., 2017; McCarthy, Trace, O'Donovan, Brady-Nevin et al., 2018). The main instrument used to measure nurses' resilience is the CD-RISC, which can be administered in its complete version of 25 items or in shorter versions of 10 or 2 items. The literature reports equally on the CD-RISC-25 and CD-RISC-10, but rarely on the 2-item version.

Most studies show that nurses, whether practising or studying, tend to exhibit a high resilience score. A resilience score of 75 and above demonstrates a high level of resilience. The current research returned a score of 76.05, affirming the results and inter-study consistency of others (Table 5.16). The researcher's results are also in line with other NS populations demonstrating a high capacity for resilience (Fowler et al., 2020; Lekan et al., 2018).

Table 5.16: Details on Included CD-RISC-25 Studies for Comparison

Authors (year)	Location	Population	Sample					CD-RISC-25	
			<i>n</i>	nf	%f	nm	%m	Score	<i>SD</i>
Schuller et al. (2020)	USA	P/G Nsg Stds	91	81	89	10	11	80.04	10.64
Gibson et al. (2020)	USA	U/G Nsg Stds	45	41	91	4	9	78.44	11.60
Fowler et al. (2020)	USA	1st yr Nsg Stds	90	85	94	5	6	77.25	13.12
Schock (2020)	USA	Graduate Nurses	20	17	85	3	15	76.45	8.70
This research	Australia	1st yr Nsg Stds	148	129	87	19	13	76.05	10.39
Hamadeh Kerbage et al. (2021) ^{a b}	Australia	U/G International Stds	22	N/A	N/A	N/A	N/A	75 ^c	N/A
Dong et al. (2021)	China	U/G Nsg Stds	698	634	90.8	64	9.2	74.12	15.96
Lekan et al. (2018)	USA	Senior U/G Nsg	27	22	81	5	19	73.26	10.70
Hamadeh Kerbage et al. (2021) ^{a b}	Australia	U/G Nsg Stds	121	106	88	N/A	N/A	71 ^c	N/A
Sahu et al. (2019)	India	U/G & P/G	102	96	94	6	6	71	11.50
Mayor-Silva et al. (2021)	Spain	1st yr Nsg & Physical Therapy Stds ^d	194	189	77	56	23	70	11.1
Hamadeh Kerbage et al. (2021) ^{a b}	Australia	U/G Domestic Stds	99	N/A	N/A	N/A	N/A	70 ^c	N/A
Devi et al. (2021)	Indonesia	U/G Nsg Stds	336	240	71.7	95	28.3	68.61	15.08
Hamadeh Kerbage et al. (2021) ^{a b}	Australia	U/G Nsg Stds	121	N/A	N/A	15	12	66 ^c	N/A

Note: CD-RISC-25 = 25-item Connor–Davidson Resilience Scale; *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students; U/G = undergraduate students; P/G = postgraduate students.

^a Separate statistics available for the same sample; ^b Data collection during COVID-19 pandemic; ^c Median score, not mean; ^d Full sample was composed of 245 nursing and physical therapy students. Each study group was divided into a control and two intervention groups. Resilience score only provided for the combined discipline group; results were not available for nursing students only.

While larger nursing samples have indicated a lesser capacity for resilience, these were practising nurses, not students (Afshari et al., 2021; Guo et al., 2017; Leng et al., 2020). This was not supported by Gabriel et al. (2011), who reported a high mean score of 91.49 for a similar population, although in a small sample of 57 nurses. Interestingly, postgraduate NSs returned a slightly higher than average resilience score of 80.04 (Schuller et al., 2020). This could be the by-product of successful achievement of prior studies, the effect of years of clinical practice or an artifact in that more resilient nurses may be those who choose to undertake postgraduate study.

Lower resilience scores may be geographical, with the cofactors that geography may entail, including culture and socioeconomic circumstances. All studies listed in Table 5.17 were conducted in Australia, the United States, India, China, or Iran. The lower scores all pertained to countries other than Australia or the United States. Leng et al.'s (2020) and Guo et al.'s (2017) studies were concerned with Chinese nurses, while Afshari et al. (2021) investigated an Iranian sample. Their respective resilience scores were all in the 60s, indicating a lower capacity for resilience. Meanwhile, Sahu et al. (2019) investigated a sample of undergraduate and postgraduate students. Their results were slightly higher than the Chinese and Iranian samples, although this might have been influenced by a lower sample size that also included postgraduate students. As observed in Schuller et al. (2020) results, postgraduate students have demonstrated a higher capacity for resilience.

Similar results are reported in studies utilising the CD-RISC-10 instrument. The resilience score for this version of the CD-RISC instrument is considered high from 29 and above. When the result is adjusted, the current research returned a median score of 30.32 (SD = 5.15). This compares to Fernández-Martínez et al. (2017), who also investigated first-year NSs' resilience and reported a score of 29.42. The high results of 39.43 returned in He et al. (2018) might have been influenced by the non-traditional sample of NSs made up by a majority of non-school-leaver and mature-age students from a regional centre. On the other hand, ethnicity has been influential in returning lower scores in Asian countries. This may explain the lower results returned in the studies conducted by Chow et al. (2020), with a score of 24.60, and 23.20 and 24.33 for Mathad et al.'s (2017) samples, all studies being conducted in Asia.

Table 5.17: Details on Included CD-RISC-10 Studies for Comparison

Authors (year)	Location	Population	Sample					CD-RISC-10	
			<i>n</i>	nf	%f	nm	%m	Score	<i>SD</i>
He et al. (2018)	Australia	Nsg Stds	538	458	85	77	14	39.43	6.24
Ríos-Risquez et al. (2016)	Spain	Final-year Nsg Stds	113	85	75	77	68	34.70	4.82
García-Izquierdo et al. (2018)	Spain	2nd yr Nsg Stds	218	165	75	53	25	31.47	6.08
This research	Australia	1st yr Nsg Stds	148	129	87	19	13	30.32*	5.15*
Grimes et al. (2020)	Australia	2nd & 3rd yr Nsg Stds	66	57	86	9	14	29.72	N/A
Fernandez-Martinez et al. (2017) ^a	Spain	1st yr Nsg Stds	48	36	75	12	25	29.42	5.18
Fernandez-Martinez et al. (2017)	Spain	1st – 3rd yr Nsg Stds	134	107	80	27	20	28.61	5.54
Chow et al. (2020)	Hong Kong	1st yr Nsg Stds	195	156	80	39	20	24.60	5.10
Mathad et al. (2017)	India	Students/Control	50	50	100	0	0	24.33	6.05
Mathad et al. (2017)	India	Students/Intervention	50	50	100	0	0	23.20	5.93

Note: CD-RISC-10 = 10-item Connor–Davidson Resilience Scale; *n* = number of participants; nf = number of female participants; %f = proportion of female participants; nm = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students. U/G = undergraduate students; P/G = postgraduate students; Interpretation: >29 = high resilience.

^a Part study sample.

* Adjusted score.

Our results for resilience score are consistent with those found in the existing literature. All findings point to NSs having ample capacity for resilience which is additionally supplemented by its correlation with adaptive styles of humour (affiliative and self-enhancing) as discussed in section 5.4.5.1. This quality is invaluable during their study and in facing difficult situations with life, disability, and death (Maben & Bridges, 2020). It also has personal value implications and value in meeting existential expectations; nurses are expected to cope and adjust quickly between situations and to attend to all patients without being negatively impaired by prior circumstances. For example, there is an implicit expectation that a nurse is to attend to the deteriorating patient and perform CPR (with potential unsuccessful results) then resume the care of their other allocated patients. Nurses are expected to 'roll with it' (Traynor, 2018).

This study not only enlarges the current body of evidence about nursing resilience but also supplements it. It does so by demonstrating that NSs' strong capacity for resilience may be influenced by their use of adaptive humour, humour that cultivates and maintains positive relationships with self and others, increases one's capacity to adjust to challenges encountered in one's personal and working life.

5.5.3 Satisfaction with Life Scale

The results reported in this study for satisfaction with life are higher than those reported by Chattu et al. (2020), conducted in the West Indies. Differences in SWLS scores between cultural groups have been reported in the literature (Zanon et al., 2014), meaning that culture and geographical location can affect a person's level of satisfaction with their life.

SWLS scores in student samples vary between countries. Results from this study were comparable with those of Samaranayake and Fernando (2011), who surveyed medical students in New Zealand ($n = 255$), reporting a mean score of 26.4 ($SD = 6.4$). They compared the medical students to another group of students ($n = 339$), which included a group consisting of nursing ($n = 36$), health science ($n = 208$) and architecture ($n = 95$) students and those classified as 'other students'. The comparison between the medical and other students reported a mean SWLS score of 23.8 ($SD = 6.2$). The overall sample of 594 students reported being 'slightly satisfied' with their life ($M = 24.9$, $SD = 6.4$). Conversely, a sample of 358 Turkish university students across 13 universities reported

being slightly dissatisfied, with a mean score of 16.72 ($SD = 6.81$) (Aslan et al., 2020). However, Aslan et al. (2020) collected their data soon after the global peak of the COVID-19 pandemic between May and June in 2020, which might well have contributed to their lowered results.

Other studies of university student populations have reported lower mean scores. Durak et al. (2010) surveyed Turkish university students ($n = 547$) and reported a mean score of 22 (slightly satisfied). This pre-COVID-19 pandemic result is higher than that reported in the same country by Aslan et al. (2020), potentially indicating an effect of the pandemic. Nonetheless, similar lower results were achieved by Dayapoglu et al. (2016), who surveyed NSs in an American university ($n = 353$) and reported a mean score of 22. A potential explanation for the higher scores observed in Australia and New Zealand may be the difference in geographical location and the impact on overall life satisfaction of climatic and economic differences.

5.5.3.1 Comparison of Life Satisfaction Results of with the Literature

The SWLS has been utilised in several research projects with students and or nursing populations. The current research identified the first-year NSs' sample as demonstrating satisfaction with life, with a mean score of 26.5 (Table 5.18).

Table 5.18: Details on Included Satisfaction with Life Scale (SWLS) Studies for Comparison

Authors (year)	Location	Population	Sample					SWLS		Interpretation
			<i>n</i>	<i>nf</i>	%f	<i>nm</i>	%m	Score	<i>SD</i>	
Arribas-Marín et al. (2021)	Spain	2 nd – 4 th yr Nsg Stds	586	486	83	100	17	26.92 ^a	4.73 ^a	Satisfied
This research	Australia	1st yr Nsg Stds	148	129	87	19	13	26.5 ^a	4.62 ^a	Satisfied
Kupcewicz et al. (2020)	Spain	Nsg U/G	208	171	82	37	18	24.04	6.13	Slightly satisfied
Por et al. (2011)	UK ^b	Nsg U/G	130	-	-	13	10	23.9	4.8	Slightly satisfied
Por et al. (2011)	UK ^c	Nsg U/G	130	117	90	-	-	23.7	4.2	Slightly satisfied
S. D. Martin et al. (2022)	USA	Nsg U/G	417	377	90	40	10	23.61	6.72	Slightly satisfied
Chattu et al. (2020)	West Indies	Nsg Stds	84	N/A	N/A	N/A	N/A	23.11	6.06	Slightly satisfied
Hawker (2012)	UK	Nsg Stds	215 ^d	198	93	14	7	22.9	6.6	Slightly satisfied
Kupcewicz et al. (2020)	Slovakia	Nsg U/G	390	379	97	11	3	22.40	5.64	Slightly satisfied
Mathad et al. (2017)	India	Students/Control	50	50	100	0	0	22.35	5.07	Slightly satisfied
Dayapoglu et al. (2016)	Turkey	Nsg Stds	353	274	78	79	22	22.05	6	Slightly satisfied
Yildirim et al. (2013)	Turkey	1st yr Nsg Stds	N/A ^e	N/A ^e	N/A ^e	N/A ^e	N/A ^e	21.82	5.72	Slightly satisfied
Mathad et al. (2017)	India	Nsg/Intervention	50	50	100	0	0	21.6	5.02	Slightly satisfied
Kupcewicz et al. (2020)	Poland	Nsg U/G	404	365	90	39	10	21.46	6.28	Slightly satisfied

Authors (year)	Location	Population	Sample					SWLS		Interpretation
			<i>n</i>	<i>nf</i>	%f	<i>nm</i>	%m	Score	<i>SD</i>	
Bodys-Cupak et al. (2021)	Poland	Nsg Stds	307	295	96	12	4	20.82	5.72	Slightly satisfied
Berduzco-Torres et al. (2020)	Peru	U/G ^b	1503	628	90	72	10	18	5	Slightly dissatisfied
Ruiz-Aranda et al. (2014)	Spain	Nsg Stds	88	88	100	0	0	18.93 ^c	0.3 ^c	Slightly dissatisfied
Jun et al. (2015)	Korea ^e	Nsg Stds	236	231	98	-	-	18.94	5.95	Slightly dissatisfied
Jun et al. (2015)	Korea ^f	Nsg Stds	236	-	-	5	2	14.60	6.26	Dissatisfied
Ratanasiripong & Wang (2011)	Thailand	Nsg U/G	200	18	91	19	9	13.86 ^c	2.77 ^c	Dissatisfied

Note: *n* = number of participants; *nf* = number of female participants; %f = proportion of female participants; *nm* = number of male participants; %m = proportion of male participants; Nsg = nursing; Stds = students; U/G = undergraduate students.

^a Adjusted score; ^b Male sample only of all health disciplines combined; ^c Female sample only of all health disciplines combined; ^d 2 participants were missing from the results; ^e Gender distribution of sample not available – full sample all study years combined: *n* = 396, *nf* = 390, 99%, *nm* = 6, 1%; ^f 46% of the sample (*n* = 700, *F* = 625, *M* = 72) were nursing students but no independent SWLS score for them.

Our results are congruent with those of Arribas-Marín et al. (2021) who reported that NSs were generally satisfied with life. Their sample however comprised second- to fourth-year students while ours only included FYNSs. Generally, all other scores found in the literature pertaining to NS samples report that they are slightly satisfied (Bodys-Cupak et al., 2021; Chattu et al., 2020; Dayapoglu et al., 2016; Hawker, 2012; Kupcewicz et al., 2020; S. D. Martin et al., 2022; Mathad et al., 2017; Por et al., 2011) which included the sample of FYNSs surveyed by Yildirim et al. (2013). Rarely, NSs were found to be slightly dissatisfied (Berduzco-Torres et al., 2020; Jun et al., 2015; Ruiz-Aranda et al., 2014) or dissatisfied (Ratanasiripong & Wang, 2011). The sample of Korean male NSs reported by Jun et al. (2015) to be dissatisfied was however small, counting only five participants and representing only two percent of the study sample. The satisfaction expressed by participants in our research may be due to the novelty and excitement experienced at the onset of the nursing degree rather than later during their educational journey. It would be interesting to repeat the measure at the end of their degree to compare whether the passage of time and study affected this and to what extent.

A possible reason for this study reporting a higher score than others may be the geographical influence. It is also the only one in the literature to sample Australian NSs, all other populations of NSs being either in Europe (Arribas-Marín et al., 2021; Hawker, 2012; Kupcewicz et al., 2020), or Asian countries (Chattu et al., 2020; Dayapoglu et al., 2016; Jun et al., 2015; Mathad et al., 2017; Ratanasiripong & Wang, 2011).

Our results add to the body of knowledge of the life satisfaction of NSs along the course of their educational journey. Our results provide demographic specific data around NSs, their satisfaction with life at the beginning of their nursing education. The only other published study that investigated FYNSs was that of Yildirim et al. (2013), which was conducted nearly a decade ago and did not provide gender differences. Also, ours is the first in investigating FYNSs in Australia around life satisfaction. Combining these results with humour and coping and resilience previously discussed provide rich information around FYNSs at the commencement of their journey into nursing education.

5.5.4 Overall Interpretation

The quantitative results established that the positive use of humour was associated with an increased ability to cope with events a person faces and with overall contentment with one's life. The clinical aspect of nursing studies can provide many first-time experiences. Such experiences can include seeing the first adult naked body, witnessing the first death and other potentially confronting situations that may contribute to a shock factor often observed in the GNs' first year (Keeping-Burke et al., 2020). Identification of causative and contributing factors to, and early formative year signs of, this shock in NSs may assist educators to integrate preventative strategies into undergraduate courses to ameliorate negative impacts including course non-completion, dysfunctional behaviours directed at self and others, and premature workforce attrition.

Most participants of this study were young females, satisfied with life and with an aptitude for coping with life's events, which included the positive use of humour. This research shows that participants attended their first practical placement with a positive attitude, equipped to deal with circumstances with optimism, confidence, and the ability to foster positive relationships.

Participants who had had prior exposure to patient care were few in numbers (total $N=8$, (2.9%); *AIN* = 4, *care worker* = 2, *support worker* = 2). Their potential to lessen possible transition shock was not deemed to be a factor in our results due to: a) data pertaining to transition shock was only collected in subsequent phases; b) of those included in the results of Phase 1 and who had participated in subsequent phases (Total $N=3$), one was an aged care activity assistant, one was a care worker and the last one was a medical receptionist. Only the care worker may have possibly been exposed to similar nursing tasks such as personal hygiene, but this is not necessarily true for all care workers. The potential to influence the results, particularly those in the qualitative phases, was therefore seen as non-significant.

The research question pertaining to the NSs' humour style score prior to their first clinical practicum resulted in the finding that the majority of students self-reported using either an affiliative style of humour ($n = 122$, 82.43%; $M = 46.47$, $SD = 6.06$) or an adaptive style of humour (affiliative and self-enhancing combined) ($n = 143$, 96.62%). Investigation of the relationship between the NSs' humour style and resilience score

prior to their first clinical practicum showed that self-enhancing humour was associated with students' resilience ($r = .44, p < .01$) and their satisfaction with life ($r = .32, p < .01$).

5.6 Chapter Summary

This chapter described and analysed quantitative data measuring baseline qualities of the NS prior to attending their first clinical placement. The snapshot established especially that the novice nurse in our study embarked on their nursing study voyage armed with the ability to address life's difficulties with positive attributes. Participants generally had a strong sense of overall satisfaction and utilised humour to cope confidently with experiences in a way that will promote effective relationships with others while maintaining positive self-esteem. This chapter provided valuable information that helped inform the qualitative data presented and analysed in Chapter 6 and further combined and compared in Chapter 7.

Further, the combination of both quantitative and qualitative findings will be presented and discussed at length in Chapter 7. In Chapter 8, the researcher will discuss the implications of these findings for curriculum and personal development and the support of future nurses. This is done to prepare students to become and remain optimistic in the face of workplace adversity, maintain a positive sense of self, and promote positive relationships with others, whether colleagues or patients.

Chapter 6: Qualitative Data Results, Analysis and Findings

6.1 Introduction

The reader was introduced to this research project and its origin in Chapter 1 and supporting literature in Chapter 2. Chapter 3 discussed the theoretical foundations while description of the framework used to shape the project was outlined in Chapter 4, including its methodology and the multiple phases expected from an MMR project. Following this, Chapter 5 provided results and analysis of the quantitative aspects of the research project. The current chapter will provide results and analysis of the qualitative arm of the research. Chapter 7 will compare quantitative and qualitative findings, followed by discussion of the recommendations in Chapter 8.

This chapter will specifically provide information regarding the participants' experience of their first year of nursing studies. Their experience will be examined across their academic, clinical, and personal journey, taking into account its impact on students' wellness and contributing coping strategies. The contents of reflective journals and individual interviews will be summarised, and analysis presented in respective themes.

6.2 Participation Qualitative Results – Phases 2 and 3

This research project aimed to capture the students' experiences along the continuum of the first year of their nursing degree. Students were addressed in their first week of academic life prior to engagement in the activity of nursing. At that time, a snapshot was captured with a survey and was discussed in Chapter 5. Here, subjects identified in their first academic semester were encouraged to complete a series of reflective journals and personal interviews. Participation was voluntary and the right to withdraw was maintained until data analysis. Some students participated in all stages, while others participated in only some.

The qualitative aspect of this research project consisted of two sources, journal entries in response to seven open-ended questions and semi-structured individual interviews. Of the original 148 participants, 118 (80%) expressed a wish to continue their participation. The criteria related to participation are presented in Table 6.1 below. The initial minimal sample required was identified as being eight participants though the researched had aimed to recruit 35. The minimal required sample of eight was achieved

for both reflective journals but not the higher target. Recruitment difficulties have already been discussed and addressed under section 1.4.6 – Modifications.

Table 6.1: Criteria for Practicum-Related Participation

Criteria items	Participants	
	<i>n</i>	%
Criterion 1:		
Agreed to participate in reflective journals/interviews	118	80
Criterion 2:		
Agreed and commenced a reflective journal	53	36
Criterion 3:		
Completed a reflective journal	12	8
Criterion 4:		
Agreed and completed an individual interview	16	11

6.3 Analytical Strategy

The process of qualitative data analysis involved two sources of data: reflective journals and individual interviews. The data sources were combined and analysed in relation to the tenets pertaining to V. Braun and Clarke’s (2006) thematic analysis.

In the context of this research, the researcher is referring to thematic analysis as described by Clarke and Braun (2017) as ‘a method for identifying, analysing, and interpreting patterns of meaning (‘themes’) within qualitative data’ (p. 297). Further, V. Braun and Clarke (2013) recommended the following stages of coding and analysis:

- transcription
- reading and familiarisation, taking note of items of potential interest
- coding—complete, across entire dataset
- searching for themes
- reviewing themes (producing a map of the provisional themes and subthemes, and relationships between them—aka the ‘thematic map’)
- defining and naming themes
- writing—finalising analysis (pp. 202–203).

The above stages of coding and analysis will be used in the following sub-sections to demonstrate how they were following during the qualitative portion of this study.

6.3.1 Transcription

The reflective journals were completed by participants online. The data were downloaded in Excel format. Interviews were conducted face-to-face and recording. One interview took place online through Zoom© due to COVID isolation restrictions. This interview was also recorded in an audio file. The files were then uploaded and sent to a third party to be professionally transcribed. Once returned, the researcher listened to the audio file while ensuring the transcription was correct. The researcher corrected elements that the transcriber was unable to hear correctly, had misspelled or had identified to be reviewed. The audio files together with their transcription were shared with the two supervisors who ensured they were also satisfied with the quality of the transcription.

6.3.2 Reading and Familiarisation

Once the data had been transcribed verbatim, the researcher read over the complete datasets comprising answers to the reflective journals and individual interviews. This approach enabled the researcher to immerse herself in the data, facilitating familiarity with the content and developing understanding by 'actively, analytically, and critically starting to think about what the data means' (V. Braun & Clarke, 2013, p. 205).

6.3.3 Coding

Following the reading and familiarisation stage, the researcher began to generate initial codes. This was completed while reading the entirety of the dataset for a third time, jotting notes on a pad, and highlighting statements and elements of significance in the text. The handwritten initial codes were typed and grouped around common themes (Appendix Q). The dataset was read in its entirety again. The codes and initial themes of 'emotions', 'competence', 'behaviour', 'relationships', 'humour' and 'roles' continued to be reviewed and refined. The list used for this process can be found in Appendix R.

The researcher undertook another complete reading and highlighted statements with different-coloured highlighters. This was undertaken in conjunction with the dynamic list

of codes. An example of the manual highlighting and coding can be found in Appendix S.

Below is an example of multiple codes within a participant's single citation:

“And now, thinking about that, yeah, that's quite a funny situation. I was so scared that I was just in that mentality. And also, he saw it as quite a funny situation. It was also a teaching lesson, but he wasn't serious about it, like, “You should do this next time”. He just didn't take the situation too seriously. He understood that it was my first day and, yeah, yeah, he was just a very humorous carer.” (C1 student)

The following codes were allocated to the text:

- Humour: “And now, thinking about that, yeah, that's quite a funny situation.”
- Emotions: “I was so scared that I was just in that mentality.”
- Learning conditions: “It was also a teaching lesson, but he wasn't serious about it, like, “You should do this next time”. He just didn't take the situation too seriously. He understood that it was my first day and, yeah, yeah, he was just a very humorous carer.”

In pursuit of reliability the researcher then met with the supervisory team to complete another round of coding. The supervisory team, consisting of an Associate Professor and a Doctor of Philosophy (Nsg), had already familiarised themselves with the data, having completed multiple reads prior to attending the joint session. They had identified individual codes. When the researcher met with them, another round of reading was completed with all three members identifying and discussing their codes and rationales. This continued until consensus among all three members of the team was reached. Their discussion then identified potential themes and subthemes relative to the research questions.

6.3.4 Searching for Themes

Once the researcher was satisfied that no further codes could be identified, the statements were printed and taped onto individual self-adhesive notes containing the appropriate codes and statement references. This ensured that the researcher could easily relocate the information in the original text for future reference. All notes containing statements and codes were affixed to large white boards and grouped according to larger codes and themes.

Themes were extracted from the groupings of boards and the codes they contained. Boards were manipulated like large playing cards and moved around until cohesion of the whole data was achieved. This visual approach enabled the researcher to gain valuable perspectives of the data and its overall meaning. This process continued until the researcher was satisfied all codes and themes had been appropriately allocated and arranged.

6.3.5 Reviewing Themes

The researcher continued to re-read and scrutinise all grouped statements and ensure that all entries were appropriately grouped. By concentrating on reading small groupings of statements, the researcher was able to continuously ensure the overall meaning of the group was upheld in each statement. This process allowed the researcher to identify a statement that did not align and could effortlessly be moved to another group where the overall meaning was more appropriate. Examples of this can be found in Appendix T.

6.3.6 Defining and Naming Themes

This repeated revision continued until the researcher was satisfied with the final collation of statements in their respective codes and themes. This included some minor adjustments of themes and codes, including the merging of some of these to produce a well-defined list. One such example can be seen in the researcher's initial themes of 'clinical exposure', 'assertiveness and communication', and 'attitude' being combined under the theme of 'adjusting to learning conditions'.

6.3.7 Writing—Finalising Analysis

Each of these themes will be discussed in the context of the participants' reflections and interviews. Because of the wide range of findings, the three themes include subthemes. The researcher has included several direct participants' statements to support the findings. These not only substantiate the findings but also offer insight into the breadth of participants' experience during their first year of nursing studies, including their thoughts, feelings, opinions, concerns and successes. The first theme to be examined is the effects that the learning journey had on participants.

Despite the two different qualitative data collection phases, the coding and theming was completed in a single instance. Even though these were collected at two different time periods, all the qualitative data were reflective in nature: the reflective journal by the suggestive name itself, and the interviews being carried out in retrospect at different points along the journey. As the second cohort of participants did not attend their second clinical placement because of COVID-19, it was deemed more logical to place all the data together and continue to investigate the elements conducive to participants' overall wellbeing.

Throughout the process, the researcher continually referred to the research questions. This ensured that the analysis of qualitative data was directly relevant to the questions posed and the answers were formulated to clearly answer them. Once the researcher was satisfied that this had been achieved, the final report was produced. The preparation of the report was done in accordance with the research process discussed in Chapter 4, detailing how the qualitative data were collected and analysed. The corroboration of findings across all sources was achieved at the conclusion of the analysis phase.

The following sections of this chapter will describe the individual qualitative data collection methods corresponding to the findings. The research's findings will be compared with current literature and discussed in Chapter 7, while the implications of such findings will be explored in detail in Chapter 8.

For identification of each separate data source, the following codes were assigned to participants' quotes:

- R: reflections completed online during practicum
- I-1: interview conducted at the completion of the first clinical placement
- I-2nc: interview conducted at the completion of the second clinical placement—non-COVID-19 affected
- I-2c: interview conducted at the completion of the second semester with no clinical placement because of COVID-19
- I-3: follow-up interview conducted with student who had already completed two clinical placements prior to COVID-19

- A to I: letters added at the end of the participant's code to identify the individual student. This means that the researcher and reader can identify not only the student but when the information was obtained and whether this was their first, second or third interview.

Following are examples of participant codes:

- I-1-I: Participant I—first interview conducted after the first semester of study
- I-2c-I: Participant I—second interview with no clinical placement because of COVID-19.

In the following section, the participants' statements incorporate all reflective journals and interviews and form part of the qualitative data analysis.

6.4 The Neophyte's Odyssey

Several terms have been used to describe NSs; 'novice', 'beginner' and 'learner' are often used but do not necessarily summarise all aspects of experience, growth and acculturation the student nurse is exposed to during their formative years. The term 'neophyte' is derived from the Greek *neos* meaning 'new' and *phytos* meaning 'to grow' or 'to produce' and refers to the 'newly planted' or the 'newly converted' (HarperCollins, n.d.-a). It is contemporarily associated with a person beginning a new kind of life or work and in their state as beginner or novice. Upon reflecting on the journey that NSs embark on, the researcher deemed that the term neophyte aptly encapsulated the nuances offered by the above-mentioned nouns. Additionally, the term 'odyssey' is used to describe a 'long exciting journey on which a lot of things happen' (HarperCollins, n.d.-b).

The overall findings of all statements proffered by participants during their first year of nursing studies is encapsulated in the following quotation: 'I've learnt how to cope with the stresses in certain ways' (I-2c-F). A concept map detailing the themes and subthemes identified in the findings of the statements is presented in Figure 6.1.

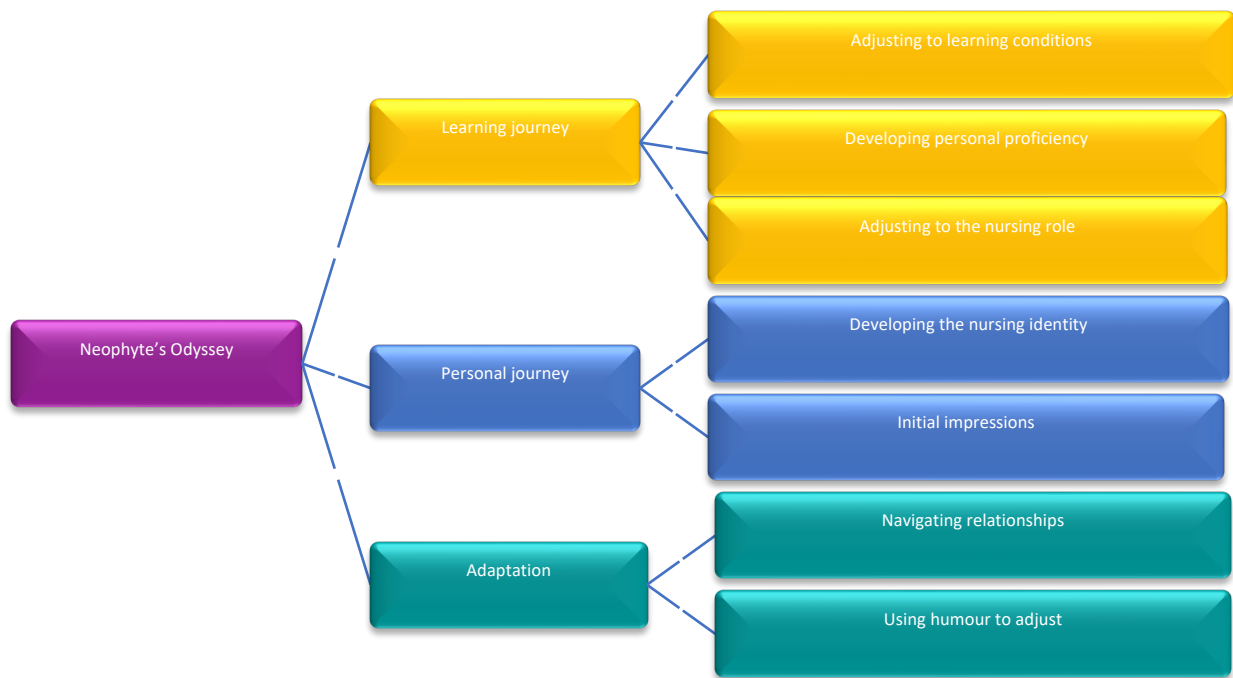


Figure 6.1: Concept Map of the Statements' Themes and Subthemes

6.4.1 Learning Journey of Participants

The learning journey took the participant on a merry-go-round. Starting off alone and, for the majority, not knowing anyone, the participants navigated through the campus maze to try to find their rooms and classes, and began to meet new people and form friendships. They engaged in practical skills in laboratories before being sent into the big unknown of a practical placement life where all the learning comes together. Several aspects marked the participants' learning journey and they are addressed here in three different subthemes, namely, how participants adjusted to the learning conditions, the development of their personal proficiency in the activity of nursing and how they adjusted to the nursing role itself. The following participant's quotation captures the learning journey experienced by participants, which transcended far beyond the classroom: "Those people who were trying to tell you these things originally ... Did it sink in at the time? Not really until I experienced it" (I-1-I).

The following three subthemes support 'learning journey' and are visually presented in Figure 6.2:

1. adjusting to learning conditions
2. developing personal proficiency

3. adjusting to the nursing role.

They will be discussed individually in the following sections.

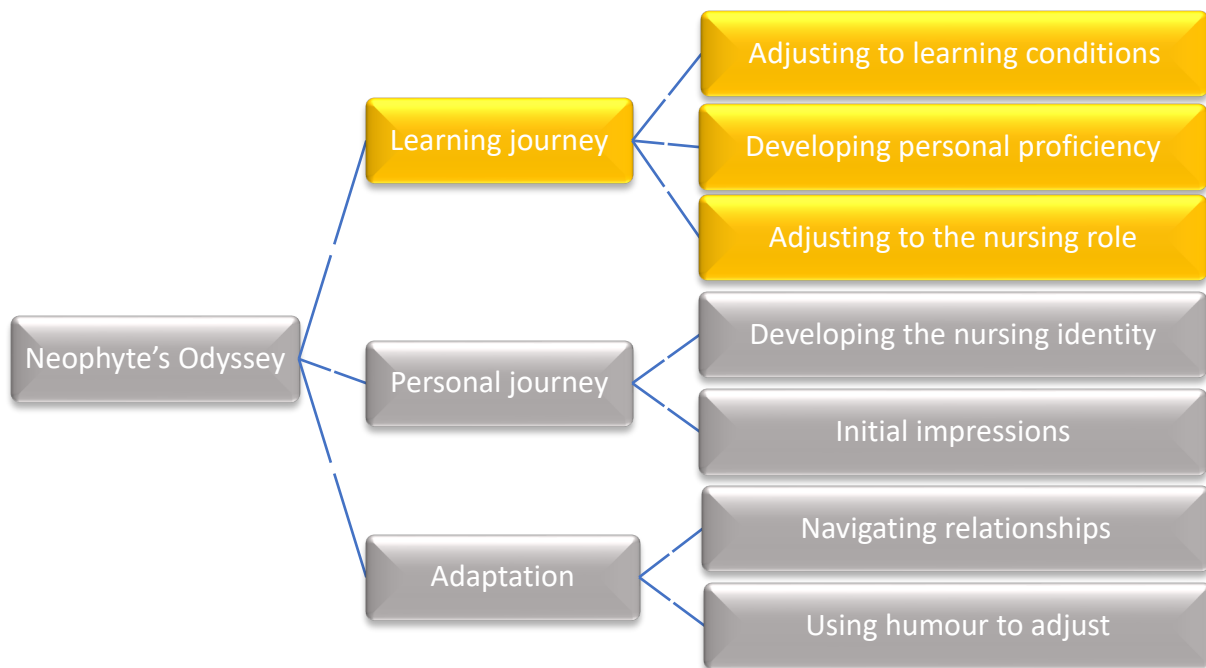


Figure 6.2: Learning Journey Themes and Subthemes

6.4.1.1 *Adjusting to the Learning Conditions*

The nursing program design played a major role in participants' experience. Participant I-2c-I stated choosing "this university because of its program and being all hands-on", while another, who was wondering whether nursing was for them, took a break and changed university in an attempt to answer this query. Participant I-2c-E finally stated, "I decided to try again at [this university] and I'm glad I did. It was just the program at [other university] I didn't like ... obviously quite a lot of students go but [this university] it's not a massive university", before adding that the hands-on, nursing-specific approach helped confirm their decision: "They learn so much more".

The availability of teaching staff was often mentioned as a significant contributing factor to adjustment. For participant I-2c-F, being able to reach out to staff improved the experience: "Just having a few staff at uni as a support network, to be able to just talk through certain concerns and stuff with ... If I was having trouble with some of the content". This was also echoed by I-2c-E, who reported:

“I think they really did all they could because at [this university], there’s the open-door policy, if you need to speak to someone, even if the person you want to speak to isn’t available, someone [else] will speak with you.”

This was in stark contrast to their previous university experience: “I never had that experience at [other university]. I remember I tried to email someone, and I didn’t get a response for five weeks”. This demonstrates that the academic personnel form an essential part of not only the students’ experience but also their overall learning and are integral to the teaching of content.

The integration of learning content is either achieved or compromised by the delivery mode utilised. Participants often mentioned the fundamental importance of face-to-face learning conditions in nursing. Participant I-2c-E stated: “I’m much better face-to-face. I do a lot better academically when I have gone to classes and my tutor is in front of me and I’m able to ask questions rather than it being online”. This is particularly true for tutorials, where I-2c-F stated that “they have to be face-to-face because it’s just the amount of content we have week by week, to me that is essential, having at least tutorials and labs face-to-face”. The benefit of this personal approach also continued in the clinical field: “I think definitely having a clinical facilitator as a point of contact was really, really good. If we had any questions and we weren’t really sure and we didn’t feel comfortable enough to go to the nurses or the carers, we could go to her” (I-1-G). Participant I-3-D, on the other hand, reaped the benefits of online learning: “I actually do really well from the online learning. I reckon, personally I thrived with the online environment”. In reflecting on the differences between face-to-face classes and tutorials, Participant I-2c-I highlighted that in class, “that experience sticks with you longer” while commenting on the absence of this personal interaction:

“It brought me down a lot. It felt very depressing. I was just learning something that can be spit out at anyone. When someone tells me a story about it, it feels very personal, you get on that level of them telling you that story.” (I-2c-I)

The advent of coronavirus (COVID-19) significantly disrupted the normal course of learning and teaching, affecting students in various ways. Participant 1-2c-F stated:

“I have no internet at home, so I was having to rely going into uni each day and still with the isolation, social distancing, trying to maintain that as well. Made things awkward. You can’t just go to another student that you recognise as a nursing student within the library going, “Hey, can we go through this?” And you can’t sit next to each other and run through things. So, things like that just makes it really hard. My laptop was playing up at the time as well, so that didn’t

help. So, having to rely on technology when it's not working for you, it's extremely frustrating."

This was corroborated by Participant I-2c-E, who stated, "I found it really difficult to say the least", while also adding, in the context of online attendance, that "it felt very optional, even though it wasn't optional". Although some participants found adjustment difficult, others demonstrated resilience and positivity. Participant I-3-D stated, "My time almost doubled, I had double the time to study because I wasn't commuting anymore", while I-2c-I candidly remarked, "It doesn't feel like I've experienced the full year of a first-year student ... I would say it sort of put a little pause in my studies as of now. I think the summer will be very, very busy".

Participants learning conditions also played a part in their motivation and personal accountability. Participant I-1-I stated:

"I'm a face-to-face person. I love going to lectures because I've seen too many times that the lecture's gone wrong and the teachers like, "Oh, well, I'll just put up an older lecture or something like that". And I also live on campus. Whenever I'm too lazy that I don't go to a lecture, I always hear in the back of my head, my brother saying, "You don't have an excuse. You need to go to these lectures and see these people". So I'm definitely more of a face-to-face person as well and it is always the back of my mind that's haunting me if I don't."

By the end of their second semester and the disruptions offered by COVID-19, that same participant then said:

"Because the last thing you want to do is to come back, and then you're underneath that weight. Because when it all went online, you sort of figured it out. You could see the easy way out of things, and that you could just get away with a lot more, rather than just being face-to-face. You read the information, and that sort of stuff, but you only had four questions to answer. It's pretty easy to answer four questions, rather than, you have four questions, but you're in a group, and then you're discussing those four questions with everyone." (I-2c-I)

This demonstrates that despite favouring a particular learning delivery mode, students can adapt and see the benefits offered to them, although this benefit could also be at their detriment, as expressed by Participant I-2c-I above. Other participants found ways to adjust despite their personal preference:

"I ensured that I was asking questions with my tutors wherever I didn't understand. And they were very forthcoming in answering the questions wherever I needed, all the concerns that I had. So that was good, but it's just ... Yeah, I just want to get back to the classroom." (I-2c-F)

Meanwhile, others were unaffected: “I probably participated the same” (I-3-D).

6.4.1.2 Developing Personal Proficiency

Participants developed proficiency along their learning journey; they left the initial shores of doubt, adjusted to the circumstances, and grew not only in competence but also in confidence. This next section will discuss the areas of personal doubt, adjustment, and growing competence and confidence.

Several participants expressed doubt and shock upon commencing their journey. The following quotation from Participant I-1-I encapsulates this well:

“It just reminds me of that first day of prac and getting shocked by what you have to do and what it means to actually be in there. Because they talk about you have to shower these people, you have to toilet them, you have to make sure that they’re always comfortable and that sort of stuff. I was like, “Oh yeah that’s not hard”. Then the day actually came where I had to do that, and I was just scared. I feel like everyone felt this way like, “This isn’t for me, I can definitely not do this or anything like that”.”

This was echoed by another participant (R2), who reported, “I was very self-aware of where I was and felt like I was an inconvenience. I was extremely hesitant to do anything or ask any questions”. That same shock even led participant I-2c-E to temporarily leave nursing studies: “Well, do I really like this? Is this really for me?’ So I ended up switching out of the other nursing”. Despite this, Participant R8 reflected by saying humorously:

“In recalling the event, I wonder what the resident (who doesn’t speak, and shows very little reaction) would have thought about me pausing the toilet trip to ensure the situation was correct ... I think on that memory with humour as the resident probably thought to themselves, come on let’s get on with it.”

Soon, the participants began to develop courage and to learn to steady their nerves. Participants learnt to ask questions and find reassurance. Some learnt this in hindsight: ‘I could have actively sought the opportunity to practise things I wanted to do’ (R5), while others aimed their queries directly at clinical staff: “I suppose I was doing what I felt was appropriate to confirm a situation that seemed odd to me, and I’m cautious to remember that I am new to this workspace and would like to clarify things over making preventable mistakes” (R8), or to residents/patients: “Over the prac I slowly learnt prompts to ask the residents and was able to engage with them more, which I believe was beneficial to my learning” (R6). Participants moved from being passive observers to actively taking charge of their learning experience.

This shift was only made possible once participants learnt to tame their performance anxiety and overall eagerness to please or sense of inferiority mixed with responsibility. One participant reported, “I felt a great deal of responsibility for treating the resident with utmost respect and making sure they felt comfortable in my hands” (R8). Participant R7’s sense of responsibility was affected by their mentor:

“I felt too intimidated by my supervisor’s superior position over me, even though they were really nice, that I didn’t want to go against anything they said ... I felt pressure from my supervisor to follow whatever they said even if I wasn’t comfortable with it. I also wanted to quickly finish the task so to avoid any further discomfort in the resident.”

In turn, the stress experienced made way for confidence and competence. Participants’ growth occurred on a daily basis. Participant R2 declared on starting their journey: “Looking back I believe I could have been more confident and positive”. Participants saw differences between diverse work shifts: “I felt a lot more encouraged in the afternoons and felt more excited to practise things like vital signs and assessing wounds and skin integrity”. The passage of weeks was felt by Participant R3: “The first day I felt quite nervous and I wasn’t sure what to expect ... Throughout the week I became more confident to perform tasks and felt more able to perform tasks”.

The following excerpt captures this overall feeling of prowess:

“That had to do with always being watched, always looking ... Sometimes the carer would step in when I was taking too long to put on someone’s socks. Then eventually, they would just leave you alone. They would be like, “All right, you stay here. I’ll go and help these other people. You just get them all ready”. It felt really good. I remember the first day I did that, it was a lot of fun.” (I-1-I)

This growing assurance over time also led some of them to develop assertiveness. Initially, on Week 1, Participant R7 reported that they “didn’t feel confident enough to speak up and say that I would’ve preferred to observe on my first day ... I should’ve used my intuition more to complete tasks and took a stronger stance”. The experience was, however, a learning opportunity, as they later added, “I will be more confident next time and let them know when I’d prefer to just observe” (R7). More confidence in themselves helped Participant R10 look for opportunities to speak up:

“This EN was refusing to give her any of her pain relief medication, just saying she was just acting and not in pain. So the resident had to go a couple of hours with no pain relief and wait till the RN started, and as soon as we saw her, we told her what happened and she gave the medication to the resident.”

This also resonates in Participant R6; their confidence and assertiveness helped them to think critically, take initiative and behave ethically: “Morally, I felt that if I was in the shoes of the resident, I would love to have someone walk with me all the way to my destination rather than leave me halfway”.

Participant R12 recalled how their assertiveness developed with the following:

“I had to work with a carer who had been rude to me previously during the practicum. From the first interaction, she seemed okay—though I had only worked with her for about half an hour before finishing. When I had to work with her again during the third week, she was rather rude to me when I didn’t move fast enough for her liking because I’m a student. I responded with “I’m only a student, you need to be patient”. She didn’t apologise, but just said “It’s okay”. I felt such relief when she left that day. When I had to work with her on my third last day (Wednesday of Week 5), her attitude towards me had completely changed and she was super kind to me and treated me as if I was a member of the team rather than just an annoyance.”

This assertiveness was in turn translated into confidence: “In Week 5, I felt confidence—as I had stood up to this carer and I gained respect for it” (R12). This personal growth was also repeated in Participant R7: “I’ve learnt not to let people in higher positions above me intimidate me.” This demonstrates that time (from Week 1 to Week 5) and exposure to opportunities helped participants manifold; they moved from the quiet observer to the student nurse who can stand up for themselves or the person they care for, look for and act on opportunities, and mature and flourish rapidly in the process.

6.4.1.3 Adjusting to the Nursing Role

While developing their skills and confidence, participants were confronted with unexpected realities experienced in healthcare, namely, heavy workloads and a general sense of being somewhat exploited as free labour rather than respected as the burgeoning student nurse.

Participant R5 summed this by writing:

“I felt a lack of support at times, which could be challenging as a new and inexperienced person in the field. It was also frustrating when it was understaffed, as I would feel as if I was free labour as a carer, rather than being a nursing student who is there to learn.”

Workload challenges affected students’ learning opportunities, described as an opportunity to learn to manage priorities but “sometimes challenging to manage tasks

and requirements” (R2). Participant R11 reflected on their care performance improvement around priorities and time:

“I just tried to make sure that with each dressing, that the resident’s comfort was a priority and that when I was to do the next dressing change for them, that I was able to get the task done in a more timely manner.”

However, Participant R5 perceived that it instead deprived them:

“I felt there was not a lot of opportunities to ask questions due to staff members being busy and largely dominated by a heavy load of showering, which I feel made me miss out on opportunity to practise vital signs and things I wanted to practise.”

Participant R6 noticed the effect of a busy workload and what it denied residents: “The residents had expressed their thanks many times when I accompanied them to places, which made me feel a little sad as I believe they did not get this opportunity often with the busy caretakers”. This affected the involvement of carers and students with residents: “Just been really busy constantly with doing ADLs [activities of daily living], no emotions really” (R4). Participant R1 also remarked on the resulting emotional impact of this: “The interaction between the resident and AIN [assistant in nursing] was rushed and cold. The residents appeared annoyed and expressed that they were frustrated”, as well as the standard of care: “The residents were feeling unwell and coughing and had fever for couple of days, which was not dealt with ASAP” (R9).

Nursing care duties performed by participants, particularly during their first practicum, often did not match their initial expectations and were viewed adversely. Participant I-1-D reported:

“It depended on who you’re working with. Like there were some people are like, you didn’t feel as like welcome or they’d come give you these insignificant tasks and you’re like, well I’m here to learn. Sometimes you feel like a free employee.”

The same sentiment was expressed by I-1-E:

“Something I did realise throughout prac as well is that you’re not there to be an extra ... well, you are there as well to help, but you’re not there to be an extra pair of hands or free labour. You’re there to work and you’re there to learn your skills that you’ve been told and everything, you’ve been taught and that you’ve read about or learned.”

Participants felt initial shock during their practicum. Participant R3 stated that they were initially “quite nervous and I wasn’t sure what to expect”, and that “at the time the

situations seemed super scary” and they were feeling “a bit nervous”; however, they commented that over time, their “initial fears dissipated”. Participant R7 expressed being generally disoriented and “I was in a complete new environment”, while Participant R10 experienced shock over what they were exposed to: “I first meet her before she became palliative and was able to walk around to eat all foods. But in a short 5 weeks [period], we watched her deteriorate ... for the first time seeing this, it wasn’t the easiest to watch”. Similar to Participant R3, as stated above, the adjustment from initial shock was also expressed by Participant I-2nc-C: “I was quite nervous at first, but ... I got used to it, and it was really good”.

Overall, and in spite of confronting situations and difficult feelings, participants experienced their first placement in a positive way, which is well reflected by R2:

“My first week showed me exactly how much is involved in working in residential aged care. AINs do so much—little bits of nursing and cooking and caring and manual handling and counselling and so much more. It is an incredible opportunity to be able to witness this, simply observing for almost a whole week.”

This was echoed by Participant R7:

“Overall, I learnt a lot from both of these experiences by diving straight into the deep end, and so even though I felt a little uncomfortable during the process, they still produced beneficial outcomes for me as a nursing student.”

Although participants were confronted with the fast pace and demanding reality of clinical practice, they overcame these obstacles. The above statements demonstrate that they were able to deal with the shock experienced between expectations and reality and adjust quickly. Once they had found their rhythm, they could recognise and take advantage of opportunities, and progress in skills and behaviour.

6.4.2 Personal Journey

In addition to developing their knowledge and experience of nursing as an activity, the flourishing nurse experiences growth on a personal level. Students begin to develop their identity and belonging in the nursing world. This is partly shaped from previous expectations, and the clashing of those expectations with reality and personal values. The initial impressions formed from the first year, which include exposure to the clinical field, affirm students’ choice of their nursing career pursuit. This section will discuss how

participants' nursing identity began to develop throughout their first year and the result of their initial impressions.

The theme of 'personal journey' has two subthemes. These are:

1. developing the nursing identity
11. initial impressions.

These are represented in Figure 6.3 and will be discussed individually in the following sections.

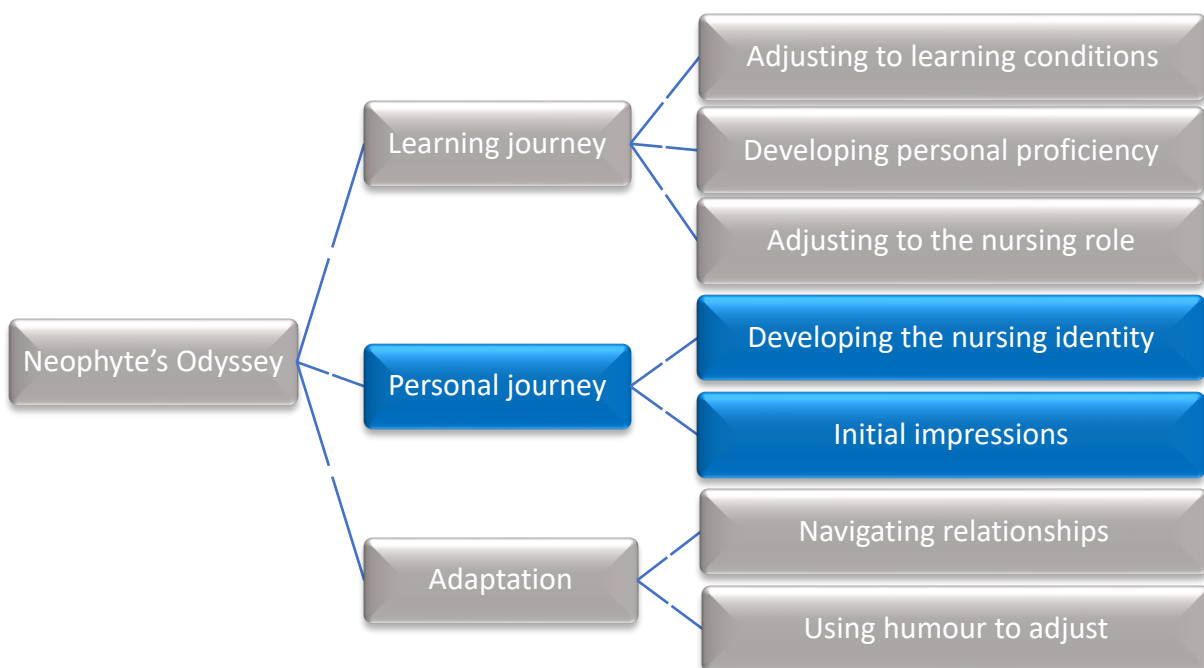


Figure 6.3: Personal Journey Themes and Subthemes

6.4.2.1 Developing the Nursing Identity

The clinical placement is designed to amalgamate academic learning and practical skills assessment, while exposing the student to the professional culture and its intricate realities and the individuals within it. Participant I-2c-E summed this well: “But with the prac thing, it’s not a bad challenge. It’s just preparing you for what’s to come in the future and what’s expected of you as a nurse”.

Participants were thereby able to evaluate their expectations against reality, while reconciling this with the limitations of being in training. Participant R10 stated:

“A part that was difficult was when you could see the resident was in pain and visibly distressed (like shaking) and calling out “I am in pain” but the nurse who was on at that time (she was an EN) wouldn’t give her any of her PRN medications.”

This episode proved a building block for the student nurse: “It made me take away you should never judge someone for saying something when you wouldn’t even look at them and saying they’re just playing the pain” (R10). Participant R3 also experienced difficulties:

“The times I felt a bit nervous were with the high risk of falls patients or in situations I had not learnt/read about prior. For example, I was not sure what to do when patients were becoming frustrated or they demanded they were able to be independent, despite their care plan saying they required help.”

However, these difficulties were also instances to be overcome with the caring nature of their colleagues: “The carers showed me what to do, and after a few times observing and helping with assistance, my initial fears dissipated” (R3).

These experiences are building blocks for students in shaping the nurse they wish to be, projecting themselves in the future. Participant R8 reflected:

“It makes me think as an RN in my future, I will always ensure a patient’s safety is a priority and I will query anything that seems to challenge my confidence in that. However, I will also endeavour not to be shocked or surprised by an individual’s capabilities, and not presume the supposedly obvious.”

These future wishes for the professional self are echoed in Participant I-2nc-C’s comments:

“I know, as a future nurse, I need to be able to do certain things, and I want to prove myself, I want to be able to become a good nurse. So in order to be a good nurse, I need to control myself.”

Even more so, participants realised first-hand the importance of the role as the future nurse. One participant stated, “In this profession, if you pretend anything, it could mean someone’s life. You have to take it seriously” (I-2c-I), while another remarked, “Obviously you’ve got people’s lives in your hands, but realising how thorough and on the ball you really have to be, that was definitely an eye opener” (I-2c-E). Participant R7 was even thinking of when they would in turn mentor a student: “If I ever mentor a student nurse when I become an RN, I’ll definitely have that understanding of how daunting a first practicum unit can be”.

The clinical experience enabled participants to experience what it was “to be a nurse”, albeit in their first stages of experience, and to observe, feel and do nursing. They were able to appreciate what it takes to be a nurse, be confident with who they are, and realise whether they can embody the very essence of nursing.

6.4.2.2 Initial Impressions

The first year of nursing studies, including practical placements, affected the students on several levels. It helped participants develop an awareness of the type of nursing and population they would like to work with in the future: “It made me realise however that I would rather deal with children. And younger kids” (R4). This was also shared with another participant: “Before starting my practicum, I was pretty keen on paediatrics (as that’s my prior work experiences), but this week has opened my mind up a lot more to work with different ages” (R3), while Participant R11 expressed their interest in the type of nursing care rather than a population: “This helped me realise that wound care is most certainly an area of nursing that I want to go into”.

The initial exposure to nursing also proved to be a reinforcer. One participant remarked, “This is easy. I could do this as a living” (I-1c-I). This was echoed by Participant I-1c-G: “The whole time I was, yeah, this is cool! I can do this for the rest of my life. So, it [practicum] definitely helped. Definitely balanced it out”.

In addition to being a decision reinforcer, the first year and clinical exposure were a motivator. Some realised future potentials: “It was a bit saddening with dementia patients who were very confused, but it definitely did help my drive to contribute to science and hopefully prevent different types of illnesses and diseases” (R3). In a similar way, Participant R7 stated: “It just fuelled my desire to become more proficient at these tasks to the point where I can minimise discomfort in the resident”. Participant I-2c-E was sparked by the efforts required: “It sounds like I’m saying it’s a really hard job. It is a hard job, but it’s such a rewarding career”.

The exposure to the clinical world did not make any of the participants reconsider their choice of study or future career: “I did not reconsider becoming an RN” (R1), “I am still set on becoming an RN” (R3), “It didn’t make me reconsider becoming an RN” (R4), and “From all the different things I have seen it hasn’t changed what I want to do and become an RN” (R10). Further, the impact was sometimes resounding, participants

stating that the experience was “eye-opening” (R2), “a most needed learning curve” (R11), and “inspiring” (R8).

The exposure to clinical practice breathed life into the idea of nursing. It was no longer a fantasy; participants had the chance to compare their expectations and contrast them with reality. This resulted in them being able to ascertain whether nursing was for them, to continue their journey. This newfound knowledge became part of the foundation to propel them into subsequent semesters of study, on the road to continue and hopefully complete their education program.

6.4.3 Adaptation

Participants’ statements from their reflections and interviews highlighted how they navigated their first year. This brought to light elements that were conducive to them coping and tapping into personal resilience, developing these elements relevant to nursing activity. These elements of coping and resilience were particularly emphasised through the various individuals that participants encountered during their journey and the numerous relationships they formed along the way. Additionally, the use of humour was highlighted in all interactions and experiences, and its presence and effects were wide-ranging, including an impact on these relationships. This section will discuss the theme of ‘adaptation’ and its two subthemes. These are:

1. navigating relationships
2. using humour to adjust.

These are represented in Figure 6.4 and will be discussed individually in the following sections.

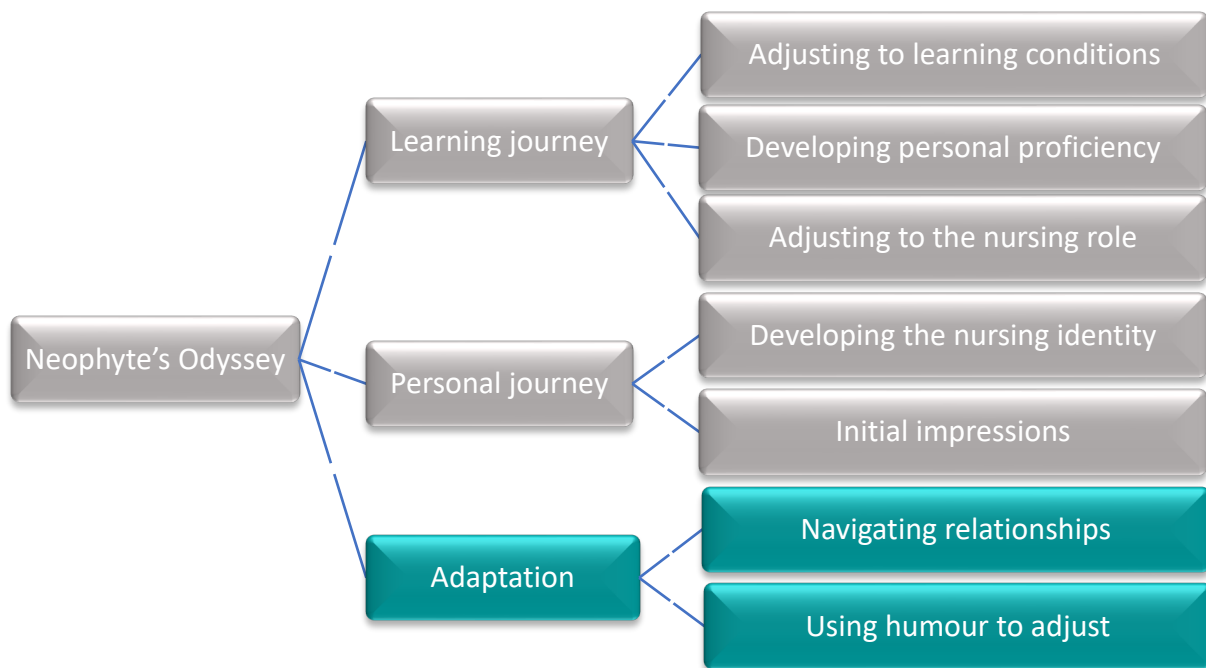


Figure 6.4: Adaptation Themes and Subthemes

6.4.3.1 Navigating Relationships

The relationships and personal interactions that participants experienced in their first year proved influential for them. They included those formed with other students, academic staff, clinical mentors and the people they cared for. This section will discuss these relationships in detail.

Personal interactions offered to students and their quality were conducive to participants successfully completing their academic and practical components. One participant (I-2c-E) was able to contrast their experience between two universities and the impact that it had for them:

“The reason I left [other university] in the first place was because I felt like a small goldfish in a massive ocean ... I prefer actually going and physically sitting in the lecture theatre with whoever is doing the lecture at the front, and then you can ask questions or, when the lecture's done, and you have a question, you can go up and ask, I just much prefer that, than sitting on your laptop, looking through the slides and writing notes ... I'm just blown away by the helpful nature of everyone at the university.”

Participant I-2c-F also remarked on the helpful nature of direct interactions:

“Just having a few staff at uni as a support network, to be able to just talk through certain concerns and stuff with ... If I was having trouble with some of the content in the units ... I found it easier in the second semester to approach my tutors and course coordinators to ask questions. I know I had to ask questions for more elaboration.”

This also translated in the clinical field, where participants remarked on the helpful nature of relationships. Some noticed this with residents:

“I believe by accompanying residents down to places they need to be at allowed me to develop my social skill and was beneficial in that the residents got to communicate with people and would feel less lonely on their usual walks. These skills I learnt from this will be helpful in my journey to be a RN as it helped me take the first step to developing therapeutic relationships with my patients/residents.” (R6)

Participant I-1-D's experience was dependent upon whom they were paired with on particular shifts: “There were some people I felt comfortable with, but others I was just like, “You obviously don't care about teaching me”, so why would I ask?”. This was also shared by Participant R1, whose mentor affected their experience: “My buddy was rushed and did not engage in verbal exchanges with me or the resident. It was clear to me that she did not want to talk or share information with me”, yet this did not deter them in engaging with residents: “I attempted to engage with the resident. Make eye contact and asked questions about how they felt or what they needed” (R1). Despite this, they summed up their experience as “lonely”.

Participant I-1-A reflected on how gentle encouragements from a mentor helped them overcome personal difficulties:

“I'm a bit more of an introvert. I don't really go out to socialise much, and small talk is a little bit more difficult for me. So, I think with this prac, at the beginning I wasn't really too social. When the registered nurse told me to go talk to the patients, I was a bit hesitant, and it was harder, a bit more awkward for me, to make small talk. But I think over the prac I slowly got used to it, and it was easier for me.”

The sudden arrival of COVID-19 robbed the participants of these face-to-face interactions. Participants felt the impact of this deeply:

“It affected a lot I would have to say, but during the studies, it felt like you just went into this haze. You just felt like you didn't know how to feel, how to react. You knew what to do, it was very easy what to do, but ... Throughout the semester, you would always complain about the assignments, and studying, and the long hours, and going through all these classes, and having four

lectures in one day, and when that was taken away from you, it felt like you missed it, but you didn't want to admit that you missed it." (I-2c-I)

However, participants coped with the difficulties by reaching out to those meaningful relationships. One participant stated:

"It was a number of times where I didn't [cope], but venting to friends, a couple of staff that I know well enough at uni to go, "This is just not working for me". Especially with the staff were, "Let's see, what can we do to help you along the way?" (1-2c-F)

This was not shared by all; Participant I-3-D welcomed this change of attendance style: "But to be honest, I always dread driving all the way to uni to sit in classes and I don't feel like that's where my time is most productive".

In summary, the role of all relationships was significant in participants' experiences. Connections made at university or in the clinical field had a deep impact on participants and were recurrently identified as meaningful in dealing with current situations faced. Relationships that were more difficult also affected participants' journeys, rendering them less enjoyable, more difficult or more confronting.

6.4.3.2 Using Humour to Adjust

Humour featured heavily in several aspects of participants' experiences. It was conducive to all manner of personal relationships, whether in improving interactions and teamwork, breaking down barriers, or regulating moods. It was experienced frequently and by all and proved invaluable in the learning experience. The role of humour will now be discussed relative to these aspects.

In improving the quality of relationships, Participant I-1-A remarked after the first semester:

"They [the staff] would banter, which was really sweet to see. And in between patients with the residents, I'm not too sure they understood some of the jokes that the caretakers tried to make, but it was still nice to see that some of the caretakers were trying to just make them a little bit happy, which is really good."

They were also able to appreciate the impact of this by their second semester:

"It definitely helped strengthen some of my relationships with some of the residents, because I feel if you weren't being able to joke with those residents

then you wouldn't really develop a strong relationship with them. It would just be a passing by kind of relationship." (I-2nc-A)

The positive impact of humour was supported by Participant I-1-E:

"In a therapeutic relationship it [humour] takes seriousness away from some of the things that may happen between a health professional and their patient. It makes them feel comfortable. I just think humour's just a part of pretty much every single relationship. You see it every day, people use it every day."

This was mirrored by Participant I-2nc-C:

"I think it kind of enhances our visits ... being able to have a jovial conversation that really could, it really brightens their day. I know a few patients have said so, or they've been really grateful for the visit by the end ... I think rather than a very serious visit where it's just all about the care, not really saying much, being able to talk to them."

Humour improved interactions and teamwork with clinical staff, and this was noted several times by participants: "I think me and my buddy really benefited ... We'd sort of feed off each other and encourage each other and laugh with each other. And that was really good" (I-1-B). This was repeated by Participant I-1-H: "Whereas throughout when you got to know them a bit more and then you became more like you were working together, not just you helping them ... that definitely helped with the partnership".

Humour helped in breaking down barriers: "And it wasn't this authority figure. It was something that we could ... there were people we could go to and talk to, because it was this relationship that had started building" (I-1-G). It was helpful in levelling perceived imbalances of power: "It makes them seem more approachable" (I-1-C).

Humour was also observed to be an emotional regulator. Humour appeased stress by reducing performance anxiety and acting as a mood enhancer. Participant I-1-A stated, 'It helped alleviate the heaviness and the stress', while Participant I-1-B reflected:

"I think people ... not laughing at me, laughing with me ... when I do little things and mess up or I dropped something or I'd just mess up and be absolutely mortified as a student nurse and the nurse that I was with would just be like, "Oh it's fine". And then tell me a story of when she messed up or did something similar or another colleague of hers had done the same thing."

This was reiterated by Participant I-1-C: "The carers' intent is just to make the atmosphere lighter. So, they just point out how serious we're being. Yeah, make a few jokes, which I thought was good. And make us less tense".

Additionally, humour served as a teaching adjunct and had a therapeutic value with residents as well. Participant R7 provided this anecdote regarding their own learning:

“My supervisor was pretty easy-going and found a lot of my small mistakes amusing, often laughing in a good-natured way. This alleviated my stress towards completing tasks appropriately and not beating myself up too much when I did make mistakes. I was also very afraid of incorrectly assuming a certain way of doing tasks; thus, I only followed what my supervisor said without using any intuition. Because of this, I buttoned up the resident’s shirt unevenly and wasn’t sure whether to redo them or not due to time constraints or something else. My carer laughed, saying “Of course you need to redo them”, which I now completely understand and also find funny that I was scared to the point that I thought it was okay to purposely leave a resident’s shirt incorrectly buttoned up. At one point I tore open a foil packet with a sterile tissue inside, when suddenly my supervisor gasped at what I was doing. I stopped what I was doing and internally panicked for a couple seconds before I realised my supervisor was just teasing me, I had done nothing wrong. It definitely alleviated the tense atmosphere in the room that I was feeling, trying to perform everything correctly, and I realised my supervisor could tell how serious I was being and wanted to poke fun at me.”

Participant I-1-H reported, “Residents would be then more open to the carers, or [to] some sort of treatment, or asking them to do certain things that would help us ... more would get done quicker”. Even more so, it helped improve socialisation, as this anecdote by Participant I-1-A reveals:

“I was assisting a resident down back to their room, and for fun I said to her, “Oh, we’re going to kidnap you”. And she thought, “Ah!” She liked to exaggerate her reactions, and she said, “Oh, no!” and she played along. And then I said, “We’ll raise all the money up for you, and then you can have half of the ransom money”. And she went, “What would I even do with all that money?” She just kept playing along, which was great. Even some the caretakers who were walking around noticed, and they’d start joking around too with her, which I thought was really great because this resident particularly didn’t seem to engage too much with other people. And so, I think with this incident made her day a lot better. And, at the end of that, she actually decided to sit outside instead of going back to her room and sit with other people.”

These effective uses of humour demonstrate its versatility. It was often a coping mechanism, affiliative and effective in improving teamwork. It also demonstrated its capacity to produce positive care outcomes.

The benefits of humour were felt by everyone. Patients and residents were beneficiaries:

“The humour just helps them, and it just gives them something extra for their daily routine. Because I’ve seen that the routine that they go to, it’s just the same thing over and over again. So, I think to have something different in their lives, like a bit of humour, it really benefits them more than it does for us.” (I-1-A)

This was corroborated by Participant I-1-G: “I think a lot of the residents, they don’t talk to many people because if their family doesn’t come in to visit then we’re their only point of contact or communication relief”. Humour also benefited students and staff:

“It made us students feel really comfortable because we weren’t on this really serious term, although it was quite a scary thing for us at the beginning because it was our first one [practicum]. And the carers really helped us ease into it and they were just making jokes, making sure that we were comfortable.” (I-2nc-C)

Overall, participants widely identified the benefits of humour to all: “Everyone benefit from that” (I-2nc-A), “Everyone benefited” (I-1-B), and “I’d say everyone” (I-1-F).

The presence and frequency of humour use were initially not easy for participants to observe. Participant R1 stated, “During the first week, I was mostly nervous and trying to take everything in”, and denied observing any instance of humour, which was echoed by R9, who simply stated, “No’ to any humour observations in practice. Some participants had a sense that humour was present but could not quite locate it yet: ‘I think that there’s a sense of humour in nursing ... Even though usually most of the time it’s not a funny situation. But, yeah, I don’t know. I think that’s present” (I-1-C). Despite being categorical about a particular aspect: “Nothing funny about someone in palliative care’, Participant R4 recognised the presence elsewhere: ‘But during ADLs, lots of laughs about the difference in age and the residents’ ages. As well as laughs about personal stories”. This awareness grew over time and became evident upon reflection. Participant I-1-B stated:

“I know reading the research study before we went on prac and agreeing to it, I was like, “Sure I’ll do it, but I don’t know what she means by using humour in healthcare. I’ve got no idea”. And then going on prac I was like, “Oh, this is how it works”. I can see how beneficial it is in healthcare.”

Additionally, Participant A remarked in the first semester, “I haven’t actually seen humour used” (I-1-A), and by the end of their second semester, replied, “Yes, it was definitely present actually most of my practicum. It was used quite frequently by the staff, by the students and even by the residents themselves” (I-2nc-A). This reveals the

importance of the prior awareness of information and education. With prior awareness of and familiarity with humour, participants were able to identify it in practice.

This difficulty in noticing the presence or effect of humour might have had to do with how participants defined the concept. When asked to define humour, most participants hesitated and took some time to answer. Participant I-1-D attempted a beginning but eventually gave up: “I guess when you laugh and find something ... I don’t know how to define humour”.

Some participants defined it as something that you do, an action, or a behaviour that affects others: “It’s anything that we can do or maybe say that can create someone else to maybe laugh about, or smile” (I-1-A), and “It’s some way of making you laugh, I guess. Yeah. And it just brings a sense of lightness and happiness in people” (I-1-C). It was also perceived as something being done in conjunction with others: “Something that makes you happy, or just makes you laugh, usually with someone else, I guess as well. Yeah, it just makes you laugh, really” (I-1-H). However, humour is also unique to the individual: “There are many different types. Everyone has their own particular sense of humour” (I-1-C).

For most, humour was all at once subtle, nuanced, even complicated. Participant I-1-B initially described the function of humour as “sort of finding the funny in situations that it might not necessarily be obvious”, and then tried to refine their answer by adding that it related to “things that make you smile in everyday life”. Participant I-1-F described it as “just to be able to have an emotional ... it’s almost like an emotional valve where you can just be able to relax at times and just not have to take certain things as serious or to make a certain situation a bit more adaptable”.

Several participants identified the coping mechanism inherent to humour. Participant I-1-F offered another version: “It’s a way of being able to translate a topic into a more relaxed way of coping with any possible difficult situations”. The beneficial aspect of humour was noted by Participant I-1-G, who reflected, “I found that humour always helps me cope a little bit better. Making a joke out of a situation makes it a little bit lighter and not as heavy”. This mood-shifting effect of humour was also described by I-1-A as something “[to] uplift people’s mood” and characterised as an overall way of being, with Participant I-1-B adding that it was about “finding the funny and finding the fun and it’s kind of important in the idea of life”. Meanwhile, Participant I-1-I was categorical; for

them, humour was: “definitely coping ... like a smooth layer over the rough patch and that sort of stuff”.

The concept was not any easier to define over time and had actually widened by including a bit of everything. During their second interview, Participant I-2nc-A stated that “humour to me means anything that can make someone laugh”, while Participant I-2nc-D reported that it was about “making laughter or light of the situation. Or it doesn’t have to be a situation, it’s just good to make someone laugh”. Being able to have a clear understanding of what humour entails, and all its nuances and applications, could have helped them to appreciate it even more than they did in practice.

Humour appeared to adapt and change over time and according to exposure and use. Participant 1-1-F reported, “We’re able to adapt and change, notice changes for residents, and learning about the various effects of dementia and different abilities of the residents throughout both areas as to how I would adapt my humour to aid them”. Participant 1-2nc-A’s use of humour grew with clinical exposure:

“My humour maybe got a little bit better since coming into this rehabilitation one, especially since most of the residents were able to better interact with me more. So, I was able to also develop a different sense of humour as well that could relate to them. Yeah, I think it’s changed quite a bit from what it was in the middle of the year.”

Participants’ comments did not indicate that humour was ever used disrespectfully: “[It was] never disrespectful to each other or to residents or anything” (I-1-B), “We never used, never derogatory towards her or anything” (I-1-E), and “Staff knew what line they weren’t supposed to cross, and the residents as well” (I-2nc-A). Participant I-1-I was able to recognise boundaries but admitted the difficulty in maintaining them at times: “It was just like a time to take a deep breath and laugh about what just happened. And sometimes, there was matters where you couldn’t really laugh at it, but you couldn’t help yourself sometimes”.

Several participants identified the pervasive effect of humour in nursing: “It helped with confidence” (I-1-H), “[In] nursing, you definitely put the humour on top to smooth out the rough patches” (I-1-I), and “It helped me stay on prac and it stopped it being so daunting” (I-1-B).

Despite being difficult to define succinctly, participants acknowledged, felt, experienced, used and saw the benefits of humour on all levels. Once aware of it, they were even more aware of its impact and used it to their advantage. It was a way to relate, break the ice and equalise relationship imbalances, and relieve tension. It was a frequently used, helpful coping mechanism.

6.5 Interpretation of Qualitative Results with the Literature

The qualitative findings contained in this chapter demonstrated how participants navigated their first year of nursing studies. Specifically, they highlighted the elements conducive to their learning, acculturation to the nursing field and the significant contributors to their successful completion of experiences.

The research qualitative findings revealed that participants manoeuvred around obstacles and ultimately found ways to adjust following their initial shock. Whether in the academic learning space or the clinical one, participants adapted to their environment and the task at hand, and became confident, having come full circle in their learning experience. Despite having been examined alone, the adaptive role of relationships and humour affected participants positively in both their learning and their personal journeys and proved at times difficult to extricate from the other themes and subthemes. A significant implication of these findings is how the quality of relationships and humour are elaborately threaded around the participants' journey into nursing. This implication will be explored in Chapters 7 and 8.

In this section, all qualitative themes and subthemes identified and will now be compared against what is currently known in the literature. The previous themes and subthemes will be used as headings and sub-headings and are represented below for ease of comprehension (Figure 6.5).

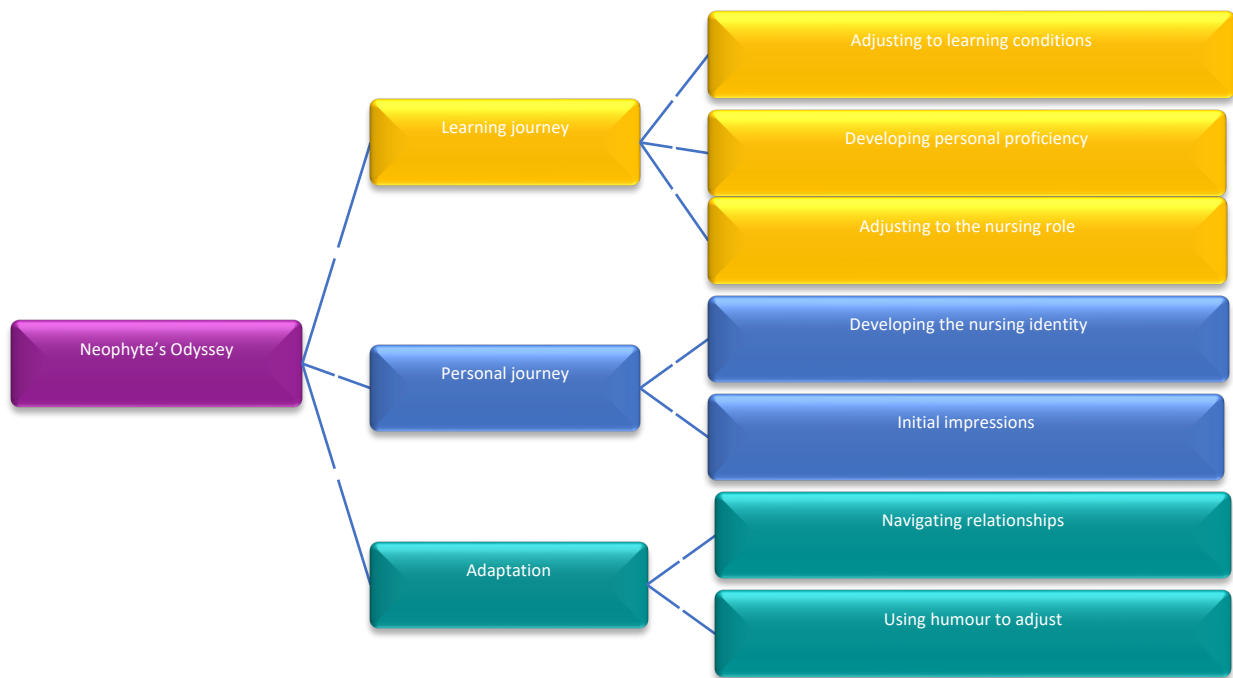


Figure 6.5: Study Themes and Subthemes

6.5.1 Learning Journey

Previously in sub-section 6.4.4.1, the researcher identified that the NSs' learning journey was affected by several elements including their relationships, the quality of interactions, and the shock experience at the onset of clinical practice and ensuing adjustment with time. Students need to adjust to a variety of learning conditions in both the academic and the clinical environments. As they navigate through this learning journey, they develop personal proficiency and adjust to the nursing role itself. These themes will now be examined in detail with reference to the published literature.

6.5.1.1 *Adjusting to Learning Conditions*

Students' adjustment to learning conditions was influenced by several factors including the program design, the availability of staff, the delivery mode of classes and unforeseen changes such as a global pandemic. These findings are mirrored in other studies and will now be compared.

This research identified that the design of the nursing program offered by universities plays a major role in the quality of the undergraduate experience and, potentially, its output. The nursing curriculum shapes the student experience in the classroom as well

as during their clinical experience. Care and consideration in developing a curriculum that scaffolds learning content and practical experience enables students to not only acquire new knowledge but also integrate it well into their practice.

Empowering students has been discussed by Sidhu and Park (2018) as being vital in the development of the nursing curriculum. Empowering students can be achieved by paying particular attention to increasing access to information, opportunities, resources, and support within the learning context (Moore & Ward, 2017). This also extends to the clinical field, where NSs need and expect guidance and leadership from their clinical preceptors (Zilembo & Monterosso, 2008). Empowerment can be defined as both a process and an outcome, positively guarding student and future RNs against bullying and incivility (Shanta & Eliason, 2014).

Section 6.4.1.1 discussed a significant finding—that staff availability played a major role in students' adaptation and overall development. Students highly valued the ability to reach out to a person with an approachable disposition. Some educational establishments may pride themselves on this level of attention to students' needs and expect academic staff to be available and offer pastoral care as part of their duties (The University of Notre Dame Australia, 2020a).

It has been demonstrated that the availability of and access to staff and resources is beneficial to students, enhancing their confidence, social support, and academic results (M. Christensen et al., 2019; B. James et al., 2016). These findings were evident in this study. Participants commented on how being able to easily access support from their academic team carried great weight in how they experienced their education, and how well (or not) they engaged and processed learning content, even weighing in the balance of whether or not to discontinue their studies.

In contrast, expectations increasingly being placed on the academic workforce have been the subject of mounting concerns, with some staff members being subjected to counter-power harassment (M. Christensen et al., 2020), which demonstrated that students identified as the consumer, with assumed entitlements derived from paying for a service that was also accompanied by high expectations (M. Christensen et al., 2020). When this perceived value for money is not achieved, some students have been known to address the matter by means including verbal abuse, cyberbullying through social media, physical aggression, and even sexual harassment (Lampman et al., 2016).

Healthy relationships are not developed nor maintained unidirectionally. Students, and academic and clinical staff, have a lot to gain by understanding and reflecting on the development and maintenance of healthy and respectful relationships. By extension, the results achieved in this study can help parties including educators and learners gain insight into factors both conducive and obstructive to the formation of healthy, positive, affiliative relationships.

The findings reported in this study suggest that the delivery mode of academic content has an impact on students' comprehension and integration of concepts taught. Online teaching does not always equate to positive learning outcomes (Ramsay et al., 2020) and is not always the preferred mode by all and can present significant challenges to students with an impairment (V. Gupta & Jain, 2017; Muwanguzi & Lin, 2010). Additionally, to mend the gap between theory to practice, NSs gain much by interacting with RNs and engaging in hands-on learning (Wyllie et al., 2020). Experiential learning has also been demonstrated to improve through self-reflection and critical thinking (Cheng et al., 2020). This supports the blending of delivery mode offered by traditional lectures, learning content (textbooks, journals, lecture slides, etc.), tutorials and practicals (J. Y. Park et al., 2016).

Kenzig (2015) discussed how educators do not always possess the adequate training in translating face-to-face courses to online learning effectively. They also highlighted the necessity for students to connect with their instructors on the online platform to produce positive outcomes. Our study supports the important role of relationships, and face-to-face and meaningful interactions, between educator and student. This fact became particularly evident in our study with the advent of COVID-19, with students experiencing significant difficulties in connecting with staff and fellow students.

In an effort to provide flexible options to students, blended approaches, such as flip-class learning, are becoming increasingly popular. Video and online options also have the added appeal of being cost effective and offering flexibility of round-the-clock availability to the learner. They can also integrate more than one modality into the course delivery, therefore increasing accommodation of students' varied learning styles (Coyne et al., 2018).

The pandemic, despite causing significant disruptions to nursing education, has increased online activities of all types, giving educational establishments and students

new opportunities. Carmody et al. (2020) found a way to enable students to access and experience, at least in part, the clinical simulation environment by utilising a virtual environment explorer tool. This tool helped provide students with the beginning of an orientation to simulation classes and reduce the incidence of fainting experienced by some in the physical setting (Carmody et al., 2020).

Interestingly, a study conducted by Peddle (2019) found that students can develop more than technical skills through virtual simulations. Students' feedback following engagement in virtual simulations was that they also promoted non-technical skills such as critical thinking, problem-solving, decision-making, communication, and teamwork, with additional potential for role-modelling, situational awareness and an opportunity to learn from errors. Nonetheless, Peddle (2019) highlighted barriers to students' learning, particularly when questions, options or instructions were unclear or too limited for students. The experience of technical difficulties and a lack of feedback from instructors also played a part in lessening their experience (Peddle, 2019). Every platform of education provides advantages and challenges. Optimising curriculum development with findings obtained from virtual and in vivo investigations offers educators a wide breadth of opportunities to enhance learning outcomes.

In their study, Ranse and Grealish (2007) established a dedicated education unit based on a communities of practice framework to blend learning and practice for NSs. Their aim was not to lengthen clinical exposure but to optimise it. Students attended a dedicated unit for 2 days a week during their semester and recorded their feelings of acceptance and belonging in the team, the value of learning, and reciprocity and personal accountability. Blending several aspects can indeed enrich both the delivery of content and the practical experience to shape the future nurse. It can also promote acculturation (Ranse & Grealish, 2007). Our study demonstrated the students' benefit from their interactions in clinical practice, the vital role of these interactions in developing the nursing identity, and the progression of students from initial disorientation and shock to adjustment by the end of their clinical rotation. Our study demonstrates how instrumental relationships support this development and the process of acculturation, developing synergistically with clinical staff and care beneficiaries including residents and patients. Together, these findings can enable educators to continue developing learning strategies to maximise the development of the nursing role.

The coronavirus pandemic disrupted students, teaching conditions, and reduced or even forced the cancellation of clinical rotations. Suddenly, lectures were exclusively online and physical proximity to lecturers, tutors, and fellow students non-existent. Face-to-face contact became screen-to-screen and produced screen fatigue, and its reception was mixed (W. Zhang, 2020). The pandemic demanded academics adapt and continue to provide education beneficial to students (Jiménez-Rodríguez et al., 2020). Both students and academics had to demonstrate quick adaptation and flexibility, which are two valuable qualities in nursing (S. Price, 1999). Our findings highlighted how students adjusted to their new reality, even if they were less fond, or plainly loathed, some of its aspects.

Personal interactions in education encourage success. M. Martin et al. (2018) studied the accessibility of face-to-face support in a drop-in centre without appointments. They found that the accessibility of the centre was conducive to a higher-grade point average by participants due to increased academic support, reduced likelihood of failing courses and an increased sense of belonging. Changes to course delivery due to COVID-19 were particularly felt in terms of reduced social interaction. This demonstrates the significance of interpersonal relationships within the academic context. It also demonstrates how students were affected by the reduced human contact despite online availability of friends and academic staff and is consistent with the findings of this research.

Adaptation of students to academic program design was observed in this study. Students adjusted to the fast learning pace introduced to them on a weekly basis during the academic semester. Presented concepts progressed quickly from theoretical to practical and were highlighted in this study by how students adjusted from classroom to finding their feet by the end of their clinical rotation. This will be discussed further in section 6.5.1.2.

Despite the challenges encountered, including a global pandemic, our study demonstrated that NSs, and equally by default academic staff, established their ability to adapt to fast-paced changes in learning conditions. They also proved their ability to manage stress imposed by unprecedented conditions and drew on personal and collective strengths and resources to overcome these challenges. Participants in this study demonstrated further qualities expected in leaders, such as identifying

opportunities offered by changing situations and being proactive rather than reactive (Bower, 2000).

6.5.1.2 Developing Personal Proficiency

This research highlighted that knowledge is acquired in many ways and encompasses a wide variety of aspects, from theoretical concepts to clinical skills. The development and integration of both culminates in clinical practice, when students translate concepts to hands-on skills, in real time. Students need time and opportunity to stay calm and manage their performance anxiety, and to grow in competence and confidence.

Confidence has been shown to grow from the repetition of skills practice (Fiedler et al., 2012) and self-efficacy (A. Martin, 2010). These elements are crucial in striving for success and developing learning conditions that are conducive to overall happiness and satisfaction with school life. Participants of this study initially experienced doubt, and shock at the beginning of their journey. They then shifted from being passive observers, fumbling through their first-time task performances, feeling like an inconvenience, to being left, at times unsupervised, to execute tasks with confidence. They were confronted with differences of expectations in the clinical field (Kol & İnce, 2018). Their courage helped them to ask questions and seek reassurance (Alshahrani et al., 2018). In turn, this translated into reduced performance anxiety, tapping into coping skills (Bodys-Cupak et al., 2018), and newfound assertiveness and aptitudes for advocacy. Students' developing capacity for advocacy was also highlighted in M. Hughes et al. (2020) following their first year of nursing studies.

The principles of the development of professional proficiency are not newly discovered. A. Martin (2013) discussed the pathway students take in their educational development along the Personal Proficiency Network. This network includes motivation, buoyancy and resilience, adaptability, growth (personal best) orientation, and interpersonal relationships and social support offered by the environment (A. Martin, 2013). They are visually represented in Figure 6.6.

Figure: Removed due to copyright restrictions

Figure 6.6: Personal Proficiency Network (A. Martin, 2013)

All elements identified by A. Martin (2013) were observed in the current research. Motivation, confidence, skills practice and growth orientation, and overall adjustment to learning conditions, which were discussed here under the learning journey, relate directly to Martin's concepts of motivation, engagement, buoyancy, resilience and growth (reader can refer to section 6.5.1.1—Adjusting to Learning Conditions). These will also be highlighted in further detail in 6.5.3.1 when the researcher discusses the role of relationships with others. Other elements of Martin's are present in this study, particularly relationships, social support, and adaptability, that will be discussed in section 6.5.3 when the researcher discusses students' adaptation through learning and humour.

6.5.1.3 Adjusting to the Nursing Role

Evidence collected in this study revealed that NSs were confronted with the realities surrounding nursing practice. They did not expect to experience such a heavy workload, especially that of physical care needs. Many of them were shocked and left feeling they were exploited as free labour rather than being treated as NSs. Despite this negative aspect, most participants reported a positive experience that bolstered their decision to pursue a career in nursing.

Duchscher (2009) adapted the theoretical framework of reality shock developed by Kramer (1974) and expanded findings of the GN's journey in their first year, coining this process transition shock (Figure 6.7). Duchscher explained this expansion by examining the gap between what a GN is taught, and the shortcomings faced in the clinical world. Duchscher's model included the personal difficulties experienced by the GN that are experienced on the physical, emotional, sociocultural, and intellectual levels (Duchscher, 2009).

Figure: Removed due to copyright restrictions

Figure 6.7: Transition Shock (Duchscher, 2008)

This period of transition experienced by the GN has been investigated by several others. Meyer et al. (2017) looked into curriculum revision to address this, while S.-Y. Kim and Shin (2020) investigated different types of transitions and their attributes against the reality of NSs' clinical experiences.

J.-S. Kim (2020) examined the link between reality shock, professional identity, and the quality of relationships with nursing educators. E.-Y. Kim and Yeo (2019) investigated NSs' transitional experience pre- and post-graduation. Graf et al. (2020) reviewed several transitional models and concluded that Duchscher's (2009) model was the most appropriate for nursing.

Adjustment difficulties experienced by NSs in this study were closely linked to Duchscher's (2009) transition shock model in several ways. This research reported similarities to how students experienced the physical demands of nursing; the discrepancies between expectations and realities of clinical practice; role uncertainty; limited performance feedback; and the experience of intense, unsettling and highly changeable emotions. Some findings relating to students developing identity and their initial impressions of the nursing work are explored further in section 6.5.2, with examination of the student's personal journey. Additionally, the role played by relationships and factors conducive to their creation and maintenance significantly assisted students' transition and adjustment. These will be discussed explicitly in section 6.5.3.

The findings of this research, particularly around a student's adaptation and the elements conducive to it, were interrelated to other concepts. This was particularly evident in the close interconnection between relationships and humour. In section 6.5.3, the researcher will discuss how relationships and humour affect learning experiences. These two concepts, relationships and humour are merged in the following chapter and will be discussed in more detail.

6.5.2 Personal Journey

The findings in this section relate to the participants' personal journey during their first year of nursing studies. This personal aspect was partly discussed in section 6.4.1 above; however, the below sub-sections focus on findings concerning the developing nurse's identity and their first impressions of the profession.

6.5.2.1 Developing the Nursing Identity

The present study identified that the combination of academic learning and clinical practicum was instrumental in establishing the ground for the neophyte nurse's identity.

These experiences provided participants with opportunities to observe the effect of nursing culture outwardly in practice and inwardly through their personal reactions, compared and contrasted with preconceived expectations. These opportunities proved to be building blocks for students' development of ethical practice, professional values and understanding of the pivotal nature of the role of nurses in healthcare.

The nursing identity is created from multiple influences and has been explored from various aspects, singularly and in combination. Hallam (2012) documented a historical compilation of popular, professional, personal and contemporary nursing-related images and mental constructs. Bell et al. (2015) performed a lexical examination of the concept of nursing and found that nurses are becoming increasingly detached from the patient, family, and community care concepts. H. Anderson et al. (2020) investigated how the intra-professional experience in nursing changes one's view about self and colleagues. Nurses were found to be either taking responsibility for developing positive relationships with colleagues (conciliating nursing), or dismissing or undermining nurses of different ranking (vertical discounting) or dismissing those of the same rank as them (lateral othering), the latter two having a destabilising effect on team cohesion (H. Anderson et al., 2020). Ewertsson et al. (2017) studied a group of 44 students after they completed a practicum in the emergency department. They reported that students were particularly affected by the quality of rapport between student and others in positions of power, such as a preceptor—how they performed tasks and the resulting impact these experiences had on their developing nursing identity.

The current research accords with the current literature on several points. It demonstrated the role played by the contrast between preconceived mental constructs and expectations of nursing and nurses' experiences through early socialisation in the clinical environment. Clinical exposure was also significant in reinforcing students' desire to pursue their studies, now able to 'be' a nurse, not just simply seeing themselves as one: they knew they could overcome obstacles, had what it took to achieve and could project this complete picture of self into the future. They wanted to be the best version of a nurse they could be not only for themselves but also for the people they cared for.

This research adds to the current body of literature examining the impact of early socialisation. Students completing a practical rotation early in their degree, in this case,

the first semester, not only adjusted their preconceived ideas of nursing images, expectations and ideals but also set the foundation for the development of professional values and ethical considerations. Our findings strengthen the case for early clinical placement in the undergraduate nursing curriculum, demonstrating the added value of the face-to-face engagement with clinical staff and residents, for which laboratory simulation is no substitute.

6.5.2.2 Initial Impressions

Clinical placements provided participants with opportunities beyond that of exercising skills. Practicum settings helped open participants' eyes to future areas of specialisation and research potentials. As previously discussed in 6.5.1.3, clinical placements are strong motivating and reinforcing factors in students continuing their journey and the opportunities open to them. Despite the at times arduous nature of nursing tasks, participants in this study identified current and future rewards for persistence.

The first clinical practicum has a strong influence on a student's developmental journey. F. O'Brien et al. (2008) questioned first-year students prior to attending their first practicum and found that students identified the act of caring as the very essence of nursing. M. Gillespie (2017) sought students' feedback following their first clinical exposure to a variety of clinical settings. Those in acute care areas deemed they had been provided with increased learning and experience opportunities, while those attending facilities for the aged and otherwise disabled identified opportunities for learning essential care skills. Many of the students from the latter group, however, perceived these tasks 'as being mundane, repetitive and basic' (M. Gillespie, 2017, p. 106). They felt disadvantaged, and their negative perceptions and experiences made it unlikely for them to return to this clinical setting after graduation (M. Gillespie, 2017). Nonetheless, an aged care practicum provides NSs with a valuable opportunity to engage with residents, and Moquin et al. (2018) found that by the end of the rotation, students had not only gained in insight regarding the care of residents but were able to advocate for them.

This was replicated in our research, although there was a significant point of difference between this research and that of M. Gillespie (2017). In our study, all students attended their initial clinical placement in an aged care facility, while in M. Gillespie (2017), there was a mix of acute and longer-term care and mental health placement locations. The

difference between the two was M. Gillespie's (2017) students were unwilling to consider returning to the care settings, while in this study, participants were able to evaluate their experience within a positive frame of mind. Our findings add further weight to the justification for the aged care sector as the first practicum setting for NSs for the development of foundational skills, rapport building, communication, interaction, socialisation, and transition. While a systematic review by Keeping-Burke et al. (2020) did not report any particular advantage of the timing of NSs' aged care placement, their focus was on students' preparedness to care for an elderly population, expectations in the setting, and interactions with regulated and unregulated staff (Keeping-Burke et al., 2020), not the wider implications for the students' future careers.

In summary, students' personal journeys in their first year of nursing education were powerfully affected by their academic course and clinical exposure. Students developed a nursing identity by learning to interact with their educators and by being confronted with the reality and demands of the nursing role during their practicum. Their clinical exposure was instrumental in reinforcing their decision to pursue a nursing career, develop technical and non-technical skills, and grow in confidence to advocate for themselves and those they care for.

6.5.3 Adaptation

The findings in this section relate to the main two elements identified in participants' adaptation during their first year of nursing studies. Although some aspects surrounding the role of relationships have already been discussed in section 6.5.2, they are covered here in more depth.

6.5.3.1 Navigating Relationships

The current research identified the crucial role played by all the relationships a student nurse encounters during their studies, including those with fellow students, academic staff, clinical mentors, carers, healthcare employees and the people they cared for. Students' personal interactions improved their learning experience, whether academically or clinically, and were instrumental in helping them succeed. When COVID-19 suddenly robbed students of face-to-face interactions, with technological substitutes, they felt the impact of this deeply and not necessarily positively. They nevertheless eventually adjusted to the new circumstances and found ways to reduce

the negative impact they felt, demonstrating capacity for quick adaptation. The role of humour was also instrumental in forming and maintaining these relationships. The particular role of humour will be discussed in the following section, in 6.5.3.2.

The students' capacity for building, maintaining, and seeking key relationships was reflected in the quantitative instruments used. This was particularly evidenced by their natural preference to use humour styles congruent with positive relationships with self (self-enhancing humour) and others (affiliative). The tendency for aggressive humour to be ill-preferred was also evidenced by the fact that their interpersonal relationships aimed at being productive rather than destructive.

The role of relationships in nursing, and their impact on care experiences and outcomes, have been demonstrated between nurses and patients as well as with students (Abdolrahimi et al., 2017; Feo et al., 2020). Fostering clinical learning environments that help students develop relationships by promoting dialogue has been shown to benefit both students and patients (Rowland et al., 2019; Suikkala et al., 2021), and increase patients' capacity for health and wellbeing (Feo et al., 2020). An integrative review conducted by McCarthy, Trace, O'Donovan, Brady-Nevin et al. (2018) identified sources of stress and coping encountered by students during their nursing education and found that the quality of relationships with clinical preceptors and educators played a major role. Students were even found to perform clinical duties to satisfy their preceptors and mentors in order to preserve those relationships at the expense of their satisfaction from the clinical placement (Khajehei et al., 2011; McCarthy, Trace, O'Donovan, Brady-Nevin et al., 2018).

A study conducted by M. Hughes et al. (2020) also emphasised the crucial role of all relationships in facilitating NSs' transition into the first year of nursing education. Students agreed on the importance of building relationships with peers and having someone to reach out to. Similarly, they recognised the significance of fostering positive relationships with their educators in the academic and clinical fields to facilitate their transition. M. Hughes et al. (2020) also reported the valuable insight gained from engaging in RP, highlighting students' pride in realising, and acknowledging their personal growth during that first year. Their findings align with those of this study demonstrating the significance of relationships are on all levels of nursing education and their link with adaptation and self-actualisation to the nursing identity.

6.5.3.2 Using Humour to Adjust

This study reveals the central role played by humour in the development and maintenance of personal and professional relationships, demonstrating humour's function in enhancing and regulating moods, breaking down barriers between people, and promoting cohesive teamwork in academia and clinical practice. Humour was shown to be pervasive, whether overt or subtle, as its presence was often noted on reflection by participants. Irrespective of degree, humour's presence was felt by all.

These findings are echoed in organisational and management research where humour has been found to increase engagement (Barsoux, 1996; Plester & Hutchison, 2016). Humour can serve as a diagnostic tool for workplace morale, promote positive environments and improve communication (Vetter & Gockel, 2016). It is therefore versatile and highly influential in the quality of outcomes, particularly with collegiate relationships.

Interestingly, until this study, humour seemed yet to be identified as a coping strategy for FYNSs. Recently, Alshahrani et al. (2018) investigated a group of 154 NSs who had completed their first practicum. One of their main findings was that students' most frequent coping strategy was to talk about their anxiety and experiences with academic and clinical staff, as well as their fellow nursing peers, friends, and family members. Here again, the presence and power of connections and relationships are crucial; however, Alshahrani et al.'s (2018) findings did not specifically highlight humour as being present. As revealed by our results, humour and relationships are closely intertwined, with humour often blending without explicitly being identified or placed under the spotlight. This absence in prior research findings does not necessarily mean that it was not present. Continuing to purposely seek it out in future research might indeed reveal a rich coping mechanism.

The current research further demonstrated that humour is an instrumental part of relationships, supported by the predisposition of NSs studied to use adaptive and relationship-promoting humour (the reader can refer back to Table 5.15). This suggests that it is not humour style per se that protects the novice nurse from negativity or adversity, but the helpful, and perhaps protective, connecting role it plays in forming and strengthening key relationships. It may be that relationships are formed because of humour style similarity, whether adaptive or not, and it is the quality of those

relationships that is instrumental in affording protection from adversity (T. Noble & McGrath, 2011). In their study, Åstedt-Kurki et al. (2001) found that humour helped nursing-care recipients express emotions and preserve their dignity, as well as facilitate communication of their needs to their nurse carers. Åstedt-Kurki et al. (2001) showed that humour helped nurses cope with the demands of their work, as well as reduce service users' anxiety. In this sense, humour is not disconnected from relationships—it nourishes them.

Our study showed humour to be omnipresent in and intricately weaved into the fabric of the participants' experience. Similar to J. Stewart et al. (2015), who discussed the powerful role humour played in developing relationships among nurses during their training, our study showed the positive affiliative and consolidating power of humour in relationships with clinical setting with staff, residents, and patients. Though not specifically highlighted through our results, there is a possibility of this also being present in the academic setting, through interactions with peers and teaching staff; this would warrant future targeted research.

The sophisticated role humour played in relationships is difficult to discuss in isolation. When participants discussed the presence of humour in their nursing experience, it was always in conjunction with a relationship with self or a significant other. It has therefore been merged with all relevant components and will continue to be discussed in the next chapter.

6.6 Chapter Summary

This chapter described and analysed qualitative data that endeavoured to capture a sample of NS's experience in their first year of nursing studies. It detailed the odyssey undertaken by a group of neophyte NS from the beginning of their studies, how they navigated through the swell of academic learning and acculturation to a new profession.

The findings of this chapter have demonstrated the elements conducive to a group of NSs staying afloat throughout the journey, particularly the role played by relationships and the use of humour in smoothing the rough waves. These elements were not experienced in isolation but were interconnected and observed throughout the overall development of the registered nurse-to-be. Education providers and clinicians in the field are thereby alerted to the role these factors play in the successful adaptation of

students, as well as the pervasive and positive effects they have on all persons involved, including therapeutic outcomes. Embedding these findings in curriculum development would assist not only students and academic and clinical staff, but ultimately the nursing profession as a whole.

Chapter 7 will offer a merging of quantitative and qualitative results and then compare these with the literature. Chapter 8 will present conclusions and recommendations for the enhancement of nursing education aiming to develop sound RNs on clinical and personal levels.

Chapter 7: Merging of Results, Findings and Discussion

7.1 Introduction

The reader was provided with the results of the quantitative aspect of this research in Chapter 5 and with those of the qualitative part in Chapter 6. Chapter 7 merges the quantitative and qualitative results and discusses their implications, with analysis informed by the literature. Overall findings will then be presented and discussed; research questions will be related to these findings and the limitations of the study addressed. The researcher's conclusions and recommendations will follow in Chapter 8.

7.2 Merging of Results

In this section, quantitative and qualitative results are merged, first presented as a function of humour and its application from theory into practice. Humour results are examined against the concepts of coping, adaptation, resilience, and assistance with transition to nursing. The quantitative and qualitative results will then be examined against participants' capacity for adaptation, with analysis from the perspectives of transition shock theory and humour theory.

7.2.1 Humour—From Theory to Practice

This section provides a link between the theoretical application of humour and its use in practice by, or around, NSs during their first year of nursing studies. First, all the questions used in the three validated instruments that formed part of the quantitative portion of the study were examined for their relevance regarding humour and their inclusion in this section. They were extracted predominantly from the HSQ, with the majority from the self-enhancing sub-scale. Those that combined the themes of humour, coping, resilience and adaptation were selected. The definitions used in selecting the questions relating to coping, resilience and adaptation were consistent with those discussed in section 2.3.2.1.

A total of 14 statements were selected from the instruments, each presented in Table 7.1, according to the concept they best suited. Following this, the qualitative data were re-examined to identify whether specific practical exemplars from participants'

experience during their first year of nursing studies could be linked back to the concepts of coping, adaptation, resilience and transition observed in our study. Direct quotations from participants supporting these exemplars are matched to the statements, followed by discussion of each of the above-mentioned concepts in relation to humour, with reference to support from the literature.

Table 7.1: Exemplars of Humour to Cope, Adapt and Develop Resilience during First Year of Nursing Studies

Concept	Survey question	Instrument	Participants' mean ^a	Practical exemplars from participants
Coping	If I am feeling depressed, I can usually cheer myself up with humour.	HSQ-SE	Slightly agree	Participant B1: [on using humour] "helped me stay on prac and it was stopped it being so daunting. (...) It made me sort of see how the work could be enjoyable even if I didn't see myself in aged care long term."
	If I am feeling upset or unhappy I usually try to think of something funny about the situation to make myself feel better.	HSQ-SE	Slightly agree	Participant D2: "I guess when people are like rude to you, you kind of make a joke about it after." Participant H1: "I think so, because especially over the, probably the third, fourth week when you'd already been there for a little while and still had a way to go. Yeah, it was quite helpful to see the more positive side of things and just keep taking something enjoyable out of each day."
	If I'm by myself and I'm feeling unhappy, I make an effort to think of something funny to cheer myself up.	HSQ-SE	Slightly agree	Participant G1: "I found that humour always helps me cope a little bit better. Making a joke out of a situation makes it a little bit lighter and not as heavy."
	I don't need to be with other people to feel amused – I can usually find things to laugh about even when I'm by myself.	HSQ-SE	Slightly agree	Participant A1: "Just to myself, I would, doing maybe just ordinary daily, day-to-day nursing activities, I would try to make the situation just a little bit funny or more entertaining for me, just so I could get through it and still remain positive when around other people."
	I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults.	HSQ-SD	Neither agree nor disagree	Participant R4: "A lot of laughs with patients, usually making fun of myself." Participant G1: "I find it's easier to just be a little bit lighter and have a laugh and when you need to be serious, but most of the time it's a little bit of a joke or just having fun, really."
	I try to see the humorous side of things when I am faced with problems.	CD-RISC-25	Often true	Participant D1: "I'd say there would be times of humour, mostly I guess when people are stressed and there's a lot going on, you kind of laugh about how busy you are."

Concept	Survey question	Instrument	Participants' mean ^a	Practical exemplars from participants
				<p>Participant F1: "Between staff members who were able to... when discussing any of the residents in regards to certain things may have... like processes maybe happening or things that throughout the day, we were able to make light of a difficult situation or any... like make it humorous when it came to any difficulties with certain residents."</p> <p>Participant I1: [on humour] "It's nice because you feel so tense in some of these moments, because sometimes you're going, and doing these invasive procedures because you have to, and if you're able to pull a laugh from it, it just releases the tension off from it. Sometimes it's invasive, and something goes south, and someone can be really mean and show off. So if you can walk out of that, and joke about it, then I feel like you're able to bounce back better."</p>
	I enjoy making people laugh.	HSQ-Aff	Totally agree	Participant R4: "The fact that I haven't been at the facility makes it easier to stay emotionally detached and just have lots of laughs(...). You only see them for a short while so trying to make them smile as much as possible is a goal."
	I laugh and joke a lot with my friends.	HSQ-Aff	Totally agree	<p>Participant R6: "One of the residents that I walked with, had very witty, exaggerated and sarcastic humour which made it enjoyable to talk to. The little comments here and there from the resident made me laugh and the resident's reactions were very exaggerated and comically produced which made the two of us laugh very much along with some of the other caretakers that were nearby."</p> <p>Participant R11: "One of the residents made light of the situation in regards to the location of one of their wounds, so it made me feel like it was just a routine wound, therefore we could have a laugh while doing the required task."</p> <p>Participant B1: "I think me and my buddy really benefited [from humour], especially towards the end. We'd sort of feed off each other and encourage each other and laugh with each other. And that was really good."</p> <p>Participant C2: "We would have a couple of conversations where we might have inside jokes or something into the practicum. So it made us students feel really comfortable because we weren't on this really serious term, although it was quite a scary thing for us at the beginning because</p>

Concept	Survey question	Instrument	Participants' mean ^a	Practical exemplars from participants
	Letting others laugh at me is my way of keeping my friends and family in good spirits.	HSQ-SD	Neither agree nor disagree	<p>it was at first one. And the carers really helped us ease into it and they were just making jokes, making sure that we were comfortable.”</p> <p>Participant E1: “I did notice that as well among my peers, or colleagues (...), we all laughed about things and used humour to get through.”</p> <p>Participant R8: “The resident amazed me with how capable they were at using a toilet no different to myself, despite our roughly 80-year age gap. The resident smiled softly at me during the event, which makes me laugh now as it was a moment to realise that the assumption of the oldest resident/person I had ever met would need more assistance, when really they needed very little at all.”</p>
Adaptation	Even when I'm by myself, I'm often amused by the absurdities of life.	HSQ-SE	Slightly agree	Participant G1: “I use it on a day-to-day basis just because.”
	If I am feeling sad or upset, I usually lose my sense of humour.	HSQ-SE	Slightly disagree	Participant B1: “And I was really lucky to have good carers and nurses who brought the humour into situations where I couldn't see it.”
	Sometimes I think of something that is so funny that I can't stop myself from saying it, even if it is not appropriate for the situation.	HSQ-Agg	Neither agree nor disagree	Participant I1: “It was just like a time to take a deep breath and laugh about what just happened. And sometimes, there was matters where you couldn't really laugh at it, but you couldn't help yourself sometimes.”
Resilience	My humorous outlook on life keeps me from getting overly upset or depressed about things.	HSQ-SE	Slightly agree	<p>Participant B1: “It helped alleviate the heaviness and the stress of, it's my first prac and what if I don't want to do this course, what happens then? And sort of wrecks your little plan that you've made for your life. But yeah, it alleviated the stress and the heaviness of that and that's made everything a lot more easy-going. And it's like even if this isn't where you want to be, you're not as stressed about it and you're like, ‘Oh, it'll work itself out. It'll be okay.’”</p> <p>Participant G1: “You can't be serious all the time. And so when we would have our handover meetings, we'd end up laughing at one point or making a joke, and it made the meetings so much easier to go through</p>

Concept	Survey question	Instrument	Participants' mean ^a	Practical exemplars from participants
	It is my experience that thinking about amusing aspect of a situation is often a very effective way of coping with problems.	HSQ-SE	Slightly agree	<p>and it wasn't as serious and heavy. And even though you're dealing with some quite heavy stuff."</p> <p>Participant R3: "Upon reflections, most situations can be viewed from a humorous perspective. At the time the situation seems super scary, however, when reflecting I think I find that I was competent I just didn't have the trust in myself to do the things I was required to do."</p> <p>Participant R7: "Because of this I buttoned up the resident's shirt unevenly and wasn't sure whether to redo them or not due to time constraints or something else. My carer laughed, saying "of course you need to redo them."- which I now completely understand and also find funny that I was scared to the point that I thought it was okay to purposely leave a resident's shirt incorrectly buttoned up. At one point I tore open a foil packet with a sterile tissue inside when suddenly my supervisor gasped at what I was doing. I stopped what I was doing and internally panicked for a couple seconds before I realised my supervisor was just teasing me, I had done nothing wrong. It definitely alleviated the tense atmosphere in the room that I was feeling trying to perform everything correctly, and I realised my supervisor could tell how serious I was being and wanted to poke fun at me."</p> <p>Participant R12: "I did not really see a funny side of this situation at all initially, I felt so embarrassed. When venting to friends, I reflected and found it funny how someone so impatient could work in a setting like aged care and that she must be very unhappy within herself if she has to treat novice or student nurses the way she treated me. I knew it was not just me either because another student on the same rotation did not like working with her either. The fact that she was treating me with respect in my last week, was not overly humorous or funny, but more so a moment of confidence."</p> <p>Participant B1: "I think people ... not laughing at me, laughing with me, I suppose, when I do little things and mess up or I dropped something or I'd just mess up and be absolutely mortified as a student nurse and the nurse that I was with would just be like, 'Oh it's fine.' And then tell me a story of when she messed up or did something similar or another colleague of hers had done the same thing."</p>

Concept	Survey question	Instrument	Participants' mean ^a	Practical exemplars from participants
				<p>Participant I1: "I would say both, at the time and afterwards. I've experienced during this situation, you pause, you say something funny, and everyone just laughs, and just makes it easier because it takes you out of the situation, and looks at it from a different perspective. Sometimes that's all you really need to do."</p> <p>Participant I1: "[Humour] ...definitely alleviates the pressure..."</p>

Note: ^a Mean of the statement achieved by participants in quantitative phase.

7.2.1.1 *Humour to Cope*

Coping is understood as the deliberate and wilful attempt to deal with a stressor through cognitive and behavioural means (Compas et al., 2001). Eight questions from the HSQ scale related to the concept of coping. The majority, namely, four, were extracted from the self-enhancing sub-scale. The general intent of each statement was considered to pair up with participants' exemplars. For instance, the statement "If I am feeling depressed, I can usually cheer myself up with humour" was interpreted as when a person is down, the use of humour was helpful in uplifting their mood.

Overall, the outcome for participants was that humour helped them deal or cope with, overcome, change, or accept a situation they were experiencing. The benefit was felt particularly on the emotive side and how participants navigated their emotional response when confronted with situations (e.g. "making a joke out of a situation makes it a little bit lighter and not as heavy" [Participant G1]) or their interactions with others (such as Participant D2 dealing with the rude behaviour from another person).

The CD-RISC-25 questionnaire also included a statement that directly related to humour. This question—"I try to see the humorous side of things when I am faced with problems"—captured the essence of participants' experiences. The majority of exemplars easily matched this specific question; however, to avoid repetition, if exemplars could also be attributed to another question, they were.

The difference between the two instruments is the intent behind the statements. The HSQ relates more specifically to relationships and interactions, whether with self or others, while the CD-RISC-25 looks at various elements that enable a person to cope, develop or demonstrate resilience. The two instruments were valuable in capturing all these aspects, whether behavioural, cognitive or emotive. These are also well expressed in the participants' experience through their reflection and interview statements.

Interestingly, the items of the HSQ that could lead to a negative outcome if used frequently, for example, "I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults" or "Sometimes I think of something that is so funny that I can't stop myself from saying it, even if it is not appropriate for the situation", were observed to have positive outcomes in the

participants' experience, as demonstrated in Table 7.1. In comparison, the quantitative results that were achieved for those questions in Phase 1 returned all the same mean; participants neither agreed nor disagreed with these statements. These are also presented in Table 7.1. A potential explanation in merging these results is that in theory participants could recognise using humour in such a way but perhaps did not agree with the negative outcome alerted in the statement, for example, "Letting others laugh at me is my way of keeping my friends and family in good spirits". The general intent of the statement can be interpreted as a person being the centre of the joke to make sure others feel better no matter their personal cost. In answering 'Neither agree nor disagree' participants potentially recognised letting themselves willingly being central to the event but not to the point of it being at their detriment. Their answer in the quantitative instrument concurred with their experience in practice.

The beneficial effect of humour around relationships was prominent both in theory and in practice throughout the study. The HSQ affiliative humour statements such as 'I enjoy making people laugh' and 'I laugh and joke a lot with my friends' both returned a mean score of 'Totally agree' during the quantitative phase. Several statements from participants also evidenced this in practice (Table 7.1). The connective impact of humour between people was prominent, with the resulting effect of helping participants to deal with a situation. This is well represented in the statement by Participant C2: "We would have a couple of conversations where we might have inside jokes or something into the practicum. So, it made us students feel really comfortable because we weren't on this really serious term, although it was quite a scary thing for us at the beginning because it was at first one. And the carers really helped us ease into it and they were just making jokes, making sure that we were comfortable". The essence here is how humour was instrumental in connecting peers and mentors with the added effect of reducing NSs' stress and improving emotional wellbeing. The intertwined association between humour, relationship and coping, which ultimately lead to adaptation, is present.

Humour use by, or by those around, participants affected students positively. This valuable use of humour exhibited by those in the teaching, mentorship, and otherwise leading positions in relation to NSs resonates with the findings of Hayden-Miles (2002) regarding the benefits of humour in building trusting and effective partnerships between NSs and teachers, as well as enhancing the learning experience. Our study did not

investigate personality trait of FYNSs, as was the case in Demir Gökmen and Firat's (2020) study. Their results indicated students' positive personality structure increased with the use of positive (affiliative and self-enhancing) humour styles. Although their findings cannot be used to compare ours directly, this may suggest that the general disposition of students or people (for example, academic staff, mentors, and clinical facilitators) students encountered during their nursing studies may have a ricochet effect on their own positivity and each other's use of humour. McCloughen et al. (2020) discussed how NSs were confronted with the management of their emotions during their clinical placements, and were rarely offered support and guidance by supervising staff. In their study, NSs engaged in informal self-reflection and socialisation as a means for emotional management that McCloughen et al. (2020) termed self-socialisation. A central feature of self-socialisation included the vital part played by positive relationships and feeling included. The impact of humour in fostering relationships may further contribute not only to its use but also to the general disposition it offers by means of influence, such as producing a positive atmosphere and promoting interpersonal connections.

7.2.1.2 Humour to Adapt

In this study, the concept of adaptation is understood as the state reached from experiencing a stressor and is taken more as an overall state. The use of humour to adapt was also identified in practice; however, HSQ statements that could fit this definition were fewer. Participants' statements were matched when the overall intent of their account was more general or referred to the outcome rather than the actual 'doing' or coping aspect. For instance, Participant G1 declared that they used humour "on a day-to-day just because" refers to their prevalent and generalised use of humour to deal with life in general. Their statement was better matched with the HSQ statement 'Even when I'm by myself, I'm often amused by the absurdities of life'. Matches were made with the most appropriate statements to maintain their intent.

Here again, the importance of relationships is demonstrated but is enhanced through reflection. On average, participants slightly disagreed with the HSQ statement 'If I am feeling sad or upset, I usually lose my sense of humour'; however, in practice, when it occurred, close relationships helped to counteract this and is well expressed by Participant B1: "And I was lucky to have good carers and nurses who brought the

humour into situations where I couldn't see it". Our findings echo those of Chaponniere and Hall (2020), who identified the presence of humour as a positive coping skill in the journal entries of NSs on international field placement. In our study, participants were not always able to identify the presence of humour at the time or its positive impact but were able to do so with the opportunity to reflect through their journals and interviews. This is further expressed by Participant R3, who stated, "Upon reflections, most situations can be viewed from a humorous perspective. At the time the situation seems super scary, however, when reflecting I think I find that I was competent I just didn't have the trust in myself to do the things I was required to do". Additionally, Participant I1 reported noticing the presence of humour "at the time and afterwards". They further adding that at the time of the situation, "You pause, you say something funny, and everyone just laughs, and just makes it easier because it takes you out of the situation and looks at it from a different perspective". Adaptation is a process that occurs over time. Opportunities for reflection were helpful in identifying instrumental aspects to a lived situation.

The benefits of engaging in reflection have been discussed, including barriers in doing so. Barbagallo (2019) discussed the value of RP post clinical placements but also emphasised students' need for structure and consistency in guiding their reflection. Barriers faced by students around reflection have been identified as a lack of time during placements, although longer placements offered students more time and opportunity to overcome situations and extract its benefits (Barbagallo, 2019; R. Kuiper et al., 2010). In our study, participants' first clinical placement was conducted over 5 weeks. However, their face-to-face interview was richer in data, and students benefited from targeted questions to generate insights. The tedious aspect of completing an online reflective journal after a long day or week of clinical placement might have deterred participants in producing abundant writing. Additionally, they may not have had enough time to process events on an emotional level, although it was a timely exercise to record specific events. This could be better achieved by keeping a journal during the clinical placement and using the information to debrief and engage in a more formal mode of RP later. In their study and through completing online reflective journals, Mlinar Reljić et al. (2019) identified the importance of NSs managing their emotional experience and navigating interpersonal relationships, and their learning experience. Humour was

identified in one of the participant's statements as an effective means to diffuse a situation and establish rapport with a resident:

"I think there was this one incident with one of the residents. He was about to head off to a hospital, and so I just sat with him and talked to him. And I engaged in a bit of humour, talking about what was on the TV because we were watching a game show. Yeah, we were just talking about the answers, and I was saying, 'Oh, surely this one, this answer'. And it was obviously the very wrong answer, but he thought it was funny, and he laughed about it, and he kept going, "No, no, no." He tried to show me the correct answer, and then when the right answer came on I would applaud him, he would laugh a little bit. And so, I think, yeah, in a way for some sad situations, humour is a good way just to get over it or just help with the situation." (Participant A1).

Contreras et al. (2020) discussed how commonly RP in nursing was conducted through writing; however, they also discussed how other forms, including verbal and photographic, were also effective. Combining reflective opportunities, whether in writing, verbal or in groups, with targeted questions could be helpful in helping NSs to identify the helpful nature of relationships with others and humour in clinical situations and to help them adapt to situations.

7.2.1.3 Humour to Promote Resilience

Resilience develops as a person reaches 'the other side' and thrives from having overcome a stressful situation, as previously discussed in Chapter 2, section 2.3.2.1. As the concepts of coping and resilience are often used and understood as a pair, it can at times be quite difficult to separate the two. This is evidenced in the two statements selected for this section: 'My humorous outlook on life keeps me from getting overly upset or depressed about things' and 'It is my experience that thinking about amusing aspect of a situation is often a very effective way of coping with problems'. These two HSQ statements linked to resilience include a generalised aspect but also implied the notion of thriving, or "being better off because of" humour.

The ability to identify the effect of humour in promoting resilience is well evidenced in its comparison between theory and practice. In theory, participants' mean answer to both statements was that they slightly agreed, yet in practice, their statements were numerous in identifying how this was so, potentially indicating that this occurs more frequently than they thought. Participant I1's statement captures well how they noticed the benefit of humour in nursing practice: "I definitely see (...) that [in] nursing, you

definitely put the humour on top to smooth out the rough patches and that sort of stuff. It's always good to laugh in a hard situation sometimes". The ability to reflect provided an opportunity to highlight this.

As an outcome to coping, resilience is better identified in retrospect than at the time of an event, here again adding value to engaging in RP. Despite this, the mean high score of participants ($M = 76.05$) on the CD-RISC-25 indicated a high capacity for resilience at the onset of the nursing studies. It would have been interesting to measure resilience at the end of the first year, and again at the end of the degree, to assess whether the activity of nursing had an impact on increasing or diminishing students' overall score. This is also perhaps where the full beneficial impact of having the opportunity to reflect is substantiated. Along their reflective journal and interviews, participants could identify not only how humour was beneficial in dealing with various situations and stressors, but also its impact on, and the conducive role of, relationships to coping and developing resilience. This statement by Participant R12 encapsulates well the benefit of reflection and identifying positives such as personal growth out of a situation: "I did not usually see a funny side of this situation at all initially, I felt so embarrassed. When venting to friends, I reflected and found it funny how someone so impatient could work in a setting like aged care (...). The fact that she was treating me with respect in my last week, was not overly humorous or funny but more so a moment of confidence". Our research findings parallel those of Bartlett et al. (2016) and Jun and Lee (2017) in demonstrating that NSs experience stress during their studies, particularly in the clinical setting in relation to their interactions with peers, patients and clinical facilitators, yet our findings also add the benefit of humour in dealing with these events.

The previous two sub-sections have already highlighted the significant benefit of engaging in reflection in coping and adapting to nursing situations and practice, including the significant role played by humour and relationships. This naturally extends to the development of resilience. The researcher seeks to avoid repetition in this section while wishing to emphasise once again its substantial value.

7.2.1.4 Humour to Assist Transition

Humour, as well as humoristic events, was helpful in assisting students to transition to their clinical practice and was also identified in participants statements. Duchscher's transition conceptual framework (reader can refer back to section 3.3.2) identifies the

emotional states GNs experience, namely, loss, confusion, doubt and disorientation, in relation to given concepts—relationships, responsibilities, knowledge and roles. The pairing of humour, in use or outcome, against these demonstrates the impact of humour in aiding participants along their journey. These are presented in Table 7.2 below.

Table 7.2: Humour in Assisting Transition

Duchscher's transition		Humour in assisting participants' transition	
Concept	Experiential response	Experiential response	Statement (ID)
Relationships	Loss	Connection	<p>Yeah, there was this one time I was assisting a resident down back to their room, and for fun I said to her, "Oh, we're going to kidnap you." And she thought, "Ah!" She likes to exaggerate her reactions, and she said, "Oh, no!" and she played along. And then I said, "We'll raise all the money up for you, and then you can have half of the ransom money." And she went, "What would I even do with all that money?" She just kept playing along, which was great. (A1)</p> <p>I think people ... not laughing at me, laughing with me. (B1)</p> <p>[In using humour] Maybe when I would be working with a carer. But that would be just making smalltalk in between maybe going from resident to resident. (C1)</p> <p>The majority of them [carers] were very easygoing, would tease the student nurses, but also make conversation and often it was very humorous. (C1)</p> <p>And then, yeah, the carers' intent is just to make the atmosphere lighter. So, they just point out how serious we're being. Yeah, make a few jokes, which I thought was good. And make us less tense, things like that. (C1)</p> <p>[Being with carer] we got along in the lunch room and stuff, we would have a couple of conversations where we might have inside jokes or something into the practicum. So it made us students feel really comfortable because we weren't on this really serious term, although it was quite a scary thing for us at the beginning because it was at first one. And the carers really helped us ease into it and they were just making jokes, making sure that we were comfortable. (G1)</p> <p>I think the presence of having other student nurses with you is really good. I had five other nursing students with me and we all became friends. And during breaks and lunch time it'd be very enjoyable. We'd just make jokes. Yeah. Because usually like we'd laugh a lot and things like that. So, yeah, I think having friends with you is also really beneficial. Because if I'd been by myself then spending those breaks alone, I'd just be reflecting on what I did. Yeah, I wouldn't have experienced the humour that I had. (C1)</p>
		Therapeutic connection	<p>Yes, definitely. It definitely helped strengthen some of my relationships with some of the residents, because I feel if you weren't being able to joke with those</p>

Duchscher's transition		Humour in assisting participants' transition	
Concept	Experiential response	Experiential response	Statement (ID)
			residents then you wouldn't really develop a strong relationship with them. It would just be a passing by kind of relationship. (A2)
			It was easier to tell if there was something wrong with them because they wouldn't be in that joking mood, and they would be more open with you if you wanted to ask what was up with them, because you've built that relationship with them. So yeah, I really think that humour really helped solidifying a relationship with them. (A2)
			[Discussing presence of humour] during ADL's lots of laughs about the difference in age and the residents ages. As well as laughs about personal stories. (R4)
			One of the residents that I walked with, had very witty, exaggerated and sarcastic humor which made it enjoyable to talk to. The little comments here and there from the resident made me laugh and the resident's reactions were very exaggerated and comically produced which made the two of us laugh very much along with some of the other caretakers that were nearby. (R6)
			when some of the carers were telling some of their stories about her. Oh well on of the funny things was when the resident was feeling a little better/ had a boost of energy. She was asking for us to push her to the gates of heaven. (R10)
	Support		I think me and my buddy really benefited, especially towards the end. We'd sort of feed off each other and encourage each other and laugh with each other. (B1)
			[Interacting with carers] We would have a couple of conversations where we might have inside jokes or something into the practicum. So it made us students feel really comfortable because we weren't on this really serious term, although it was quite a scary thing for us at the beginning because it was at first one. And the carers really helped us ease into it and they were just making jokes, making sure that we were comfortable. (C2)
			I did notice that as well among my peers, or colleagues as you'd call them, we all laughed about things and used humour to get through. (E1)
	Parity		For me, I get quite intimidated by people in a superior position such as carers and things like that. But then when they joke about these things, and they're really friendly and engaging, it definitely breaks down that barrier a bit more, so that I feel more confident and comfortable working around them. (C1)

Duchscher's transition		Humour in assisting participants' transition	
Concept	Experiential response	Experiential response	Statement (ID)
Responsibilities	Confusion	Positivity	Well, I think in relationships, and whether it be personal or therapeutic or professional, I think humour is just something, it breaks the ice. (E1)
			<p>[In using humour in performing mundane tasks] But I would just make it like a little game, or just somehow see the funnier side. Like, "Oh, okay. I didn't do this right, I'm going to have to redo it," and that kind of thing. Just just to keep myself upbeat. It worked. I felt like I was quite positive during that whole thing with that. (A1)</p> <p>[Using humour] Just to myself, I would, doing maybe just ordinary daily, day-to-day nursing activities, I would try to make the situation just a little bit funny or more entertaining for me, just so I could get through it and still remain positive when around other people. (A1)</p> <p>You can't be serious all the time. And so when we would have our handover meetings, we'd end up laughing at one point or making a joke, and it made the meetings so much easier to go through and it wasn't as serious and heavy. And even though you're dealing with some quite heavy stuff. (G1)</p> <p>I think even communication between staff, humour helped as well, because you're working together all day, every single day. (G1)</p> <p>I definitely see (...) that [in] nursing, you definitely put the humour on top to smooth out the rough patches and that sort of stuff. It's always good to laugh in a hard situation sometimes. (I1)</p>
Knowledge	Doubt	Self-confidence	<p>And that I was able to make mistakes and own it and deal with it. That was good. (B1)</p> <p>I think confidence as well mainly, because I think when I first started my first placement I lacked confidence to be able to also interact with them and be humorous. Whereas the second one, because I have experienced in my first placement, I was able to put myself more out there, and because I was able to start on a really good confidence level, I was able to keep progressing. So, I think I've really improved my ability to talk to the residents and be humorous with them as well. So yeah, it was a really good prac for me, yeah. (A2)</p>
		Reassurance	When I do little things and mess up or I dropped something or I'd just mess up and be absolutely mortified as a student nurse and the nurse that I was with would

Duchscher's transition		Humour in assisting participants' transition	
Concept	Experiential response	Experiential response	Statement (ID)
			<p>just be like, "Oh it's fine." And then tell me a story of when she messed up or did something similar or another colleague of hers had done the same thing. (B1)</p> <p>My supervisor was pretty easy-going and found a lot of my small mistakes amusing, often laughing in a good-natured way. This alleviated my stress towards completing tasks appropriately and not beating myself up too much when I did make mistakes. I was also very afraid of incorrectly assuming a certain way of doing tasks thus I only followed what my supervisor said without any using any intuition. (R7)</p> <p>Upon reflections, most situations can be viewed from a humorous perspective. At the time the situation seems super scary, however, when reflecting I think I find that I was competent I just didn't have the trust in myself to do the things I was required to do. (R3)</p> <p>And then another example was when I was doing wound care. So, it was my first time doing wound care on a resident. And, yeah, again, I was very focused, very serious. I didn't want to mess anything up. I wanted to be efficient as well. And then a carer was instructing me. And then I think I picked up something and cut it open, and then she gasped as if I'd done something wrong. But I hadn't. She was just teasing me because I think she could tell I was focusing way too much on, yeah, what I was doing. And that definitely relaxed me a lot more. Yeah. I felt more supported, I guess. (C1)</p> <p>One of the residents made light of the situation in regards to the location of one of their wounds, so it made me feel like it was just a routine wound, therefore we could have a laugh while doing the required task. (R11)</p>
	Awareness		<p>[on observing staff using humour] a lot of times some of the residents might be a bit on edge. I think one of [the staff] their ways of coping about it was just to be funny with the residents, jokingly. I think that really helped them to cope through all of the stress of that instead of being under pressure about the whole thing. They were able to work through it really well with the humour that they used. (A2)</p> <p>And I was really lucky to have good carers and nurses who brought the humor into situations where I couldn't see it. (B1)</p> <p>[In attending to residents on different wards] having time on both sides, we're able to adapt and change, notice changes for residents, and learning about the</p>

Duchscher's transition		Humour in assisting participants' transition	
Concept	Experiential response	Experiential response	Statement (ID)
			<p>various effects of dementia and different abilities of the residents throughout both areas as to how I would adapt my humour to aid them. (F1)</p> <p>I would say both, at the time and afterwards. I've experienced during this situation, you pause, you say something funny, and everyone just laughs, and just makes it easier because it takes you out of the situation, and looks at it from a different perspective. Sometimes that's all you really need to do. (I1)</p>
Roles	Disorientation	Confidence	<p>[Humour] helped alleviate the heaviness and the stress of, it's my first prac and what if I don't want to do this course, what happens then? (...) it alleviated the stress and the heaviness of that and that's made everything a lot more easy-going. And it's like even if this isn't where you want to be, you're not as stressed about it and you're like, "Oh, it'll work itself out. It'll be okay." (B1)</p> <p>I think it [humour] kind of enhances our visits with the second prac, being able to have a jovial conversation that really could, it really brightens their day. I know a few patients have said so, or they've been really grateful for the visit by the end. Yeah, yeah, I think rather than a very serious visit where it's just all about the care, not really saying much, being able to talk to them, because a lot of them, some of them might live alone, they mainly only go out, sorry, for hospital checks. (C2)</p> <p>Obviously we were so nervous and scared. Didn't know what to expect, and it [humour] helped us just ease into it. (G1)</p> <p>I did not really see a funny side of this situation at all initially, I felt so embarrassed. When venting to friends, I reflected and found it funny how someone so impatient could work in a setting like aged care and that she must be very unhappy within herself if she has to treat novice or student nurses the way she treated me. I knew it was not just me either because another student on the same rotation did not like working with her either. The fact that she was treating me with respect in my last week, was not overly humorous or funny, but more so a moment of confidence. (R12)</p>

The presence of humour was conducive to participants navigating their initial transition into nursing study, particularly during their practicum. Humour assisted them in developing and improving relationships with mentors and peers through connection, support and parity, as well as aiding to develop therapeutic connections with residents and patients. Around their sense of responsibility, humour supported participants by creating positivity and self-confidence while providing reassurance and awareness around their knowledge. Finally, humour supported participants in developing confidence around their role as NSs in the clinical field. These findings are summarised and presented in Figure 7.1.

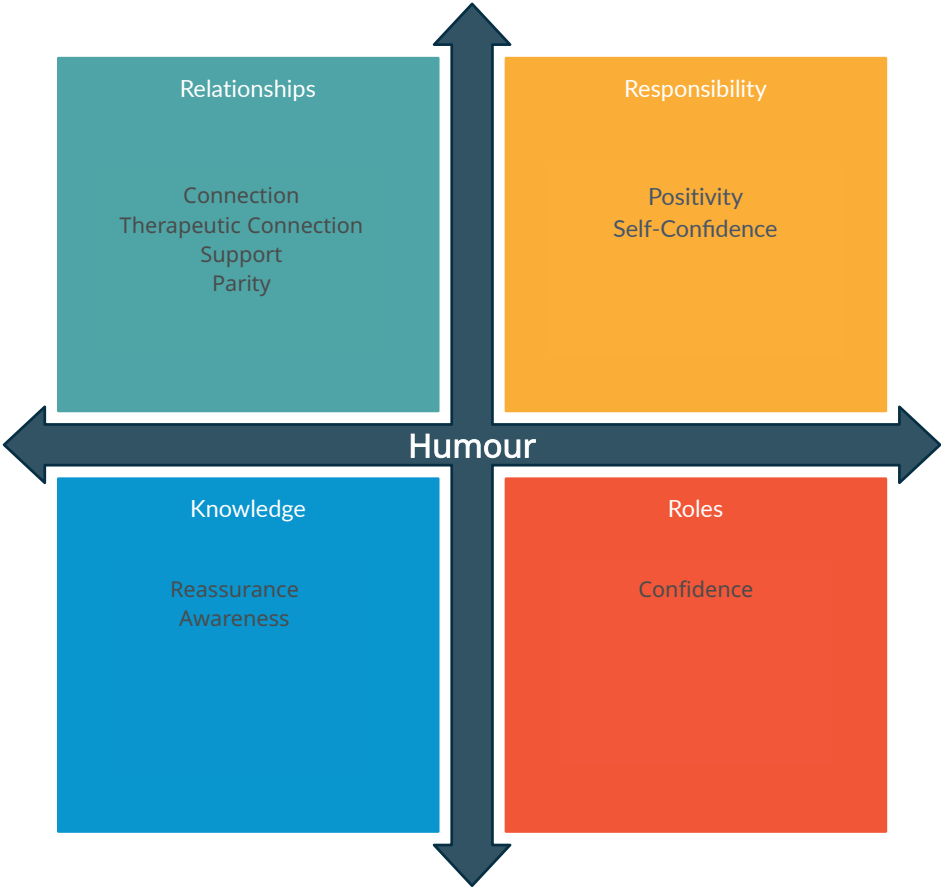


Figure 7.1: Transitional Impact of Humour

This study is novel in pairing the impact of humour with the experience of the FYNSs, particularly in the clinical field. However, the merging of our results support in part other findings in the published literature. For instance, F. Chen et al. (2021) discussed how

the emotional, sociocultural and developmental factors and the preceptor's experience influenced GNs' competency. Humour and the mentorship role displayed by carers and nurses in our study were instrumental in assisting NSs to connect on a personal level with them as well as the residents and their peers. Additionally, they were a source of support and helped in the breaking down of barriers, which helped students learn. Furthermore, some of our participants expressed the lack of positive support from some mentors encountered in practice, such as Participant R12 discussed in the previous sub-section. Their feelings eased with time, even being able to see the humoristic side of things upon reflection. This is consistent with the findings of Ho, Stenhouse and Snowden (2021), who reported that GNs expressed not being helped, and feeling unsupported and alienated at the onset of their graduate year, but that the feeling lessened over time. Prymachuk et al. (2019) assessed FYNSs' transition into nursing through a non-graded written reflection assignment; however, most students were yet to experience their first clinical practicum. Their findings highlighted the importance of social and academic support networks and the practical tools in helping students to transition into their studies. Our results, therefore, further supplement these studies' findings by reinforcing the role played by effective relationships and reflection but also add how humour can assist in stringing these together. This was achieved either independently - for example, humour in relationships, or humour identified while reflecting - or jointly – by identifying how humour promoted relationships through reflection.

Research has shown how intellectually GNs are confronted with discrepancies between concepts learnt and their experience in practice (Cao, Li, & Gong, 2021; Nour & Williams, 2019). In our research, humour had an interesting impact on the concepts of knowledge and responsibility. Humour had the effect of reassuring FYNSs, affording them awareness of situations, and alerting them to opportunities. Further, around the importance of their responsibility as NSs, humour helped them to develop positivity or to remain positive. The sociocultural measures of transition shock assessed by Xu et al. (2021) did not reveal an improvement over time, with their participants already returning initial mid-range results. As suggested in our literature review, a potential explanation for this could reside in the fact that changes to socialisation begin earlier, namely, during the educational period. Our results around the connective role of humour in developing effective relationships could offer a hypothesis for this early adaptation to

the nursing sociocultural domain. They provide ground for further research in exploring these possibilities.

This section has reviewed the specific role humour played in helping FYNSs to cope, adapt and develop resilience. Duchscher's four transitional concepts and their emotional states were paired with the experience of humour in our study and highlighted the positive consequences for participants. Ground for further research to explore this connection further around socialisation and adaption in both NSs and GNs was presented. The following section will discuss participants' general capacity for adaption.

7.2.2 Capacity for Adaptation

In this section, the reader will be presented with how study participants displayed adaptation. This concept of adaptation will be examined against the transition shock theory and how it applied against Duchscher's three stages—doing, being and knowing. Finally, the section will also examine adaptation against humour theory, emphasised particularly through relationships.

7.2.2.1 Adaptation in Relation to the Transition Shock Theory

As previously discussed in section 6.5.1.3, students' capacity for adjustment and adaptation is influenced by several factors, both intrinsic and extrinsic. The current research findings align with the stages of transition theory experienced by the GN and developed by Duchscher (2008). Duchscher's transition theory sees the GN moving through stages of initially 'doing' nursing, where they are focused on learning and performing of tasks and adapting to the sociocultural demands of their work. The learning curve is fast and steep, the demands and expectations at times overwhelming. Once they find their feet with tasks and demands, usually within a few months, they transition to a stage where they now adjust to trusting their own self and their ability to make decisions and overcome their initial self-doubt. Over these months, the new nurse finds a balance between knowing themselves and their practical limitations; feels less 'imposter syndrome', being a common occurrence; and progresses the development of their nursing identity. This culminates a few months later in the nurse integrating the senses of doing nursing and of 'being' a nurse, as well as developing a sense of detachment. It provides them with the ability to reflect on their own learning experience

and adjustment journey, to then become a source of information and mentor others beginning the same journey.

Duchscher's (2008) stage of 'being' was also identified in the current research. Participants sought validation and feedback from their mentors and even directly from the residents they cared for. They looked for this in verbal cues as well as non-verbal responses in residents' comfort, or discomfort, and their buddies' interactions with them. This particular aspect of 'being' was significant in acculturating participants and reinforcing their decision to pursue a career in nursing, allowing them to confirm their belongingness to the profession and recognise opportunities past their clinical rotation.

The third stage of transition identified by Duchscher (2008) was that of 'knowing'. It was also highlighted in this study, particularly towards the end of the practicum. Participants' placement, being for 5 weeks, provided them with enough time to adjust and to reach a stage where they could consolidate their skills. This was evidenced when participants were left to perform certain tasks independently with the approval of their mentors. It served to boost their confidence, but also gave them the courage to advocate for themselves and the people they cared for when they identified undesirable situations.

Strong similarities exist between the newly graduated nurse's transition journey discussed by Duchscher (2008, 2009) and the NS navigating their first year of studies and clinical practice as observed in this research. The steep learning curve of academic content and hands-on skills experienced by the students during their first semester is quickly followed by immersion in clinical placement as they attempt to integrate knowledge from semester one into practice. Duchscher's stages can be identified on a micro level during the academic semester and the clinical placement. The rapid development of events during a student's academic semester may make it difficult to identify all of Duchscher's elements on a distinct time frame; however, the same themes of learning, adjusting, acculturating and adapting are present in both. These findings suggest the notion that FYNSs experience similar transition stages to those developed by Duchscher (2009).

Ensuring that students successfully complete their degree is the first hurdle in workforce development and recruitment. Several factors play a part: motivation and grade point average (Pence & Suerth, 2020), EI (Benington et al., 2020), and academic support (Everett, 2020). The rationales and strategies involved in nursing curriculum

development must account for how students operate, including their individual qualities, strengths, and coping strategies. To minimise the complexity of addressing every individual's relevant characteristics, there is a need to recognise elements that are applicable to most, if not all, students. This research did so by emphasising the roles played by relationships and humour. Devising strategies and interventions that acknowledge these components could positively influence a significant proportion of the student population. The simple act of reflecting on humour helped students identify how useful and pervasive it was, affording them an opportunity to consolidate their learning and experience. It also enabled them to identify and reflect on crucial formative and supportive relationships formed during this time.

The successful transition from student to newly graduated nurse has been explored in several research projects in the hope of uncovering strategies conducive to assisting GNs adjust and flourish (K. B. Hampton et al., 2020; van Rooyen et al., 2018). Meyer et al. (2017) identified that the first three months of practice as a GN is the most critical time for positive transitioning. They concluded that any gains achieved from curriculum redevelopment had to have the capacity to carry forward into nursing practice. Early implementation of strategies in the curricula allows time for them to be reinforced during the formative years, which may lead to a greater chance of success once the student becomes the graduate. As suggested by this study's results, introducing academic strategies into the curricula, such as providing education around humour and imbedding it within RP tasks, could influence students to care for not only themselves but others as well, whether service users, peers, colleagues or mentors. Their implementation and reinforcement early within the degree means that their success could be carried from students' formative years to their transition to practice.

The current study demonstrated that students have a strong capacity for adaptation. This was evidenced by their quick adjustment to highly variable learning contexts and conditions that affected them on multiple levels. Personal preferences for learning conditions were limited or unavailable, at least for a restricted time during COVID-19. Access to resources was significantly diminished, and usual coping mechanisms were again either restricted or only available within significant limitations. The quantitative results of this study demonstrated high capacity for coping and overall resilience at the onset of students' study program (Tables 5.16 and 5.17), as well as high scores for affinity to use adaptive humour styles (Table 5.15), consistent with positive results in

overall satisfaction with life (Table 5.18). These findings were corroborated by the qualitative data. Participants demonstrated their ability to cope and adapt both through measured instruments and through actions during their first year. A study by S. Park et al. (2019) emphasised the role played by social support and students' resilience in their adaptation to academic life and acquisition of clinical competence. They also found that positive adaptation to academic life had the greatest influence on clinical competence (S. Park et al., 2019). Our study confirms the mediating role of relationships in students' adaptation, but not the link between academic adaptation and clinical competence, except as a function of improvement in the quality of relationships. This suggests the possibility of further research to explore this aspect.

Despite these challenges, NSs demonstrated the ability to adapt to rapid changes in learning conditions, to manage stress imposed by unforeseen conditions, and to draw on personal and collective strengths and resources to overcome challenges. Participants demonstrated initiatives in identifying opportunities offered by change and being proactive rather than reactive; these qualities have been identified in the nursing literature as effective leadership qualities (Bower, 2000). The COVID-19 pandemic demonstrated the capacity of nurses, whether student, academic or practising, to adapt quickly to changing circumstances. Renfrew et al. (2021) discussed how key pre-existing, trusting and collaborative relationships proved instrumental in meeting the fast need for the adaptation of nursing education in the face of COVID-19. This was demonstrated in our study by how students adapted to the reality they faced and how they met the challenge. Here again, relationships helped all parties cope with precipitous changes and helped, at least in part, reduce the stress experienced in the process. Our findings offer added suggestions for developing and promoting positive, helpful and affiliative relationships to help NSs not only during their study but also to develop as persons.

The delivery mode of academic content has an impact on students' comprehension and integration of concepts taught. Online teaching does not always equate to positive learning outcomes (Ramsay et al., 2020) and is not always the mode preferred by all. As discussed previously, students' preference for kinesthetic learning, combined with traditional lectures, learning content, tutorials and practicals (Meehan-Andrews, 2009; J. Y. Park et al., 2016), optimises nursing education. Several participants felt the negative impact caused by COVID-19. Students managed to complete their semester,

but the reduced staff availability, the reduction in blended learning, or the complete and swift transition to online education delivery complicated an already challenging situation, further affecting their learning experience. Students in our study engaged in written reflections (pre-pandemic) and had the benefit to continue their reflection through the semi-structured interviews. This extends the findings of Cheng et al. (2020), who reported on the benefits of self-reflection and critical thinking with FYNSs during the COVID-19 pandemic.

In an effort to provide flexible options to students, blended approaches (such as flip-class learning) are becoming increasingly popular. Video and online options have the added appeal of being cost effective and offering the flexibility of round-the-clock availability to the learner, and can integrate more than one modality into course delivery, thereby accommodating students' varied learning styles (Coyne et al., 2018). COVID-19 accelerated the uptake of remote learning technologies already commenced in response to some providers' difficulties providing face-to-face lectures and tutorials over an extended period. This has created increased possibilities for all, educators and learners alike (Jackson et al., 2020; Jowsey et al., 2020), as well as some downfalls such as concerns for academic integrity (Mukhtar et al., 2020). Ha and Pepin (2018) trialled an intervention that combined showing FYNSs visual clinical nursing leadership through videos, some of which provided moments of humour; engaging in RP through journaling about their personal and observed clinical leadership; and engaging in small group discussions. Their findings indicated the need for students to be provided with concrete examples when introducing concepts unfamiliar to them. This combination of audio/visual instruction and reflection opportunities, whether in writing, groups or interviews, suggests the possibility to educate NSs around humour, its use, and outcomes including its several benefits with the potential to influence adaptation to the academic and clinical field. Developing such interventions requires future research.

This research offers an added dimension to the notion of NSs' ability to cope and adapt. It demonstrates that when students are provided opportunities and occasions, whether through adversity or deliberate policy, they can rise to the occasion and transcend past mere adaptation: they demonstrate resilience. As seen in Chapter 2, Figure 2.4, this trajectory leads to overall eudaimonia, or happiness. Therefore, if the true motivation for adequate curriculum development is for quality of graduate output and industry wellbeing, efforts made in the educational space may improve GNs' transition to practice

and may also lead to improvement in general welfare of future practising nurses. By extension, this may also have ricochet effects on retention by diminishing intentions to leave the profession.

7.2.2.2 Adaptation in Relation to Humour Theory

Section 7.2.1 has already discussed at length the influential impact of humour in coping, adaptation, resilience and transition. However, the following paragraphs will discuss how the adaptation displayed by the participants of this study compares to the humour style theory developed by R. A. Martin et al. (2003).

There exist several humour theories and these were presented in Chapter 3, section 3.3.1. The humour style theory suggests that the use of humour can either be adaptive or maladaptive (R. A. Martin et al., 2003). This is seen particularly in the type of humour used by a person and the resulting impact that this use of humour has on relationships with self and others. Positive use of humour is said to be affiliative, helping a person to form positive social and emotional bonds with others and to be self-enhancing, helping a person to develop positive qualities and attributes (R. A. Martin et al., 2003). In contrast, a more negative use of humour is said to affect relationships with others since it is aggressive in nature and will, at least over time, be detrimental in keeping healthy and respectful relationships. Negative use of humour also has a personal impact on the person using it due to promoting self-defeating behaviours such as ridiculing oneself to entertain or maintain relationships (R. A. Martin et al., 2003).

Our study demonstrated the impact of humour on FYNSs' adaptation to their first year of study. The overall impression of its outcome was positive and adaptive. Initially, participants recognised using the affiliative style of humour to greater extents, and this also translated in practice. Participants also initially reported minimally using the maladaptive styles—self-defeating and aggressive—of humour, indicating that they neither agreed nor disagreed with the given statements of humour use. This was also upheld in practice. These negative uses of humour styles are said to be detrimental if used frequently or over an extended time (R.A. Martin et al., 2003). Their sparse identification in practice in our study was not observed to produce negative outcomes, rather the opposite: for instance, participants who were the centre of humoristic events benefited from this by improving their connection with others. The humour might have had a humbling effect, but was delivered in a way that had levelling and affiliative

consequences with others rather than being divisive. Humour use, including aggressive styles, was not recognised to be offensive or disrespectful and was only recognised to serve a positive purpose, such as dealing with an absurd situation calling for spontaneous use of humour in dealing with the situation. Overall, humour was used, and seen to be used, in a productive light.

The chief revelation in analysing the use of humour against adaptation centred around the self-enhancing humour style. Participants did not recognise using it as frequently as the affiliative styles (14.2% versus 82.4%). In practice, its use was prevalent and more readily recognised through reflection. This could be due to perhaps the more direct and felt impact of affiliative humour that promotes relationships with others. One difficulty may be in parting the two humour styles as if they happen in silos when, in fact, they may happen simultaneously. This is evidenced by several of our participants' statements for a given event that could be classified under each style. The following examples of statements highlight well this dual occurrence of humour use:

Participant C1: "And then, yeah, the carers' intent is just to make the atmosphere lighter. So, they just point out how serious we're being. Yeah, make a few jokes, which I thought was good. And make us less tense, things like that."

Participant R11: "One of the residents made light of the situation in regards to the location of one of their wounds, so it made me feel like it was just a routine wound, therefore we could have a laugh while doing the required task."

Participant C2: "[Interacting with carers] We would have a couple of conversations where we might have inside jokes or something into the practicum. So it made us students feel really comfortable because we weren't on this really serious term, although it was quite a scary thing for us at the beginning because it was at first one. And the carers really helped us ease into it and they were just making jokes, making sure that we were comfortable."

The affiliative impact might have been easier to recognise directly—because of the immediate connection with someone, the ability to assess this through verbal and non-verbal means—while the results of the self-enhancing use of humour—because of taking a back seat relative to the affiliative style—had a more gradual impact and was better identified when participants were provided opportunities to reflect. Additionally, at the onset of this research project, participants were uncertain they could identify the presence of humour or were having difficulty in providing a definition that included all of humour's subtleties and refined use. This further suggests the appropriateness,

relevance and value of providing education and opportunities for targeted reflection around humour.

The integration of our findings against the humour style theory is summarised and presented in Figure 7.2 below. This includes how participants initially identified their use of humour through the HSQ questionnaire, the identification of humour in practice, and the overall impressions they offered once amalgamated.

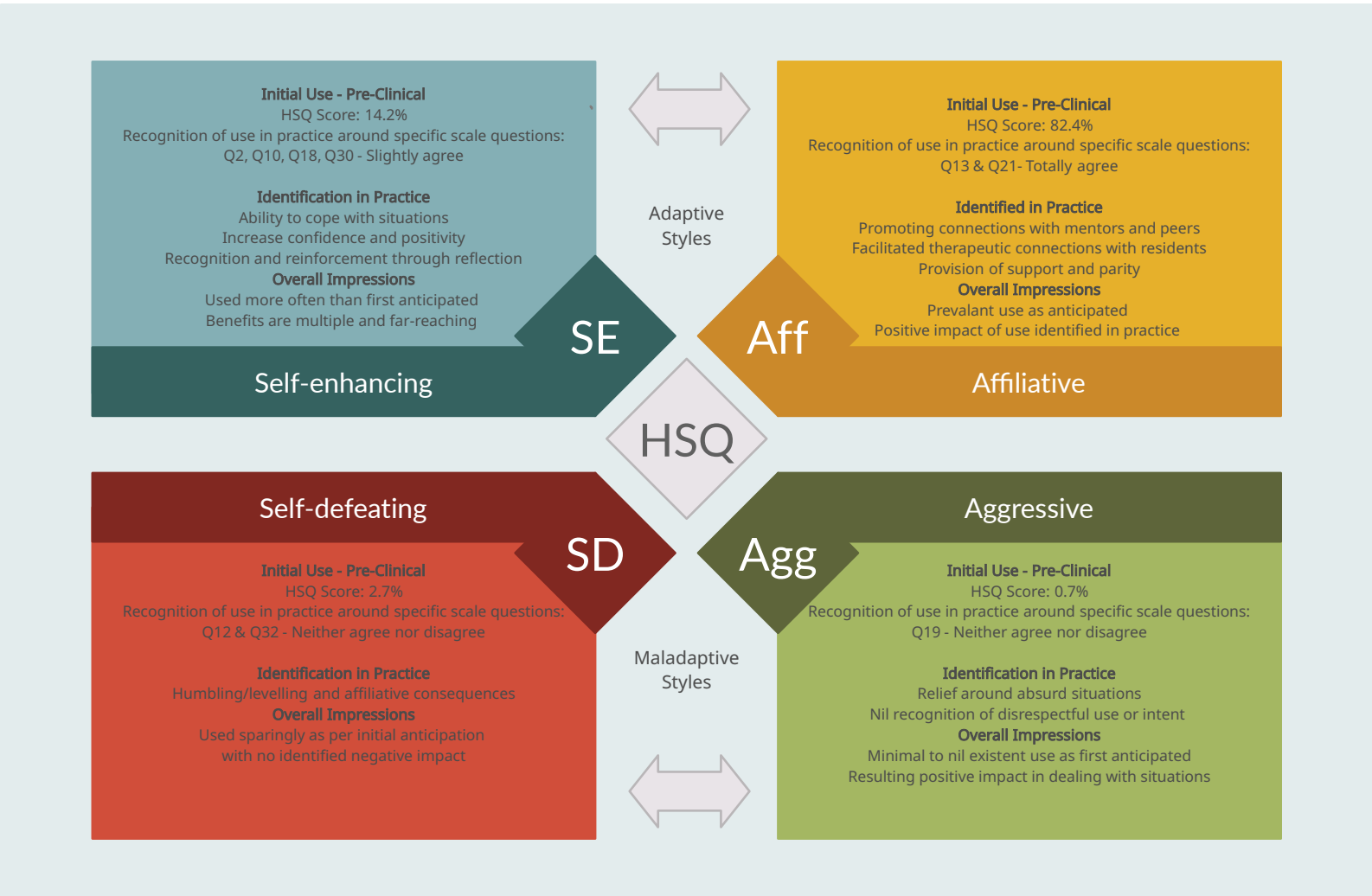


Figure 7.2: Adaptation and Humour Styles Used by First-Year Nursing Students

7.3 Major Themes, Findings and Discussion

This research identified several factors affecting students' adjustment throughout the first year of their undergraduate nursing degree, as discussed in depth in previous chapters. The themes identified in qualitative analysis highlighted the vital role of relationships in facilitating facets of the student's journey, including learning, acculturation, and adaptation to the world of nursing. The quantitative and qualitative results discussed in Chapters 5 and 6 demonstrated that new NSs displayed a good foundation for resilience and satisfaction with life, together with a shared positive use of humour in managing relationships and events.

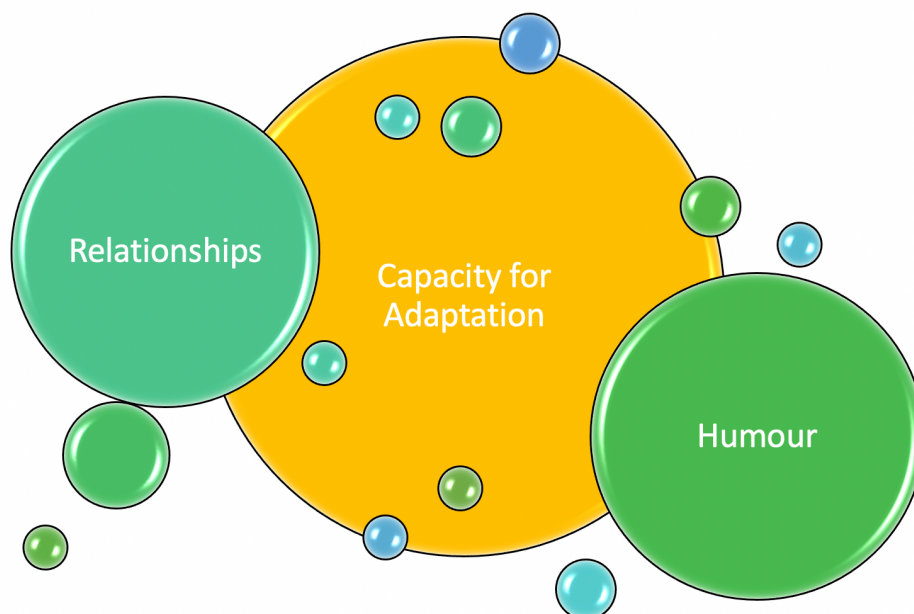


Figure 7.3: Study Themes and Findings

During the analysis of results, it became evident to the researcher that the results were so intertwined that new themes and findings emerged and were necessary for the drawing of meaningful conclusions—they are visually presented in Figure 7.3 above. The students' high results in coping and resilience (the reader is invited to refer to Chapter 5, Tables 5.16 and 5.17) and satisfaction with life (Table 5.18) reflected the participants' natural disposition to adaptation. The role played by relationships in participants' capacity for adaptation was felt and recognised on all levels of learning and social interactions and was instrumental in navigating adversity and achieving success. The power of its role isolated it as a distinct contributor. Similarly, the presence of

humour, particularly participants' high results in adaptive styles of humour (Table 5.15), was significant in its own right, influencing both relationships and general adaptation. By virtue of its pervasive presence and positive effect, humour stood alone as a particular strength and contributing factor in participants' relationships. It is therefore also represented as a distinct finding in Figure 7.3.

Simply put, the relationship within oneself (the student's relationship with themselves) and the relationships formed with others are intrinsic to students' successes throughout their first year of nursing study. The quality of these relationships is intertwined into the fabric of the student's adaptive journey with the humour thread. Whether initially identified or not, humour is present to some degree in most, if not nearly all, interpersonal interactions. This study demonstrated that humour facilitates the formation and maintenance of relationships and the educational interactions of students with their clinical educators or mentors, residents/patients, and peers. It alleviates stress and improves mood, and facilitates learning and reflection, cooperation, and teamwork. Findings indicated that it is the glue that brings all elements together, at times subtle or concealed, yet continually and strongly present.

The design of the nursing programs offered by universities plays a major role in the quality of graduate output. The nursing curriculum shapes the student's experience in the classroom as well as during their clinical experience. Empowering students has been discussed as being vital in the development of the nursing curriculum (Sidhu & Park, 2018). It can be achieved by paying particular attention to increasing access to information, opportunities, resources, and support within the learning context (Moore & Ward, 2017). This also extends into the clinical field, where NSs need and expect guidance and leadership from their clinical preceptors (Zilembo & Monterosso, 2008). Empowerment can be defined as both a process and an outcome that positively safeguards students and future RNs against bullying and incivility (Shanta & Eliason, 2014). Identifying and including elements conducive to student empowerment is necessary. The role of humour, with its effect on learning conditions and positive relationships, therefore justifies its use in the nursing undergraduate context.

In the following sub-sections, the main findings of this research will be discussed and compared with the literature. The findings are centred around NSs, the key role offered

by relationships, and the benefits of humour and RP. Finally, this section will present an overview of the overall findings.

7.3.1 Key Role of Relationships

This study demonstrated the omnipresent positive effect of relationships throughout participants' first year of nursing studies. The role of relationships throughout the learning journey has been discussed in section 6.4.1. Relationships with fellow students, academic staff, clinical mentors, and persons cared for were instrumental in learning. Relationships also featured heavily in the development of the nursing identity (section 6.4.2.1) and in forming initial impressions made on participants (section 6.4.2.2) (Brito, 2020; M. Hughes et al., 2020; J.-S. Kim, 2020). Relationships help shape the nurse in training, providing motivation to learn to both 'do nursing' and 'to be a nurse'.

As noted in 7.2.2.1, participants' experiences were similar to transition shock experienced by GNs, the difference shown in the current research being the positive impact of strong relationships. It is equally helpful to investigate the causes of difficulties in coping and adaptation as well as their reinforcing factors. The role of relationships in this study proved to be the armour protecting the participants from emotional adversity, enriching their treasure chest of coping strategies. The literature persuasively describes the benefits of key relationships throughout the nursing journey in providing their outward benefits (Åstedt-Kurki et al., 2001; Beyhan, 2020; J. Stewart et al., 2015; Tremayne, 2014). Teamwork, support and communication have been found not only to enhance the student's experience during their practicum but also to help them to socialise and adapt to the clinical context and nursing setting (Hasson et al., 2013; B. James et al., 2016; Ranse & Grealish, 2007). Thus, the development and maintenance of positive relationships has been widely shown to have a beneficial impact on the activity of nursing.

Relationships formed and available to students are crucially linked to success in all aspects of their learning journey on both inward and interpersonal levels, including wellbeing (Rawlins, 2017). The health status of relationships affects not only the person but also those they live, work and socialise with (Murray et al., 2021). Mentors foster enthusiasm, facilitation and mediation with other staff members, and their knowledgeable position is beneficial to students' learning and overall experience (B. James et al., 2016). Brito (2020) highlighted the strategic role played by the student–

instructor relationship in helping the student succeed. Clements et al. (2016) discussed the vital importance of social support to the educational process and the central role it played in developing and maintaining students' commitment. This study also identified the role played by all who gravitate towards the student during their journey: fellow students, clinical staff, mentors, and patients. It also identified how positive relationships can affect belongingness, learning, commitment, and the desire to continue on the learning journey, consistent with Clements et al.'s (2016) findings. Key relationships appear to equally influence students on an innermost level as on an external one.

The research into nursing relationships more often addresses an external activity. There is ample literature examining bullying (Alisha H. Johnson & Benham-Hutchins, 2020), clinical belongingness (Pourteimour et al., 2021), and recently the dyadic relationship between the nurse and the nursed (person who is a participant in the nursing experience) (Alforque et al., 2020). As a common denominator, the nurse's ability to develop and maintain relationships, both with self and others, warrants consideration. As Gen Z NSs value responsive feedback and have underdeveloped relationships and social skills (Chicca & Shellenbarger, 2018), it is fitting that the relationship component of our research was one of its main findings. What our findings add is how humour bridged the gap between individuals and enabled NSs to learn with and from those relationships, cope, and adapt.

As a result, our findings supplement the literature and offer an added perspective to students adapting to their first year of nursing studies. Seyedfatemi et al. (2007) had previously discussed the vital role of social support and self-actualisation as coping strategies to address NSs' sources of stress, while Labrague et al. (2017) identified how relationships with others (including clinical and academic staff) were sources of stress for NSs. Our findings show that humour is an often-present coping strategy, but also link the concepts of social interactions and support with self-actualisation as seen in adaptation and the development of resilience. Our study offers contemporary data and novel findings in the NS population.

Highlighting the same multiple relationships instrumental to their learning journey, our study also adds an important element noted because of COVID-19. Students were significantly affected by the disruptions in their relationships due to the pandemic, especially the reduced human contact despite the availability of online communication.

They felt the impact of this deeply: it affected their learning experience and reduced access to their social networks, denying them their usual coping mechanisms. Despite this, the study demonstrated that the participants were able to navigate through sudden changes, maximise available opportunities, tap into their personal resources, and maintain relationships as best as they could during stressful times. This provided students with a crucial opportunity to demonstrate their adaptability and overall resilience in the face of adversity. Their resulting individual success was attributable to not only their personal qualities but also the pooling together of all other meaningful relationships, reaching the safety of the shore together. Participants swam in a sea of uncertainty on their own at the onset of their first year, adjusted as if they were part of a pod—a school of NSs—and successfully adapted.

Nursing can be performed as an individual task; however, nurses rarely work in isolation. The ability to form, maintain and support relationships is conducive to success in nursing. The humour expression forms part of our language. Language used by clinical mentors, lecturers and mentors can influence positions of power and in turn affect the activity of nursing (Dahlke & Hunter, 2020). Understanding major factors promoting relationships on all levels serves the nurse and the wider profession, and our findings provide key insights into these relationships, namely, how humour assists in promoting connections with others, providing support and assisting in encouraging parity.

7.3.2 Benefits of Humour

This study into humour demonstrated its pervasive nature—when an individual was unable to engage in humour because of stress, another person near them, such as a clinical mentor, would often engage and utilise it to benefit the situation and relieve the tension. Humour was present—initiated, felt or responded to by all involved. Benefits were multi-layered and had a compounding effect. Humour could be seen as having several extensions, with each having its own purpose to help the participant overcome stressful situations. Humour facilitated relationships, reduced stress in learning situations, helped participants engage with others, was a tool to lighten the atmosphere, improved enjoyment in life, and aided debriefing of problematic experiences (Figure 7.4). Every aspect was beneficial and rarely, if ever, was it used, or seen to be used, in an aggressive way or with the potential to cause harm. Similar to water that slowly

infiltrates every nook and cranny, participants might not have been able to see the presence of humour immediately, but they felt its effect always and realised its presence in all things through reflection.

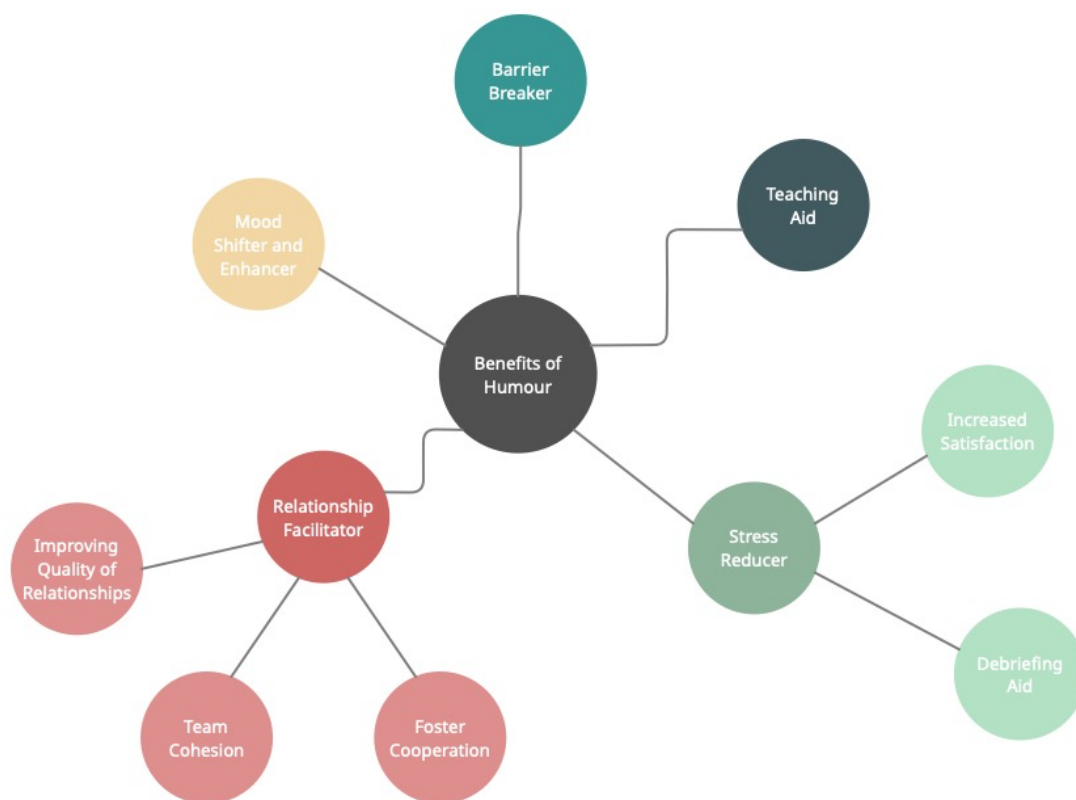


Figure 7.4: Benefits of Humour

This study revealed the central role played by humour in the development and maintenance of personal and professional relationships. It demonstrated humour’s function in enhancing mood regulation, breaking down barriers, and facilitating cohesive teamwork in both academic and clinical fields. Humour was pervasive, habitually outwardly obvious, and frequently so subtle that it revealed itself only in retrospect. Our findings supporting humour education for NSs echo those of Flynn (2020), who recommended the need for students to improve humour recognition and identify their own humour trigger to assist interpersonal interactions. However, this would also serve to increase NSs’ awareness of humour, its use and advantages, as our results did not demonstrate that humour was ever used in an inappropriate, disrespectful or divisive manner, although this is not to say that this could not be the case. Educating NSs about

humour as a whole concept could offer countless benefits, particularly concerning relationships.

Educating NSs around humour could not only improve their awareness but also help them define it. Hayden-Miles (2002) identified NSs' narrow view of the concept, and this was also demonstrated in this research. Initially, participants had difficulty in providing a definition or description of humour and their answers underlined how humour was subtle, nuanced and intricate. They had difficulty identifying moments of humour, yet with prompts from the reflective journals and interviews, the concept of humour and its applications and benefits began to come to light. NSs may find it difficult to grasp abstract concepts without prior concrete examples, and providing them with creative audio/visual opportunities coupled with reflection can assist in grasping these concepts (Ha & Pepin, 2018). Nahas (1998) and Hayden-Miles (2002) also spoke of the benefit of humour in building effective relationships between NSs and clinical teachers. Our findings also support theirs, adding that providing NSs with opportunities for RP is a powerful teaching and learning strategy in achieving these goals around humour education. Our findings add weight to the promotion of the positive use of humour in the work setting, 'work setting' being that of the nursing education or the clinical context, known to require self-awareness provided by reflection and education (North, 2018).

Education does not always have to be serious; it can be fun. In Minden (2002), NSs on a psychiatric clinical placement received a 2-hour class on the therapeutic use of humour and developed a student-led group post education. This not only helped to dispel the erroneous belief that therapeutic group work had to be serious but also aided the improvement of mental health, social interactions, and skills. Minden's study failed to report on students' experience; however, our findings suggest that similar outcomes could have befallen NSs as a result of this newly acquired knowledge and experience. Introducing the humour concept within nursing curricula could not only be personally beneficial to NSs but also increase their therapeutic skills toolbox.

Despite sporadic published literature into humour and NSs, as previously discussed in Chapters 2 and 3, there is a dearth of humour research into this population. Navarro-Carrillo et al. (2020) investigated a cohort of working nurses and assessed their use of humour and levels of wellbeing in the healthcare setting. Adaptive humour styles (affiliative and self-enhancing) were associated with wellbeing, including life

satisfaction. However, they concluded that these positive humour styles did not protect nursing professionals in stressful situations. On the contrary, the current research indicates that Navarro-Carrillo et al.'s (2020) conclusion may not apply to FYNSs. During data collection, participants underwent unprecedented levels of stress with disruption of their academic and personal lives—COVID-19 stressed all participants severely. The qualitative data showed that participants' natural penchant for healthy humour endured in the face of adversity and that they used it as a protective coping mechanism. It was shown that humour could be absent during a stressful event, only to surface effectively afterwards; retrospective humour was noted to occur, with significant benefit to participants in debriefing sessions.

An extensive literature search has shown no published investigation into the use of humour by NSs at the beginning of their undergraduate studies. This included the period during the disruption of a globally catastrophic event such as the COVID-19 pandemic. Our research data are therefore relevant in providing departing measures for future research projects by adding to the limited body of research into nurses' humour. It documents its presence and characteristics at the onset of the nursing journey before the activity of nursing can change it. It also provides a starting point for research into the factors that change humour styles in nurses with time and practice.

The original combination of humour and its applications and effects can provide academic writers with additional perspectives from which to examine their own data. Additionally, our findings provide an opportunity to influence the inclusion of humour education coupled with RP within nursing curricula to assist students in the transition into nursing studies, and potentially beyond graduation.

The benefits of humour were also recognised by students in retrospect. In the direct moment in time, students did not identify humour. As discussed in previous paragraphs, their limited definition of the term and its application in practice narrowed their ability to identify it. However, the fruitful effect of reflection, in writing through journals and verbally through interviews, enabled them to identify and contemplate its numerous applications and benefits. This facilitated perception of the discreet yet central presence and effect of self-enhancing humour. This pairs with Mathews (2016), examining humour-generated tasks combined with a writing exercise. Humour was beneficial in upregulating positive and downregulating negative emotions. In our study, students

used humour to cope in a variety of tense situations and it helped them reduce their anxiety. Devising creative RP activities, as per Mathews (2016), could provide curriculum developers with options to embed humour education, stress management and wellbeing into their unit and course content.

As discussed by Raslie (2021), Gen Y and Z NSs engage differently to other generations—they communicate at a slower pace, thrive on affirmations, and expect to be valued and respected. Additionally, humour plays a central role in engaging them (Munsch, 2021). Our study's findings tie these aspects together well; humour was used to engage with others, communicate, and process both intellectually and emotionally.

7.3.3 Essential Role of Reflective Practice

The third main finding was the essential role that RP played in helping NSs along their journey and its unsuspecting benefit. RP contributed not only to providing data for this research but also assisted students throughout their journey. As discussed previously, RP, whether formal through journals and interviews or informal through debriefing with peers or engaging with clinical mentors, contributed to NSs identifying not only how humour, including its benefits and frequency, was prevalent during their first year, but also the role played by key relationships encountered. RP was found to be beneficial by Jenkins et al. (2019) not only as an academic assignment but also in encouraging NSs in practising self-care activities. Similar findings were reported by Mills et al. (2020), whose participants profited from RP in realising how they coped during their first year of nursing study, acquiring insight and tools, and valuing the importance of social support throughout their journey.

Additionally, engaging in regular RP could assist NSs to reflect on the development of their communication skills and cultivate self-awareness, some of the essential qualities identified by Sortedahl et al. (2017) in nurse leaders. Awareness of self and others is a significant contributor to EI and promotes a variety of outcomes, including adaptability, communication, building bonds, teamwork, and collaboration with others (Jain, 2018), and can be taught in higher education (Gilar-Corbí et al., 2018). RP was also identified as one of the elements included in successful transition to practice programs (Spector et al., 2015), as well as in improving student engagement (Swart & Meda, 2021). As seen in our study, introducing RP early in the nursing curricula could both support students' transition to nursing studies and potentially offer postgraduate benefits.

Our study did not identify events in which NSs were bullied directly. NSs encountered some relationships and personalities that were more difficult to navigate than others, and some participants also learnt to speak up for themselves and display assertiveness. However, bullying and uncivil behaviour towards NSs has been demonstrated in the literature (Birks, Budden, et al., 2018), and NSs have expressed a belief that their university had not prepared them well to address bullying (Courtney-Pratt et al., 2018). Bullying is an inevitability some NSs will encounter during their clinical placement and in later practice. The use of aggressive humour can to some degree disguise unpleasant behaviour. Guiding NSs to identify and reflect on such behaviour and relationships through effective RP could assist them in navigating and managing these as best as they possibility can. As discussed throughout this thesis, adaptation and resilience result from overcoming stressors and difficult situations; they cannot always be eliminated, and learning from these, rather than avoiding them, can provide fertile ground for personal growth. Therefore, educators are called upon to maximise such learning and growth opportunities.

RP helped our participants ponder practising their new skills and their interactions with clinical staff, residents, and patients, some of which were sources of stress for them. Maintaining critical and reflective abilities was seen as the most pressing need of NSs in the clinical area (Liljedahl et al., 2016). In their study and through psychometric tests, Bhurtun et al. (2021) reported that NSs rarely experienced stress, but when they did, it was mainly centred around confronting their lack of knowledge and skills, and their communication difficulties with those encountered in clinical practice, such as patients and educators. One of their identified coping strategies involved talking with one another, interpersonal debriefing being a form of reflection incorporating the significant role of relationships NSs seek in managing stressors. L. J. Thomas and Asselin (2018) advocated for resilience education to better prepare novice nurses; this can be done by combining RP and peer support. Our study identified similar sources of stress to Bhurtun et al. (2021), augmenting the role of RP and relationships by adding humour to the suite of coping skills.

7.3.4 Summary of Findings

The following section provides a synthesis of the findings of the previous sub-sections, namely 7.3.1, 7.3.2 and 7.3.3:

- Humour was used by FYNSs and all those around them frequently. Humour styles used were predominantly adaptive, and the minimal use of maladaptive humour styles had positive consequences for students.
- The frequency of humour use was higher than first anticipated by students, and its presence and value revealed through RP.
- Humour helped FYNSs cope and adapt during their first year of study, including during their clinical practice, and socioculturally aided their early clinical nursing practice.
- Humour had several benefits, including the intimate role it plays in developing and maintaining effective connections with self, peers, mentors and educators, as well as in establishing therapeutic connections.
- Opportunities for RP through multiple means were beneficial in helping FYNSs identify elements conducive to their coping and adaption, chiefly humour and relationships. Additionally, RP helped students connect elements with experience.
- FYNSs demonstrated a strong capacity for adaptation at the onset of their degree; this capacity was further evidenced in clinical practice and supported by the use humour and key relationships.

7.4 Research Questions

The principal research question was: How does humour influence the NS's wellbeing and coping mechanisms at the onset of their undergraduate degree?

The following research questions directed the study:

1. What is the humour style score of NSs pre first practicum?
2. What is the relationship between NSs' humour style and their overall resilience score pre first practicum?
3. What is the relationship between NSs' humour style and their satisfaction with life?
4. How do NSs perceive their engagement with the activity of nursing studies (both academically and during practicum), how it impacts on personal wellness, and contribute to their coping strategies?

Answer to the principal research question: Humour was found to have a significant influence on students' wellbeing. While omnipresent, it acted synergistically with key relationships, affecting self and interactions with others. It was possible to observe the presence of humour in all aspects of a student's journey, across all interactions and situations. Despite this, it was not humour alone that facilitated coping, adaptation and wellbeing, but the combination of it with relationships with others, individually and in groups.

7.4.1 Research Question One

Students had a tendency to utilise adaptive styles of humour at the onset of their degree. The most favoured humour style was affiliative, followed by the self-enhancing style. Both are adaptive in nature, foster good relationships and have a positive effect on self-esteem. Self-enhancing humour was also used more frequently than students first estimated. RP was central in revealing this aspect.

7.4.2 Research Question Two

Adaptive humour styles were positively correlated with high resilience in first-semester NSs. The strongest association was with the self-enhancing humour style. This association is logical in that it promotes a positive outlook on life and is a strong coping strategy in times of stress. The self-defeating humour style had a negative impact on a person's resilience, and here again, the association is reasonable on the grounds that it serves to amuse others at a person's own expense, devaluing their sense of self and overall self-esteem. Used sparingly, this humour style can be entertaining without long-lasting negative consequences. If this humour style had been the participants' most favoured style, it could well have negatively affected their overall resilience score. However, sparse use of maladaptive humour styles had resulting positive effects for participants.

7.4.3 Research Question Three

Adaptive humour styles were significantly correlated with students' overall satisfaction with life, while, interestingly, aggressive humour was negatively correlated with life satisfaction, manifesting its negative effects on relationships by being offensive,

manipulative, derisive and disparaging. Humans thrive on positive relationships and tend to wither in the presence of relationship-damaging influences.

7.4.4 Research Question Four

Over the study period, students underwent a series of intense experiences, adjusting to cycles of transition shock in the clinical settings, as well as the major complications afforded by the advent of an international pandemic. Enduring relative adversity, they drew on available relationships with the assistance of humour, overcame significant obstacles, and adapted. The role played by humour was intricately weaved within relationships. Meaningful rapport with others, whether friends, academic staff, persons they cared for, peers or mentors, combined with humour to strengthen the fabric of students' psychological armour. RP was instrumental in helping students to identify these and played a key role in their adaptation.

7.5 Limitations

Several limitations have been noted in this research project. These will now be discussed individually and will address recruitment challenges, study site, sample size, order effect, and the effect of COVID-19 on the project.

7.5.1 Recruitment Challenges

Several factors contributed to W1's low response rate. During the first face-to-face interaction, students were only provided with a hard copy of the survey on request and were otherwise encouraged to complete the survey online, later, because of time constraints. Not securing completion prior to students departing the lecture theatre would undoubtedly have reduced the completion rate, motivation fading with time and distance. Additionally, academic demands and organisational difficulties encountered by students during their first few weeks of their first tertiary study course would have been likely to deter completion through numerous other demands for attention and anxiety, for which assistance might have been difficult to find, contributing to additional difficulties (Andrew et al., 2008; Pitt et al., 2012). This combination of increasing demands on potential participants might have culminated in them prioritising other aspects of their course at the expense of participating in a research project.

The researcher sought to modify the approach with students in W2 to achieve a higher response rate. In doing so, she reviewed critical aspects that can influence recruitment. Manohar et al. (2018) listed these as whether the best location, the best time to approach students and the best methods of contact had been selected, inspiring modifications that produced a higher response rate and sample size similar to those of several published studies of similar population sizes.

This study was limited to the context of the first year of a nursing undergraduate 3-year education program and its corresponding practicums. It excluded ENs on the articulation pathway and RNs completing a re-entry to practice program.

7.5.2 Study Site

The research was conducted in a single university in WA, Australia. This limitation did not preclude the generalisation of the results because nursing programs across universities all combine a mixture of academic learning and practical components. All new NSs typically perform their first clinical placement in the aged care setting and in the first year of their degree. Further, theory-supported generalisation may be possible because this study was underpinned by transition shock theory and the quality of the qualitative data yielded from this research (Knottnerus et al., 2019). However, data collection in multiple sites could increase sample size and possibly response rate.

7.5.3 Sample Size

Despite several results of statistical significance, the quantitative findings must be regarded with caution because of sample demographics and small effect size. The sample was heavily weighted around the young female with some prior studies or minimal exposure to the healthcare industry through paid employment. Gender- and age-based conclusions cannot therefore be equitably made.

Nonetheless, results inferred from the findings do offer a snapshot of the NS's portrait before being influenced by the activity of nursing in their first clinical placement. The results were used to further inform and shed light on qualitative data obtained during and after clinical placements, which were discussed in Chapter 6.

7.5.4 Order Effect

As discussed in Chapter 4 under the heading of Bias (section 4.2.6), there was a possible question-order effect present in our survey. The researcher sought to minimise this effect by logically sequencing the demographic questions and the three validated instruments. The HSQ was the initial instrument presented to the participant as it sought to capture the critical information about humour in the first instance. However, despite all best efforts, it is possible that the order of the questions had an effect on responses.

7.5.5 COVID-19 Effect

COVID-19 placed additional stress on participants, which could not be entirely evened out among participants. This is particularly evident for the second interview: W1 conducted their second interview prior to the full force of COVID-19 disrupting classes and clinical placements. The disparity was decreased by conducting a third interview with W1 participants. However, another limitation is the fact that only one of the original W1 participants agreed to participate in that third interview. The information collected through this interview might only have represented the experience of one person and not the whole cohort.

Additionally, during the second wave of data collection, the COVID-19 pandemic significantly altered how the world worked, attended educational establishments, and lived in general. This resulted in practicum placements being cancelled and altered how data were collected. This meant that part of the sample of participants experienced their first year of study unevenly. However, the research sought to minimise this limitation by inviting students from the first wave to answer additional questions relating specifically to the semester affected by COVID-19. Despite the low uptake of the offer, this is thought to have at least in part compensated for any artefactual discrepancies between sample participants.

Further, there were no students identified in the study who had withdrawn from the program. There was also no possibility for the researcher to obtain evidence about, or to contact directly, those who might have decided to leave prior to their clinical placement or thereafter. Interviewing any such students could have provided further information on coping strategies, or lack thereof, which might otherwise not have been identified throughout this research.

7.6 Chapter Summary

This chapter presented the reader with the merging of quantitative and quantitative results of this research. It then amalgamated the results, and these were compared with the literature, with similarities and differences discussed. The reader was then presented with the overall study findings. The significance of these findings was articulated and highlighted in the case of significant contributions to the body of knowledge and when novel findings were made. Further, the researcher related the findings to the original research questions underpinning this research project. A discussion around the findings was presented, and limitations of the research project were disclosed.

The next chapter will discuss recommendations following on from the findings of this study, with emphasis on clinical and academic implications and the future wellbeing of nurses and the nursing profession.

Chapter 8: Implications and Recommendations of Findings

8.1 Introduction

This research project was implemented to investigate factors conducive to FYNSs' wellbeing during their study, with a view to provide information to help them complete their education. The study was designed to begin the enquiry at the start of the nursing journey, before nurses become nurses, from the first semester of their odyssey. It was expressly designed to capture the reality of FYNSs at the onset of their voyage into the profession of nursing before laying hands on their first patient.

The findings of this research are that FYNSs demonstrate a strong inclination to develop, maintain and value all interpersonal relationships along their journey. They embark with great enthusiasm and a high degree of resilience. They are buoyed by positive, adaptive humour and a wonderful propensity for *joie de vivre*. In essence, this study showed that new NSs begin their journey as best equipped as they can be.

This research also highlighted that FYNSs can quickly adapt to challenging and fast-evolving situations. Despite adversity, they continued to tap into their resources, to seek help and to assist fellow colleagues. Humour was one of those valuable resources, yet was on the surface often unnoticed. Participants became aware of its presence and effect upon reflection. Participants navigated learning and clinical practice by utilising these resources, relying on each other to complete their first year of study.

The implications of these findings provide valuable information for educational institutions, clinical educators, mentors, and others interested and motivated to develop healthy and happy NSs and encourage them to complete their studies and eventually join the workforce. The findings imply that the quality of relationships around NSs will play a significant part in navigating the ups and downs of life, including life in the clinical field. They also suggest that humour is a strong contributing factor in the development and maintenance of those relationships. Additionally, the findings suggest that care and consideration towards the role that humour plays in the tapestry of human interactions can benefit everyone involved, including health consumers. Humour was significant in all aspects of interpersonal engagement and personal coping and resilience.

Opportunities for self-reflection enabled FYNSs to gain much in identifying how they coped throughout their first year. Whether in writing, through interviews or informally with peers, they were able to identify coping skills, including how humour and relationships played a part in navigating the uncharted territory of their first year of nursing education. Moreover, these reflective instances were conducive to students piecing elements together and becoming aware of their adaptation and their accomplishment.

The students exhibited all aspects of transition shock, yet with a remarkable adjunct. When explored in conjunction with humour, FYNSs' resulting emotional state demonstrated positive outcomes. These were particularly noticeable in relationships where humour served to promote connections with peers as well as foster therapeutic connections with health consumers. Humour also benefited relationships by encouraging support and parity by breaking down barriers between relationships of power. Humour also promoted positivity and self-confidence towards NSs' new responsibilities, helping them develop awareness of and reassurance around their knowledge and confidence in their new roles. Humour provided one of the significant threads in helping students adapt and move through stages of doing, being and knowing. Here again, reflection generated understanding to lead them to develop awareness and appreciation of their achievement.

Students' capacity for resilience was high at the beginning of their journey and so was their satisfaction with life. Their ability to overcome difficulties, reflect and succeed during the first year suggests that their venture into their desired profession further increased their resilience. This was not, however, formally confirmed through quantitative means because of changes in the design following unforeseen challenges due to COVID-19 that affected the study. Nonetheless, the positive outcomes reported by students did not suggest a downward trend in their resilience or satisfaction, warranting further exploration.

Educational institutions and clinical educators need to consider the above findings and their implications for the development of future education curricula and strategies to assist students develop into the finest nurses possible. The implications of this research are synthesised in Figure 8.1.

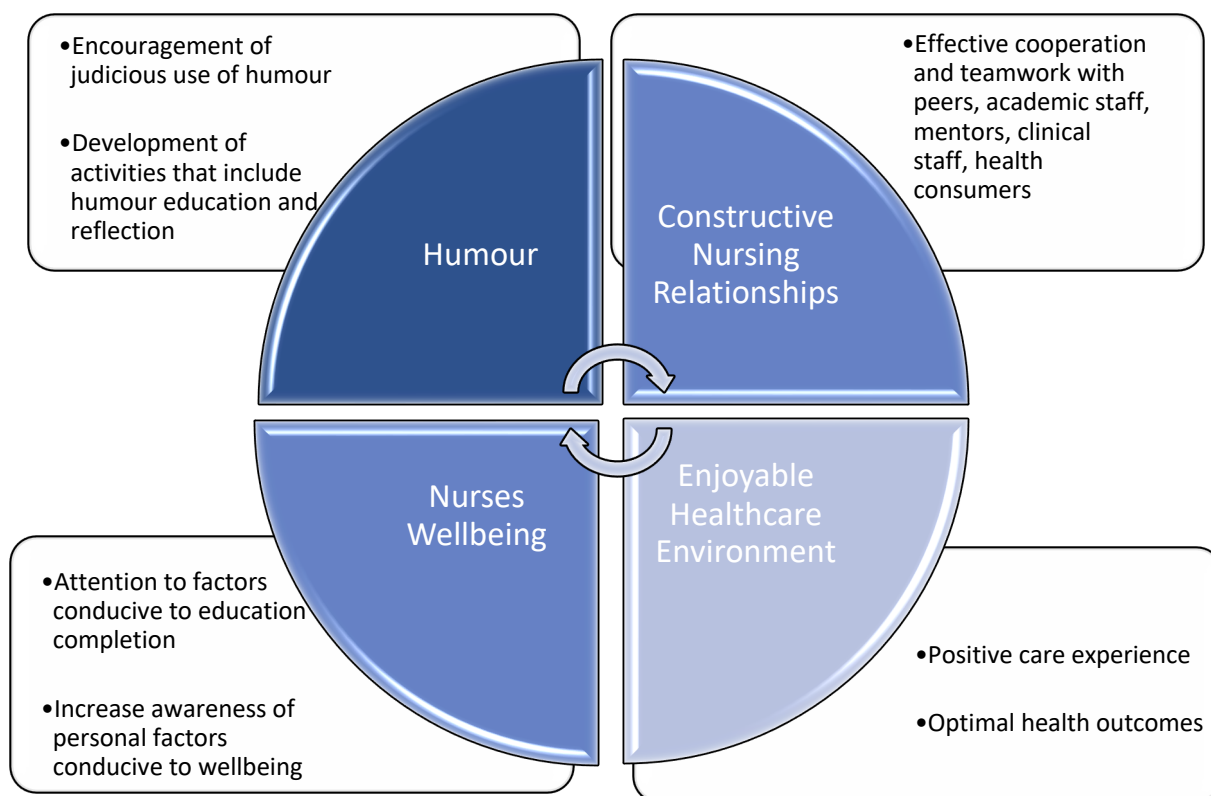


Figure 8.1: Implications of Findings of Future Nurses Wellbeing

Academic institutions are greatly encouraged to educate emerging nurses not only around skills competency leading to course completion but also to promote care for the person who will soon be practising nursing. Addressing wellbeing during formative years forms part of the protective measures contributing to everyone’s safety, from NSs to health consumers.

Each of these implications will be addressed in the following sections. They will be addressed in line with the educational, clinical and research recommendations resulting from this research.

8.2 Education Implications

The findings of this research highlighted the vital importance of relationships present at all levels of the student’s journey into nursing education. The functions served by these relationships are affiliative, nurturing and supportive at their core. They are also vital to two of the main aspects of nursing as a profession: cooperation and teamwork. An individual can only bring their best self to the team and only give of what they currently possess. Not all individuals are outgoing or able to form relationships easily. Some will

naturally surround themselves with a large group of people and be known to many, while others will be the silent observer in the background, with selected key relationships in their lives. In essence, there is no right or wrong, only a matter of preference and personality. The ability to understand oneself can help students harness their personal attributes, making them work to their advantage.

A large proportion of nursing activities are achieved as a team or, at the very least, have a flow-on effect involving a greater team. This team is made up of individuals all summoned to look after persons with healthcare needs. It is therefore appropriate for educational institutions to address elements conducive to effective teamwork and cooperation, especially considering that the current generation of NSs have underdeveloped social and relationship skills (Chicca & Shellenbarger, 2018). This thesis discussed in detail how the supportive role of humour and relationships enabled students to engage and perform well during clinical placements and navigate the first year of their journey and any adversities they encountered. Consequently, nursing curricula, content and delivery would benefit from focused attention on the effects, positive and negative, of humour and relationships within the nursing setting.

This research has described multiple occasions when students found sources of support during their first year of study. Whether among peers, mentors or clinical staff, students recalled the benefits they obtained from constructive interactions with others, and the resulting positive effect on achieving successful outcomes during their study. Students gained insight into these occasions through formal and less formal RP. Therefore, educational institutions could incorporate these findings into their student support interventions to improve students' satisfaction and academic learning and achievements.

Additionally, currently little attention is devoted in instructing NSs around their self-care. As highlighted in Chapter 1 and supported by the literature review around wellbeing, coping and resilience, imbedding these topics in nursing curricula could assist NSs along their education journey and also later on during their nursing practice.

The following considerations for education programs are proposed:

- inclusion of targeted education and activities that increase knowledge of the role and use of humour in nursing;

- nursing mentors, whether academic or clinical staff, to encourage and support the development of healthy relationships by all;
- inclusion of targeted education and activities that increase knowledge around personal coping, resilience, and general wellbeing;
- development of curricular activities that include multiple forms of RP and include targeted tasks around the use of humour and its outcomes, particularly relationships, and its helpful role in learning and emotional management; and
- inclusion of RP early in the nursing curricula, namely, during the first semester.

8.3 Clinical Implications

Clinical placements completed by students during their formative years enable them to practise various skills. The majority of these are centred on nursing competencies, such as administering medication and performing assessments. Some practicum outcomes centre on students' general professional conduct, communication skills and teamwork. However, there is an implicit expectation for students to be proficient in these aspects prior to attending their placement. It is unreasonable to expect students with varying life and relationship experience to instinctively 'know' what is conducive to effective relationships, or how to discern and influence them positively.

Therefore, there exists a gap between academic education and the clinical field regarding the building, promotion and maintenance of mutually respectful, collegial and purposeful relationships. Educational institutions cover a varying degree of academic content, with no specified compulsory learning outcomes imposed by an education program accreditation body regarding effective and healthy relationships. Establishments may address the quality and impact of human relationships in the provision of nursing care; however, this is left to their discretion. Students' professional conduct is therefore at best assessed on the premise of previously developed social skills, which may be neither adequate for purpose nor consistent between individuals.

This study has described how students benefited from reflecting on their practicum, quality interactions and the presence of humour in all aspects of their first year of nursing studies. Through RP and purposeful conversation, they were able to isolate such elements and appreciate their generally positive effects. The study also revealed that

once students were aware of these elements, they were better able to recognise them in practice and use them to their advantage.

8.4 Research Implications

This research project was centred on the person beginning their nursing journey, at the onset of their studies. It provided valuable information on interactions between FYNSs' wellbeing, general capacity for coping and resilience, and preferred humour styles. Similar enquiries repeated in second- and third-year NSs could provide insight into the continued effects of these factors; extending this enquiry to nurses with varying years of experience could provide valuable longitudinal information. Additionally, coping, resilience and life satisfaction measures post year of study or graduation could indicate whether the activity of nursing has an impact on such measures.

Students at the beginning of this project found it difficult to provide a definition of humour. As they were yet to experience the clinical field, they also did not have any points of anchor around humour in healthcare. More research is required to develop both a definition and explanation of humour as it is perceived by students in nursing practice. Research into contrasting the experience of humour by students through lived experience with literature and humour theory could be valuable. This could provide a shared understanding of the phenomenon in the context of practice. The data offered in this research can provide departing points and offer avenues for future research.

Supplementary research is recommended into the effect of the passage of time and clinical exposure to the activity of nursing and its impact on resilience, adaptation and the use of humour. Our study sample was limited to one establishment, during the first year only. Similar studies using different nursing populations, along different time points, could provide additional insight into whether and how the activity of nursing itself affects and is affected by these variables.

This study also identified the presence of transition shock and adaptation in FYNSs. More research is required, particularly into the identification of positive emotional states afforded by the mediating presence of humour—the current research offers only early indicators to inform future studies.

Additionally, more research evidence into different methods of conducting RP are possible, and desirable—while most studies refer to or utilise written reflection activities in their methodology, technological advances and generational changes in communication preferences, including voice recorded reflections transferred to text, visual and art diaries, individual and group interviews, and café-style conversations, all warrant exploration.

8.5 Recommendations

Several recommendations were drawn from the educational, clinical and research implications discussed in Chapter 7. The following are made by the researcher on the basis of this study:

- the inclusion of academic content and activities centred on positive relationships within the nursing curriculum;
- the provision of education around the concept of humour and its lived experience in nursing practice;
- the inclusion of academic content and activities, including reflection, targeting the role and benefits of humour on relationships and nursing activities;
- the inclusion of RP, including targeted questions or activities into the use and presence of humour and its effect on relationships;
- the implementation, promotion or review of student-driven initiatives to improve relationship building and peer support within their cohorts. Such initiatives could draw on the use of humour as an effective means of promoting affiliative and supportive interactions and help them debrief and adapt to nursing experience;
- research into the benefits of including humour and relationship educational content and its impact on students' transition shock during later years of nursing study;
- further research into the development of a shared definition of humour by NSs and the explanation of humour use in practice. Further research into extending these into general nursing practice would also be valuable;
- further research regarding whether NSs' humour style changes over the course of their degree;
- further research, including observational and field studies, to identify the frequency and style used in clinical practice as well as the academic setting;

- further research into whether measures of coping and resilience are affected by the activity of nursing over the time of the nursing degree;
- further research regarding whether the mediating role of humour reproduces positive emotional states in NSs of all years;
- further research regarding whether nurses' humour style changes following their professional registration;
- further research into whether the connective role of humour in developing effective relationships contributes to early nursing sociocultural adaptation by NSs;
- further research into whether relationships play a mediating role between academic adaptation and clinical competence; and,
- further research regarding whether humour style and relationships extend beyond formative years and support RNs similarly to the findings observed in NSs.

8.6 Conclusion

To ensure students' adaptation to their education and their overall wellbeing, elements conducive to these need to be considered at the start of the journey. For the development and implementation of effective strategies, baseline considerations must be known. This research project collected and examined FYNSs' baseline measures regarding their initial disposition at the commencement of their degree and their qualities and effects during the first year of undergraduate nursing study.

The research demonstrated the powerful role played by relationships in overcoming obstacles and navigating hardship, as well as the interlaced role of humour in all manner of relationships established along the journey. The implications of these findings provide educators with valuable information to target study programs, strategies and interventions, with the potential to improve the wellbeing and health outcomes of those helped as well as those helping.

Reflection was instrumental in students developing awareness. Using reflective measures, research participants were able to identify both their progress and the role played by relationships and humour in facilitating successful completion of their studies and the fostering of positive outcomes in their clinical practice. Developing and utilising

multiple forms or means to stimulate RP could benefit students throughout their degree and beyond.

Nonetheless, this is the beginning of the journey. The quality of relationships has a domino effect. Several features can aid or hinder them. Humour has been proved to contribute intimately to the development and maintenance of relationships on all levels, as well as being a positive contributing factor in the experience of transition shock. It has the ability to work undetected and permeate all ranks. It can change over time and continue to directly affect the quality of relationships. Continued investigation into the drivers of positive nursing outcomes, including degree completion, qualified professional practice or being the recipient of care, can enhance education of educators, curriculum development and students' wellbeing. The combination of these elements can bring the fun back into nursing and could contribute to improve the general wellbeing of the profession as a whole.

Epilogue

Most, if not all, nurses I have encountered vividly remember their nursing training. Many, if not most, are still friends with someone they trained with. Given any chance, any group of nurses ($n + 1$), whether in a clean utility room or on a night out with colleagues, will invariably launch into a story of past nursing events with a funny, sardonic twist. For the outsider listening in, these stories can sometimes be too graphic and detailed. If the outsider also happens to be a non-nurse or someone from a non-health background, the poo stories or those involving intimate body parts and vulnerable positions may well put them off. To that non-nurse, this is sometimes 'Too much' or 'Oh, so gross!' with the added 'I could never do your job!'. Yet, all the nurses will laugh, relate, and have another better story in their repertoire to add one up on the gross and laughing scale. Nurses are said to have their 'own sense of humour'. It is often thought to be dark or harsh, and to worsen over years of practice.

In my personal experience, it has always amazed me how nurses can cope with so much, be of utmost professionalism at the point of care, and turn into the best storytellers and comedians once the events and crises have passed. None of them ever had any intention of being disrespectful towards the activity of nursing, let alone the people they cared for. I still remember get-togethers where colleagues would launch into 'one of those stories' and all of us would be belly laughing, lips cracking from smiling, cheeks and abs aching for hours afterwards. The fun times.

It was always my personal observation that this is how we cope, how we hold strong together as a team, and how we can deal with the most terrifying situations with calmness and purpose, handle parts of bodies or their fluids without flinching (at least that others will be aware of), and be present for individuals at their most vulnerable times and dispositions.

When fellow nurses enquired about my PhD topic, I replied in short that I was investigating nurses' sense of humour. Invariably, they were quick to say, 'Oh my god, I have so many stories to tell you. How much time do you have? Where do I sign?'. Many added, 'Things have changed since I started, with all this politically correct stuff, it is not the same anymore'. Despite this, they still had a lot to offer: 'You just need to sit in the tearoom for a few hours, you won't believe the stories!'. Disappointingly, they

understood my reasoning for starting 'before' nursing had a chance to alter that seemingly typical sense of humour in the hope of tracking the 'nursing humour' trajectory over time.

During my years as a university lecturer, I have also seen the laughs and the stories from NSs throughout the semesters. It was with great interest that I discovered through this research that embryonic nurses do not start off on their journey using self-defeating or aggressive humour as perhaps we would assume from the gory stories heard. Their humour was found to be adaptative and conducive to positive relationships with self and others. It demonstrates to me that deep down, we may use humour to navigate through the hardest of times, but nurses have the utmost respect for people.

In the meantime, I will continue to laugh my way through my personal journey and continue to seek what helps nurses and nursing remain as healthy as we possibly can in the face of adversity. First and foremost, we hold a position of privilege in all the lives that we encounter.

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Appendix A: Demographic Questions

Student ID: [student unique identifying number with the University of Notre Dame]

1) What is your gender?

- F (female)
- M (male)
- Not specified

2) How old are you:

- _____ years old

3) Have you previously enrolled or completed other undergraduate or VET/Tertiary studies?

- Yes – specify:
 - Undergraduate in a health discipline
 - Undergraduate in a non-health discipline
 - Completed VET/Tertiary studies in a health discipline
 - Completed VET/Tertiary studies in a non-health discipline
- No (please go to Q5)

4) If yes to Question 3, how long ago?

- Less than 6 months
- 6-12 months
- Between 1 to 2 years
- More than 2 years

5) Do you currently work in the healthcare industry?

- Yes
- No

6) If so, what is your current employment title?

- _____

7) Are you willing to complete an online reflective practice at the end of each week during your practicum?

- Yes
- No

If yes, please provide your email address below for the researcher to contact you

_____@_____

Appendix B: Humor Styles Questionnaire

Student ID: [student unique identifying number with the University of Notre Dame]

Instructions: Please rate the extent to which you agree or disagree with each item.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I usually don't laugh or joke around much with other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If I am feeling depressed, I can usually cheer myself up with humor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If someone makes a mistake, I will often tease them about it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I let people laugh at me or make fun at my expense more than I should.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I don't have to work very hard at making other people laugh – I seem to be a naturally humorous person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Even when I'm by myself, I'm often amused by the absurdities of life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. People are never offended or hurt by my sense of humor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I will often get carried away in putting myself down if it makes my family or friends laugh.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I rarely make other people laugh by telling funny stories about myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If I am feeling upset or unhappy I usually try to think of something funny about the situation to make myself feel better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. When telling jokes or saying funny things, I am usually not very concerned about how other people are taking it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I laugh and joke a lot with my closest friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. My humorous outlook on life keeps me from getting overly upset or depressed about things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. I do not like it when people use humor as a way of criticizing or putting someone down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I don't often say funny things to put myself down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I usually don't like to tell jokes or amuse people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. If I'm by myself and I'm feeling unhappy, I make an effort to think of something funny to cheer myself up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Sometimes I think of something that is so funny that I can't stop myself from saying it, even if it is not appropriate for the situation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I often go overboard in putting myself down when I am making jokes or trying to be funny.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I enjoy making people laugh.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. If I am feeling sad or upset, I usually lose my sense of humor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I never participate in laughing at others even if all my friends are doing it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. When I am with friends or family, I often seem to be the one that other people make fun of or joke about.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I don't often joke around with my friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. It is my experience that thinking about some amusing aspect of a situation is often a very effective way of coping with problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. If I don't like someone, I often use humor or teasing to put them down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. If I am having problems or feeling unhappy, I often cover it up by joking around, so that even my closest friends don't know how I really feel.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I usually can't think of witty things to say when I'm with other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I don't need to be around other people to feel amused – I can usually find things to laugh about even when I'm by myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Even if something is really funny to me, I will not laugh or joke about it if someone will be offended.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Letting others laugh at me is my way of keeping my friends and family in good spirits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Thank you!

(R. A. Martin et al., 2003)

Appendix D: Satisfaction with Life Scale

Student ID: [student unique identifying number with the University of Notre Dame]

Instruction: below are five statements with which you may agree or disagree. Using the 1–7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

_____ In most ways my life is close to my ideal.

_____ The conditions of my life are excellent.

_____ I am satisfied with my life.

_____ So far I have gotten the important things I want in life.

_____ If I could live my life over, I would change almost nothing.

- 31–35 Extremely satisfied
- 26–30 Satisfied
- 21–25 Slightly satisfied
- 20 Neutral
- 15–19 Slightly dissatisfied
- 10–14 Dissatisfied
- 5–9 Extremely dissatisfied

This document has been authored by: Ed Diener, Robert A. Emmons, Randy J.

Larsen and Sharon Griffin as noted in the 1985 article in the *Journal of Personality*

Assessment.

<http://labs.psychology.illinois.edu/~ediener/SWLS.html>

Appendix E: Reflective Journal—Holistic Reflective Model

Source: Bass et al. (2017).

Student ID: [student unique identifying number with the University of Notre Dame]

Instruction

- Ensure that find a quiet space and take some time to centre within yourself.
- Start thinking about your last few days during your clinical practicum and consider events that you experienced and the thought and emotions they generated for you.
- The questions to follow are guiding prompts. Answer them as they apply. Read and think about them then “free write” your answer.
- Write as much information as possible. Try to aim for a minimum of 50 words per question, though more the better!

Start by **thinking** about the following:

- The context where you were;
- Who was present with you and their role; do not disclose names or identifying information;
- What were you doing, what were others doing;
- What happened, what parts did people play;
- What was the results;
- Identify the significant parts that you need to take notice.

Describe what happened

Now start writing:

- Write about your thoughts and feelings at the time of the event and do not try to analyse them. Just free type.

[student answer]

Reflect on the events and how you felt

Write about the thoughts and feelings you experienced during that episode.

[student answer]

Prompts:

- What were you trying to do?
- Why did you act like this?
- What were the consequences of your action(s)?
- How did you feel about the experience whilst it was happening?
- How do you think the resident felt?
- How do you know what the resident felt? Did they express it (verbally, body language, etc.)?
- What were you thinking throughout the experience?
- How did others present made you feel?
- How did the situation made you feel?
- How did you feel about the outcome of the event?

Fresh eyes on the situation

Now think about the experience from a different perspective.

Prompts:

- Was there any part of the event, before/at the time/afterwards that was/were either funny and created a humoristic situation?
- Was anything funny or humorous at the time? Or was it funny or humorous afterwards when you retelling this situation? Is there a funny side to what happened?

[student answer]

Analyse the events

Was/were there any other elements that played a part in your actions, the actions of others or the outcome of the situation? For example, an issue that was challenging

either ethically, morally, personally (self-awareness, previous experience, intuition), politically, or anything else you can think about?

[student answer]

Evaluate what happened—the good and the bad

Now that you have explored the issues from different perspectives, think about if and how you could have dealt with the situation differently. Evaluate, or make a judgement about, the events; what went well, what did not go so well, what did you, or other do well or not so well. If the events did not turn out as best as they could have, what could you or other have done to me

[student answer]

Now blend it together

Now that you have thought and written about your experience, how do you feel about it? Did you learn anything? Are you happy with how you behaved and your contribution? How do you plan on handling a similar situation in the future? How has this experience helped you on your journey to become a Registered Nurse? Has it changed how you view or understand things? Will you take anything away from this event for your future work as an RN? Did it make you reconsider becoming an RN at all?

[student answer]

Anything more?

Please summarise your moment or week in one word. And if you feel like there is more you would like to say about your moment or your week, write it here.

[student answer]

Appendix F: Informed Consent—Reflective Journal



CONSENT FORM – REFLECTIVE JOURNAL

Journeying through uncharted territory: The role of humour influencing undergraduate nursing students' adaptation to their first clinical placement.

Human Research Ethics Committee (approval no: 018164F)

- I agree to participate in the above-mentioned research project by Ms Marie-Josée Boulianne, Doctoral candidate in the School of Nursing and Midwifery, University of Notre Dame Australia, Fremantle (Phone: 9433 0563).
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to:
 1. Answer a questionnaire before my first practicum
 2. Complete reflective practice during my practicum
 3. Complete the same questionnaire that I did before my practicum
- The researcher has answered all my questions and has explained possible problems that may arise as a result of my participation in this study.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I understand that research data gathered may be used for future research but my name and other identifying information will be removed.
- The reflective journal component may involve a small sample size. I am aware and understand that the information provided in the reflective journals will be uniquely coded against the participant and any identifying information will be removed. This is to ensure that the risk of identifying participants or facilities have been minimised.

- Marie-Josée Boulianne, or another internal member of the research team has provided with an opportunity to ask questions and, if any, have all been answered clearly and fully.
- Should you have any complaints or reservations about any aspect of your participation in this research project which you are unable to resolve with the researcher, you may contact the Human Research Ethics Committee through the research Ethics Officer (Ph: (08) 9433-0964 or email natalie.giles@nd.edu.au), and quote the reference number: 018164F. Your confidentiality will be assured throughout the process, your concern will be investigated fully and you will be informed of the outcome.

Name of participant			
Signature of participant		Date	
Participant's Student ID			

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	
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Appendix G: Informed Consent—Interview



CONSENT FORM – INTERVIEWS

Journeying through uncharted territory: The role of humour influencing undergraduate nursing students' adaptation to their first clinical placement.

Human Research Ethics Committee (approval no: 018164F)

- I agree to participate in the above-mentioned research project by Ms Marie-Josée Boulianne, Doctoral candidate in the School of Nursing and Midwifery, University of Notre Dame Australia, Fremantle (Phone: 9433 0563).
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to (where I have given consent, page two):
 1. Answer interview questions after my first practicum
 2. Answer interview questions after my second practicum
 3. Answer the interview questions even in the event that I may have been granted Leave of Absence or have decided to terminate my nursing studies and agree to be contacted by the researcher
- The researcher has answered all my questions and has explained possible problems that may arise as a result of my participation in this study.
- I understand and agree to this interview being recorded in an audio format. Such recording will be kept in a locked filing cabinet until it has been fully transcribed verbatim and it will then be destroyed.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I understand that research data gathered may be used for future research but my name and other identifying information will be removed.
- The interview component may involve a small sample size. I am aware and understand that the information provided in the interviews will be uniquely coded against the participant and any identifying information will be removed. This is to ensure that the risk of identifying participants or facilities have been minimised.
- Marie-Josée Boulianne, or another internal member of the research team has provided with an opportunity to ask questions and, if any, have all been answered clearly and fully.
- Should you have any complaints or reservations about any aspect of your participation in this research project which you are unable to resolve with the researcher, you may contact the Human Research Ethics Committee through the research Ethics Officer (Ph: (08) 9433-XXX or email XXX), and quote the reference number: **018164F**. Your confidentiality will be assured

throughout the process, your concern will be investigated fully and you will be informed of the outcome.

- Follow up interviews will be conducted after the completion of your first and second practicum. Do you agree to be contacted to participate in such interviews?

Yes or No.

- Should you decide to take a leave of absence or withdraw from your nursing program, you agree to be contacted by the researcher to answer interview questions.

Yes or No.

Name of participant			
Signature of participant		Date	
Participant's Student ID			

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	
-------------------------	--	------	--

Appendix H: Participation Sheet—Initial Questionnaire



Dear Participant,

You are invited to participate in a research project titled:
Journeying through uncharted territory: The role of humour influencing undergraduate nursing students' adaptation to their first clinical placement. (018164F).

Who is doing the research?

My name is Marie Boulianne and I am a Registered Nurse, Credentialed Mental Health Nurse, Counsellor and a Doctoral Candidate at the University of Notre Dame (Notre Dame) Fremantle. My supervisors are Associate Professor Kylie Russell and Dr Tracey Coventry from the School of Nursing and Midwifery at Notre Dame. I am interested in nurses' wellbeing, how we can build and maintain happy and resilient nurses and what contributes to our particular "nursing sense of humour".

What is the research about?

The aim of my project is to gather information surrounding how first semester undergraduate nursing students (FUNS) – yes, that is you! – experience their first clinical placement ("prac") of their nursing degree. The project looks at how FUNS cope before going on prac, what style of humour they have and how they generally feel about their life. Then it looks at what happens during prac and what FUNS make of that time spent putting their skills in to practice and being the "real deal" for a few weeks. I also specifically want to find out how much fun students have during their prac and if humour is helpful in dealing with all the ups and downs experienced. So overall, I am trying to form a picture in what is going on for you, what helps and what does not.

Why you?

Because you are FUNS and you have not been a clinical placement before.

If I say yes, what will it involve?

First, you will be required to complete a questionnaire that should take no more than 30 minutes.

If you wish to participate in the next FUNS study phase, you will be able to tell me in that questionnaire. I will contact you just before prac starts and explain what you have to do however it would involve completing 7 questions on a weekly basis.

Are there any risks?

There are no risks anticipated in completing the initial questionnaire. However, if for some reason you feel concern or distressed, free counselling is available through the Student Counselling Office at Notre Dame. Phone: 9433-0580 or email: fremantle.counselling@nd.edu.au

Will any information or my details be kept confidential?

Your information will be kept totally confidential. All documents are kept in a locked filing cabinet at Notre Dame. and all electronic data is kept on a password-locked computer. Your details and information will not be shared with anyone.

The general results of the questionnaire are expected to be published in peer reviewed journals once they become available.

Do I have to say yes?

No, you don't have to participate in the project.

What will happen if I say no?

Nothing. You will not be penalised in any way.

If I say yes, can I change my mind later?

Yes, you can change your mind later and decide not to participate any further.

Are there any costs to me?

No, participating in this project will not cost you anything.

Who do I contact if I have any questions about the project?

For any further information, you can contact me directly, Marie Boulianne on 9433 0563 or marie.boulianne@nd.edu.au

You can also contact my supervisors directly at the School of Nursing and Midwifery ND:

Associate Professor Kylie Russell on 9433 0654 or kylie.russell@nd.edu.au or

Dr Dianne Juliff on 9433-0669 or dianne.juliff@nd.edu.au

What if I have a concern or a complaint?

You can contact myself, Marie Boulianne on 9433 0563, any of my supervisors, Dr Russell or Dr Juliff, or you can also contact the Research Ethics Officer on 9433-0964 and quote this number 018164F

Appendix I: Participation Sheet—Reflective Journal



Dear Participant,

You are invited to participate in a research project titled:

Journeying through uncharted territory: The role of humour influencing undergraduate nursing students' adaptation to their first clinical placement. (018164F).

Who is doing the research?

My name is Marie Boulianne and I am a Registered Nurse and a Doctoral Candidate at the University of Notre Dame (Notre Dame.) Fremantle. My supervisors are Associate Professor Kylie Russell and Dr Tracey Coventry from the School of Nursing and Midwifery at Notre Dame. I am interested in nurses' wellbeing, how we can build and maintain happy and resilient nurses and what contributes to our particular "nursing sense of humour".

What is the research about?

The aim of my project is to gather information surrounding how first semester undergraduate nursing students (FUNS) – yes, that is you! – experience their first clinical placement ("prac") of their nursing degree. The project looks at how FUNS cope before going on prac, what style of humour they have and how they generally feel about their life. Then it looks at what happens during prac and what FUNS make of that time spent putting their skills in to practice and being the "real deal" for a few weeks. I also specifically want to find out how much fun they have during their prac and if humour is helpful in dealing with all the ups and down experienced. So overall, I am trying to form a picture in what is going on for you, what helps and what does not.

Why you?

Because you are FUNS and you have not been a clinical placement before.

If I say yes, what will it involve?

You will be required to complete a weekly reflective diary that should take between 15 to 30 minutes. All reflections will be completed at the end of each clinical week.

A unique SurveyMonkey© link will be sent to you on the Friday. No one other than you will have access to it and the link will change from week to week.

Are there any risks?

There are no risks anticipated in completing the initial questionnaire. However, if for some reason you feel concern or distressed, free counselling is available through the Student Counselling Office at Notre Dame. Phone: 9433-0580 or email: fremantle.counselling@nd.edu.au

Will any information or my details be kept confidential?

Your information will be kept totally confidential. All documents are kept in a locked filing cabinet at Notre Dame and all electronic data is kept on a password-locked drive. Your details and information will not be shared with anyone.

The general results of the questionnaire are expected to be published in peer reviewed journals once they become available.

Do I have to say yes?

No, you don't have to participate in the project.

What will happen if I say no?

Nothing. You will not be penalised in any way.

If I say yes, can I change my mind later?

Yes, you can change your mind later and decide not to participate any further. This can be done until the data collection has been completed and the data has been de-identified.

Are there any costs to me?

No, participating in this project will not cost you anything.

Who do I contact if I have any questions about the project?

For any further information, you can contact me directly, Marie Boulianne on 9433 0563 or marie.boulianne@nd.edu.au

You can also contact my supervisors directly at the School of Nursing and Midwifery ND:

Associate Professor Kylie Russell on XXX or kylie.russell@nd.edu.au or

Dr Dianne Juliff on 9433-0669 or dianne.juliff@nd.edu.au

What if I have a concern or a complaint?

You can contact myself, Marie Boulianne on 0407 315 240, any of my supervisors, Assoc Prof Russell on 9433 0654 or Dr Juliff 943 0669, or you can also contact the Research Ethics Officer on 9433-0964 and quote this number (018164F).

Appendix J: Electronic Communication with Participants

Dear students

As you are aware, your compulsory clinical lecture will be held on the 18 February 2019.

During the lecture you will be addressed by Marie Boulianne, a PhD candidate. Marie is also a lecturer and tutor in the School of Nursing and Midwifery and will likely teach you in your third Semester. She will briefly discuss her PhD research project and invite you to participate. I have included the research study information sheet for you to read prior to the lecture. I support Marie's study and also invite you to consider whether you would like to participate actively.

If you choose to participate, a questionnaire will be available for you to complete either online or in paper-based format. A link to the online survey will be available on Blackboard. Marie will address you once again during the compulsory workshops to be held later in the semester.

As discussed in the study information sheet, participation is voluntary.

Thank you for considering this important research study and I look forward to seeing you at the lecture.

Kind regards

Corinne Kusel | Professional Practice Course Coordinator / Lecturer

Chris Adams | Professional Practice Coordinator and Senior Lecturer

School of Nursing and Midwifery

The University of Notre Dame Australia

19 Mouat St (PO Box 1225) Fremantle WA 6959

T [+61 8 9433 0183](tel:+61894330183)

ND37/214

Chris.adams@nd.edu.au

nd.edu.au | CRICOS Provider: 01032F

I acknowledge that this land that I live and work on is Whadjuk country and that the Whadjuk Noongar people are the traditional owners and custodians, who have a rich social, spiritual and historical connection to this country, which is as strong today, as it was in the past.

Appendix K: Electronic Communication with Participants—Wave 2

Dear Students,

I wish to thank you for listening to my short presentation during your nursing care lecture last week regarding my study (Journeying through uncharted territory: The role of humour influencing undergraduate nursing students' adaptation to their first clinical placement).

This is an important study for undergraduate nurses because it helps us understand the factors conducive to becoming a resilient nurse and the role played by humour in how to protect the nursing workforce.

I am seeking your participation which will involve completing an online questionnaire.

Thanks to those of you who have completed the first online questionnaire!

For those of you who may be considering whether to participate, please go to my research page on your Nursing Care Blackboard site to find the information sheet and all relevant documentation.

The following link will take you to a short online survey <https://www.surveymonkey.com/r/29YDSHK>

The survey takes on average just over 9 minutes to complete.

As I mentioned in the lecture, I will speak to you again during your clinical workshop.

Kind regards,

Marie Boulianne

PhD Candidate

Appendix L: Electronic Communication with Participants – Phases 2 and 3

From: Marie Boulianne <marie.boulianne@nd.edu.au>
Sent: Wednesday, November 27, 2019 7:06:26 AM
Subject: Research Participation

Dear Participant,

You have now commenced your first practical placement and I hope it is going well.

I wish to thank you for participating in Phase 1 of my research project and for you agreeing to be contacted to participate in Phase 2.

Enclosed to this email is a **Participation Sheet** that details what Phase 2 consists of. Should you have any questions regarding this phase, please feel free to contact me by phone or email.

Your participation remains voluntary. The expectation is that you complete at least one reflective journal either during or at the completion of your practicum. You are more than welcome to complete more than one should you wish to do so.

Once you have signed the consent form, you can access the electronic link here to complete your first reflective journal. <https://www.surveymonkey.com/r/DHLXPWM>

Thank you once again for being part of my research project.

Kind regards,

Marie Boulianne
BN, GradDipMHN, MN, Dip.Couns., CMHN, RN, MACMHN, MACA, MACN
Course Coordinator/ Lecturer
PhD Candidate

School of Nursing and Midwifery, office ND37/300
The University of Notre Dame Australia
19 Mouat St (PO Box 1225) Fremantle 6059
Phone: + 61 8 9433 0563 Fax +61 8 9433 0227
Email: marie.boulianne@nd.edu.au Web: www.nd.edu.au

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Participation
Sheet - ...2b.pdf

From: Marie Boulianne <marie.boulianne@nd.edu.au>
Sent: Sunday, December 22, 2019 7:42:23 AM
Subject: Well done on finishing your first prac!

Dear Participant,

You have now completed your first practical placement. Well done!

If you have not done so yet, could you please complete a reflective journal? You can access the electronic link here to complete it. <https://www.surveymonkey.com/r/DHLXPWM>

Your participation remains voluntary.

If you would like to participate in a one on one interview, you can email me directly to set up a time or I will send an email invitation in the new year.

Thank you once again for being part of my research project.

If you have any questions regarding or issues in completing the journal, please do not hesitate to contact me.

Wishing you all a wonderful holiday and a merry Christmas.

Kind regards,

Marie Boulianne
BN, GradDipMHN, MN, Dip.Couns., CMHN, RN, MACMHN, MACA, MACN
Course Coordinator/ Lecturer
PhD Candidate

School of Nursing and Midwifery, office ND37/300
The University of Notre Dame Australia
19 Mouat St (PO Box 1225) Fremantle 6059
Phone: + 61 8 9433 0563 Fax +61 8 9433 0227
Email: marie.boulianne@nd.edu.au Web: www.nd.edu.au

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Appendix M: Semi-Structured Interview Questions

- Introduction
- Demographic questions
 - Student Name
 - Student ID
 - Area of last nursing practicum
- Confirm that you are in Semester Two and have not commenced your 2nd practicum
- Research topic and context
- In your own words, define what humour means to you?
- Thinking back during your last clinical placement, do you remember if humour was ever present at any time during your practicum?
 - Can you think of any other examples when you have used humour during your clinical placement?
- Who do you think benefited them most from that moment of humour?
 - Anything else you want to add or any other moment(s) you can think about when humour played a part?
- It is thought that humour is used to cope through different situations. What does it mean to you and in relation to your nursing practice (in relation to yourself)?
 - Around yourself, in terms of dealing with the day-to-day nursing activity - not necessarily direct patient care – did you ever use humour to help yourself through those weeks of practicum?
 - Any specific examples?
- Questions to clarify content based on Reflective Journal Answers

Appendix N: HREC Approval Phase 1—018164F



THE UNIVERSITY OF
NOTRE DAME
A U S T R A L I A

19 Mouat St (PO Box 1225) Fremantle WA 6959
+61 8 9433 0555 | enquiries@nd.edu.au

31 January 2019

A/Prof Kylie Russell & Ms Marie-Josée Boulianne
School of Nursing & Midwifery
The University of Notre Dame Australia
Fremantle Campus

Dear Kylie and Marie-Josée,

Reference Number: 018164F

Project Title: “Journeying through uncharted territory: The role of humour influencing undergraduate nursing students’ adaptation to their first clinical placement.”

Your response to the conditions imposed by a sub-committee of the University of Notre Dame Human Research Ethics Committee (HREC) has been reviewed in accordance with the *National Statement on Ethical Conduct in Human Research* (2007, updated 2018). I am pleased to advise that ethics approval has been granted for Phase 1 of the proposed study.

Other researchers identified as working on this project are:

Name	School/Centre	Role
Dr Tracey Coventry	School of Nursing & Midwifery	Co-Supervisor

**All research projects are approved subject to standard conditions of approval.
Please read the attached document for details of these conditions.**

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Dr Natalie Giles
Research Ethics Officer
Research Office

cc: A/Prof Caroline Bulsara SRC Chair, School of Nursing & Midwifery

Broome Campus 88 Guy St (PO Box 2287) Broome WA 6725
Sydney Campus 140 Broadway (PO Box 944) NSW 2007

Fremantle

Broome

Sydney

ABN 69 330 643 210 | CRICOS Provider Code: 01032F

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Appendix O: HREC Approval Subsequent Phases—019062F



9 May 2019

A/Prof Kylie Russell & Marie-Josée Boulianne
School of Nursing & Midwifery
The University of Notre Dame Australia
Fremantle Campus

Dear Kylie and Marie-Josée,

Reference Number: 019062F

Project title: “Journeying through uncharted territory: The role of humour influencing undergraduate nursing students’ adaption to their first clinical placement.”

Your response to the conditions imposed by the University of Notre Dame Human Research Ethics Committee (HREC) has been reviewed in accordance with the *National Statement on Ethical Conduct in Human Research* (2007, updated 2018). I am pleased to advise that ethics approval has been granted for this proposed study.

Other researchers identified as working on this project are:

Name	School/Centre	Role
Dr Dianne Juliff	School of Nursing & Midwifery	Co-Supervisor

Please note: Researchers are to ensure that a copy of newly designed data collection tools are provided to the Research Ethics Officer for HREC review prior to their implementation.

All research projects are approved subject to standard conditions of approval.

Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Dr Natalie Giles
Research Ethics Officer
Research Office

Cc: A/Prof Caroline Bulsara, SRC Chair, School of Nursing & Midwifery

Broome Campus 88 Guy St (PO Box 2287) Broome WA 6725
Sydney Campus 140 Broadway (PO Box 944) NSW 2007

Fremantle Broome Sydney

ABN 69 330 643 210 | CRICOS Provider Code: 01032F

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Appendix P: Exposure to Healthcare Industry

Baseline characteristic	Female		Male		Full sample	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Currently working in healthcare industry						
Yes	21		5		26	82.4
No	108		14		122	17.6
Total	129		19		148	100.0
Current role						
Assistant in nursing (AIN)	2		2		4	2.7
Care worker	2		0		2	1.4
Clinical trial assistant	2		0		2	1.4
Dental nurse	1		0		1	0.7
Support worker – all	0		2		2	1.4
Domestic	1		0		1	0.7
Human service assistant	0		1		1	0.7
Receptionist – medical/dental	4		0		4	2.7
Patient services officer	1		0		1	0.7
Patient transport	1		0		1	0.7
Pharmacy assistant	2		1		3	2.0
Aged care – other	1		0		1	0.7
Volunteer	1		0		1	0.7
Sports & fitness	2		0		2	1.4
Health-related field – unknown	1		0		1	0.7
Total	21	78	6	22	27	18.2

Appendix Q: Data Familiarisation—List of Codes from First Reading

Emotions

- nervous
- stress – stress management

Competence

- in the way
- rush
- not wanting to be slow
- intimidated
- not wanting to disappoint

Confidence

- believing in self
- self-belief
- assertiveness

Challenge

Lack of support

Busy

Accountability

Motivation

Acceptance

- illness process
- life
- death
- care for the elderly
- things you can't change

Behaviour

- observer
- watch
- confidence
- growing
- lack of
- knowledge
- growing
- negative attitude
- perseverance
 - push through
 - encouragement

Relationships

- with buddy carer/nurse
- residents/patients
- through purpose
 - get to know resident whilst assisting
 - observing buddy – helping each other

Humour

- extracted after event
- with pts/residents
- to bond/connect/belong
- to bridge differences & gaps
- to build trust
- goal oriented: to make someone happy or smile
- reduce stress, relax, appease
- ice breaker
- mood changer/lighten the vibe
- not recognised as a coping mechanism in 1st prac – easier to see in 2nd prac
- mood changer
- to cope

- with embarrassment
 - self
 - resident/pts, e.g. invasive/intrusive procedure/care
- new practice
- laughing at self
- debrief with group/friends
- present before commencing nursing
- to balance between heavy/sad stuff
- nurses
 - around stress
 - incl. reducing student's performance stress
 - to cope with hectic workload
- quantity: who benefited
 - student
 - residents/patients
 - nurses/nursing
 - all
- boundaries
 - appropriateness
 - timing

1st prac

- scared
- confronting
- shock
- in the way
- incompetence to competence: automatic behaviours/routine/used to it

2nd prac

- straight into it
- growing confidence
- increased interactions with pts/buddy/others
- feeling more supported
 - difference due to setting
 - around nurses not just carers

Online learning

- decreased motivation
- lack of accountability

- learning: decreased or improved

1st year of uni

- adjustment – sem 1
- importance of making friends/support
- help from uni/lecturer/tutors
- early expectations

Appendix R: Data Familiarisation—List of Codes from Second and Third Readings

Emotions	Nervous				
	Stress	Stress Management			
	Loss				
	confusion				
	doubt	Lack confidence uncertainty			
	disorientation				
	Lonely Acceptance Confronted/confronting				
Competence	In the way				
	rush				
	not wanting to be slow				
	intimidated				
	not wantint to disappoint				
	Growing confidence				
Confidence	self-belief				
	assertiveness				
	growing				
	lack of				
Challenges	lack of support				
	busy				
	accountability				
	motivation				
acceptance	of illness process				
	life				
	death				
	Care for the elderly Things you can't change				
Behaviour	observer				• TAFE Focused
	Watch				
	knowledge	growing			• Prof. Guid. exps
	perseverance	push through	encouragement		
	TO Foster Help Decision Making Solution				
Relationships	with buddy carer/nurse	Lack of Disconnect	confidence - encourage Builds/relates build/foster		to mentor/teach Pink. Givness
	residents/patients	Engagement			
	through purpose	get to know resident whilst assisting	observing buddy	helping others	

Applications

Humbour	Extracted after event					
	with patients/residents					
	to bond	connect	belong			
	to bridge difference	to bridge gaps				
	to build trust					
	goal oriented	to make someone happy or smile				
	reduce stress	relax	appease	to balance the heavy stuff		
	ice breaker					
	mood changer	lighten the vibe				
	to cope	with embarrassment	self	other	residents/pts	
		to laugh at self	to self-compass			
		with new practice				
		debrief with group/friends				
		present before commencing nursing				
		with hectic workload				
	nurses	around stress	reducing student's stress			
	Quantity	who benefited	student	nurse	residents/pts	all
	boundaries	appropriateness				
		timing				
1st prac	scared					
	confronting					
	shock					
	in the way					
	incompetence to competence	automatic behaviours				
2nd prac	confidence	straight into it	growing			
	increased interactions	with pts	buddy	others		
	feeling more supported	difference setting	with nurse/not just carers			
online learning	decreased motivation					
	lack of accountability					
	learning	decreased	improved			
1st yr of uni	adjustemnt	sem 1				
	importance of making friends	suppor				

	help	from uni	academic staff	friends	family	
	early expectations					
Knowledge	intellectual					
	Socio-developmental					
Roles	STAND	OBSERVE				
	Recommen	Maintained	Reconsider	Reinforce		
	UNCLIN R/POST					
Learning conditions	- teaching					

Appendix S: Reading Rounds Manual Coding

then a carer was instructing me. And then I think I picked up something and cut it open, and then she gasped as if I'd done something wrong. But I hadn't. She was just teasing me because I think she could tell I was focusing way too much on, yeah, what I was doing. And that definitely relaxed me a lot more. Yeah. I felt more supported, I guess. — (D) support/encouragement

Participant C: For me, I get quite intimidated by people in a superior position such as carers and things like that. But then when they joke about these things, and they're really friendly and engaging, it definitely breaks down that barrier a bit more, so that I feel more confident and comfortable working around them. Yeah. Yeah, I think humour really does that, [crosstalk 00:08:49] interacting. (H) of power (E) as leveler

Interviewer: Oh, good. So, it played a role in terms of interactions and bringing you together? Yeah? # V Power imbalance

Participant C: Yeah. It makes them seem more approachable. Yeah. I feel more comfortable just around them. Yeah. Because if I'm not too comfortable and I'm not that confident, then I'm more likely to make mistakes as well, because I'm just overthinking everything, worrying about what they're thinking of me, like if I'm doing it correctly. But, yeah, if I know that they're quite humourous in nature, then I know they're not going to come down on me really heavily if I do something wrong. I'll still try my best to do everything right. But, yeah, I'm just more relaxed that way. * Learning conditions Doubt Anxiety Performance

Interviewer: So, it took the pressure off in some way, reduced the pressure?

Participant C: Mm-hmm (affirmative). Yes, definitely.

Interviewer: So, who do you think in those moments, in terms of around the residents, the carers, the nursing stuff and all of them, and you, who benefited more from that humour, do you think? Or that moment of humour.

Participant C: Can I say myself?

Interviewer: Yeah.

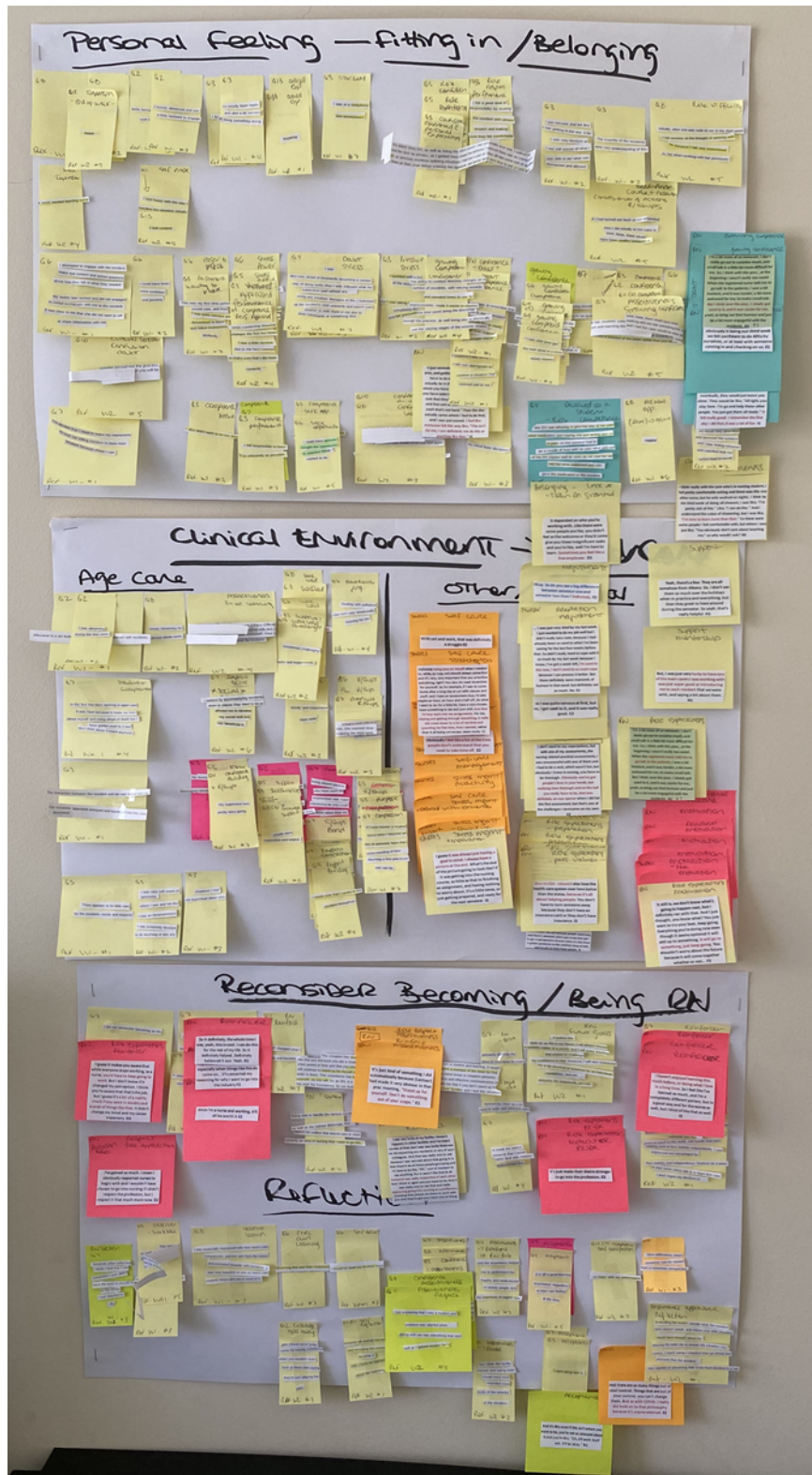
Participant C: Yeah, yeah. I would say myself. * # = benefit to whom

Interviewer: Yeah.

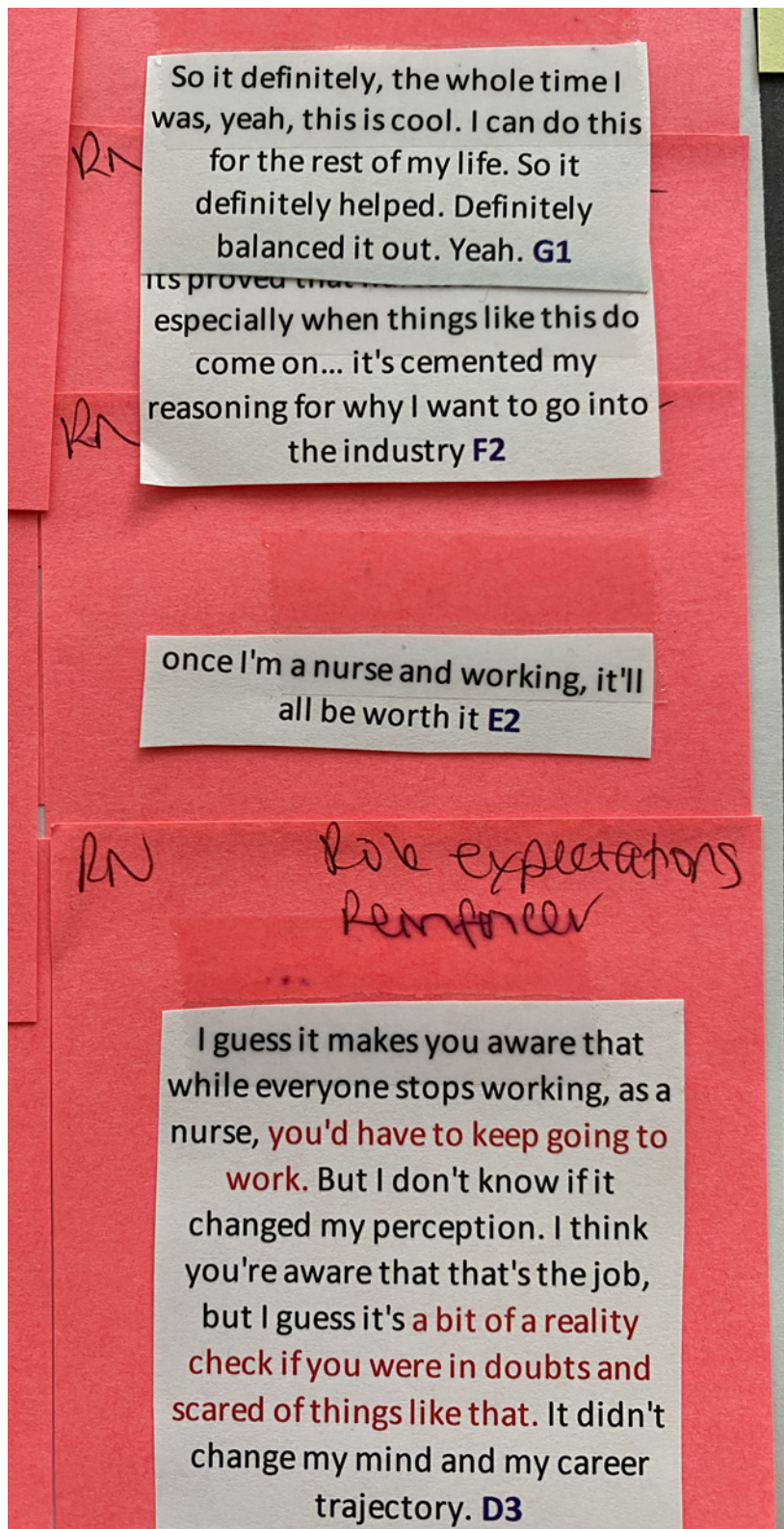
Participant C: Yeah. In those situations, well, with one of the residents, yeah, I think it would have made the experience more enjoyable instead of just having to watch a really nervous student dress them and things like that. But in the other case, one of the residents was cognitively impaired. So, I don't think she would've been aware of what was going on. And I don't think it would've affected the carers in any way. I think it's just like their personality, just them engaging with (H) Personality trait

PhD Interview #3 Participant C 17 Sept 2019 (Completed 10/27/19)
 Transcript by Rev.com Page 4 of 10

Appendix T: Development of Themes and Subthemes



Example of individual entries, identified to participants and easily movable across the boards



Refinement of themes and subthemes

Personal Journey

STRESS PERFORMANCE

63 Growth Stress
64 Confidence Performance
65 Personalized Performance
66 Confidence Performance
67 Confidence Performance
68 Confidence Performance
69 Confidence Performance
70 Confidence Performance

Assestiveness // Communication

71 Confidence Performance
72 Confidence Performance
73 Confidence Performance
74 Confidence Performance
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95 Confidence Performance
96 Confidence Performance
97 Confidence Performance
98 Confidence Performance
99 Confidence Performance
100 Confidence Performance

Personal Journey

Doubt

101 Confidence Performance
102 Confidence Performance
103 Confidence Performance
104 Confidence Performance
105 Confidence Performance
106 Confidence Performance
107 Confidence Performance
108 Confidence Performance
109 Confidence Performance
110 Confidence Performance

Growing Competence

111 Confidence Performance
112 Confidence Performance
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127 Confidence Performance
128 Confidence Performance
129 Confidence Performance
130 Confidence Performance

PERSONAL JOURNEY

ADJUSTMENT

ADJUSTMENT

You know what you've got ahead of you

65 OVERCOME

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GROWING CONFIDENCE

CONFIDENCE

I haven't enjoyed learning this much before, or doing what I love in a long time. So I feel like I've learned so much, and I'm a completely different person, but in a good way and for the worse as well, but I kind of like that as well.

62 CONFIDENCE

63 CONFIDENCE

64 CONFIDENCE

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100 CONFIDENCE

PERSONAL JOURNEY

Relationships	Clinical Setting	Academics	Residents - Patients
<p>Relationships</p> <p>Peers</p> <p>Learning Goals</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p>	<p>Clinical Setting</p> <p>Support Mentorship</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p>	<p>Academics</p> <p>See LEARNING CONDITIONS</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p>	<p>Residents - Patients</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p>

LEARNING CONDITIONS

Learn COND **Deliberate Practice**
I'm much better face to face, I do a lot better academically when I have gone to classes and my tutor in front of me and I'm able to ask questions rather than it being online. So it was a challenge for me. E2

I actually do really well from the online learning. I prefer, personally I think with the online environment. E3

I remember the nursing one because they weren't a lab anyone, but we were always put in a group, and we had to come up with nursing care and that sort of stuff, and you would bounce around in all those ones, and you didn't have to be right, while online, you felt like you had to be right, because you got marks for it. I remember the physio one, it wasn't the same, it was like, "Well, this is the way it's done," usually, my tutor would tell me a story about why it's done this way, that's why I like you're reading a bit, and see that with it. E1

High School. I remember (learning) that experience sticks with you longer. E2

I remember the nursing one because they weren't a lab anyone, but we were always put in a group, and we had to come up with nursing care and that sort of stuff, and you would bounce around in all those ones, and you didn't have to be right, while online, you felt like you had to be right, because you got marks for it. I remember the physio one, it wasn't the same, it was like, "Well, this is the way it's done," usually, my tutor would tell me a story about why it's done this way, that's why I like you're reading a bit, and see that with it. E1

I'm making connections I was definitely nursing. Oh, the key factor was definitely being in the same lab, having that practical, and seeing how other people are performing that, and that sort of stuff. Like, figuring out a connection, is the best one or not, finding someone's branch table as someone that's impossible to find their branch table as. It was a bit of fun with those guys. We were on the same side of the bench and that sort of stuff. E3

Learn COND **Online - conversational learning**
At the end, I would say, around about an hour after your tutorial, you would go back and they would have responded to it, saying like, "Yes, that's right," or "No, it can be seen that this was wrong, and that you should have done this because..." And it would be a textbook answer, not quite like the experience answer. That I feel is a huge difference, that experience, when your hands in hands teaching in that. E2

Yeah, we never used Zoom for our tutorials, we always used Blackboard Collaborate. And for our Pathology and Pharmacology classes, for our tutorials they were all live, and we were going through the worksheets and that sort of stuff. It was a lot of fun, and he walked us through it, and explained a lot of the stuff that it was a story. If I wasn't feeling that day, I would have been very hard to motivate me to participate in lectures, because it's as easy as just looking away or... we heard some people even muted. E2

Being robbed of learning experience with online? Yes, it brought me down a lot. It felt very depressing. I was just learning something that can be got out at anyone. When someone tells me a story about it, it feels very personal, you get on that level of them telling you that story. E2

I figured that I was asking questions with my tutors whenever I didn't understand. And they were very forthcoming in answering the questions wherever I needed, all the concerns that I had. So that was good, but it's just... Yeah, I just want to get back to the classroom. E2

Learn COND **Belongs - pers. context - interactivity**
The reason I felt better was that I was able to ask questions and get feedback in a more relaxed, because it's not like in a lecture where you're just sitting there and you're not really listening, when they call an interprofessional tutor where their philosophy is that they're trying to help you as a health professional. I love that with health professionals, they're students just like us. E2

But with the tutorials for me, and especially with labs, they have to be face to face because yeah, it's just with the amount of content we have to work with, to me that is essential. Having at least the tutorials and labs face to face. E2

A 100%... Even the lectures, I mean, for me reading off the slides, it's not that much different, but I prefer actually going and physically sitting in the lecture theater with whoever is doing the lecture at the front, and then you can ask questions or, when the lecturer's done, and you have a question, you can go up and ask. I just much prefer that, than sitting on your laptop, looking through the slides and writing notes. E2

There's always that one person on the chat that has every answer in the book, and they type the answer, and they do all the work for you as a group. Well, in a tutorial I feel like you get more motivated from someone in person than just jumping jack in front of you, rather than someone doing it on the screen. E2

Learn COND **Interaction**
[Reflections] Some of them would show them that dogs. That captured my attention. I would just have to be in that good mood which I hate to say because, well, when I learned that my dad had Coronavirus I wasn't too interested in learning at that point. Going from that little hair of not knowing what to feel, to just feeling straight up depressed. E2

I've been to face person. I mean going to lectures because I've seen some of the lecturers' genuine and the teachers like, "Oh, well, I'll just get an extra lecture or something that that." And you see on campus. Whenever I'm out they don't go to a lecture, I always have in the back of my head, my brother saying, "You don't have an excuse. You need to go to these lectures and see those people." It's definitely not a bunch of face person as well and it's always the back of my mind that's haunting me. E1

Learning COND **Accountability**
I think they really did all it could because at [This Uni], there's the open door policy. If you need to speak to someone, even if the person you want to speak to you, isn't available, someone will speak for you. I've never had that experience at [Other Uni], I remember I tried to email someone at [Other Uni], and I didn't get a response for five weeks. E2

Learning COND **Dynamic Belonging - Adjusted**
[Dynamic teaching adaptation] They tested it out, it's the tried and true possible way. And of course my experience is that they're still trying one thing and that sort of stuff. E2

Learn COND **Scaffolded Learning**
At [Other Uni], sorry, in that semester, we literally learned how pressure and how to handle someone, that's it. Whereas in [This Uni], you learn about pressure and other stuff like, wound, you do talk about someone's tubes, death, and things. At [Other Uni], we didn't learn anything about death and things, nothing. I didn't feel very prepared at all. I mean, yeah, I did watch me what was expected of me, but [This Uni] taught me that mean and showed that a lot more for me. E2

But with the practical thing, it's not a bad challenge. I'm just preparing you for what to come in the future and what's expected of you as a nurse. [Scaffolded learning] E2

I'm just blown away by the helpful nature of everyone at the university. E2

Learn COND **Too much - pace of time - miss msg**
Something that really could have been improved. I touched on how I failed. It was a simple dressing assessment that was unsuccessful with it. I didn't feel I got very much time in practice in the lab because obviously in practice time we were learning other things because obviously it's a short eight week semester, so we've obviously got to squeeze our content in to the eight weeks. So in some ways we do have to learn the same things that we learn. E2

Learn COND **NSQ Program**
"Do I really want to do nursing? Is nursing for me? Is this program that I've chosen, or is it the whole thing?" So I took about a year and a half thinking about it and I decided to try again at [This Uni] and I'm glad I did. It was just the program at [Other Uni], I didn't like it. E2

Obviously, quite a lot of students go, but it's not a massive university. E2

Coming over from literally halfway around the world to attend this university because of its program sort of stuff. I would definitely be impossible to meet the expectations I definitely had for it, but for what it was it was really good. E2

Learn COND **Peer context**
I think they really did all it could because at [This Uni], there's the open door policy. If you need to speak to someone, even if the person you want to speak to you, isn't available, someone will speak for you. I've never had that experience at [Other Uni], I remember I tried to email someone at [Other Uni], and I didn't get a response for five weeks. E2

Learn COND **Shock**
I think as much as people seem to prepare you for what you're going to see, you never know what you're going to see, whether it be on your first day, first week, whatever. So yeah, I mean, there was a bit of a shock because I remember on my first day of practice, that was orientation, but my first actual day of being a student nurse was, that's when my first head butt, and I was shocked because I never knew that. There's only so much that you can do to prepare you for what you're going to see on your first day of being a student nurse, and everyone's experience is different. You can't take it to a way. E2

[Best experiences] these people who were trying to tell you these things, originally did it in a way for you the time? Not really until I experienced it. E1

Learn COND **Agreement Shock**
That sounds so funny to me but having never really been exposed to something like that. Obviously in my first and second week we'd have to change people or rolling tasks and whatever, and you had to deal with subsides or whatever for the first time. But yeah, that was just one thing that I'd never dealt with before. And that's just the first day. E2

And for some people that's not easy at all. E2

Learn COND **Peer context**
I think they really did all it could because at [This Uni], there's the open door policy. If you need to speak to someone, even if the person you want to speak to you, isn't available, someone will speak for you. I've never had that experience at [Other Uni], I remember I tried to email someone at [Other Uni], and I didn't get a response for five weeks. E2

Learn COND **Peer context**
I think they really did all it could because at [This Uni], there's the open door policy. If you need to speak to someone, even if the person you want to speak to you, isn't available, someone will speak for you. I've never had that experience at [Other Uni], I remember I tried to email someone at [Other Uni], and I didn't get a response for five weeks. E2

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**Appendix U: Sigma Psi Alpha at-Large: Nursing Research Symposium, Perth,
Western Australia, Australia**

Sigma Nursing Research Symposium
Friday, 10 May, 2019
Program



Time	Harry Perkins Institute of Medical Research, Nedlands	
0800 – 0845	Registration -Foyer-	
0845 – 0915	<p align="center">Welcome to Country Ingrid Cumming Official Welcome Psi Alpha at-Large President: Gina Mata WA Chief Nurse and Midwifery Officer -McCusker Auditorium-</p>	
0915 – 1015	<p align="center">Keynote Speaker Prof Debra Anderson <i>Women's Wellness Research Program</i> -McCusker Auditorium-</p>	
10.15 – 10.35	<p align="center">Morning Tea <i>thanks to the Nursing and Midwifery Office</i> -Foyer-</p>	
	<p>Concurrent Session Stream A Connect -McCusker Auditorium-</p>	<p>Concurrent Session Stream B Catalyze -Seminar Room G24-</p>
10.35 – 10.55	<p><i>Enhancing the relationship with nurses that choose to stay in direct care roles.</i> Dr Pam O'Nions University of Notre Dame</p>	<p><i>Written feedback: the experience of midwives and student midwives.</i> Kirsty Haywood, Prof Sandra Carr & Assoc. Prof Alexandre Tregonning University of Western Australia</p>
10.55 – 11.15	<p><i>The use of video-assisted reflection as part of the debriefing process for undergraduate nursing students.</i> Sharon MacLean, Fiona Geddes, Michelle Kelly & Prof Phillip Della Curtin University</p>	<p><i>The impact of postgraduate nurses on quality of care, nurse practice, and patient and nurse satisfaction: a systematic review.</i> Dr Ma'en Zaid Abu-Qama, Dr Beverley Ewens, Dr Deb Sundin, Caroline Vafeas & Manonita Ghosh Edith Cowan University</p>
11.15 – 11.35	<p><i>Maternal assault admissions are associated with increased risk of child maltreatment allegations.</i> Carol Orr, PhD Candidate University of Western Australia</p>	<p><i>Laughing through the nursing journey.</i> Marie Boulianne, PhD Candidate University of Notre Dame</p>
11.35 – 11.55	<p><i>Acupuncture and holistic nursing.</i> Dr Carol Wang Edith Cowan University</p>	<p><i>Promoting student belongingness: the development, implementation and evaluation of a toolkit for nurses using an e-learning format.</i> Chris King, PhD Candidate University of Notre Dame</p>



Psi Alpha at-Large Chapter

psialpha.sigmanursing.org

**Appendix V: Australian College of Mental Health Nurses: The Ripple Effect of
Self Care on Others, Perth, Western Australia**



CONFERENCE PROGRAM

**Australian College of Mental Health Nurses
Western Australia Branch Symposium 2021
'The Ripple Effect of Self Care on Others'**

**Friday 25 June 2021
Anzac House, Perth CBD, Western Australia**



the Australian College
of Mental Health Nurses Inc.

Time	Format	Room
8:30am – 9:00am	Registration	Level 5 Foyer
Opening Plenary: 9:00am – 10:00am		Level 5 Plenary
9:00am – 9:15am	Welcome to Country Ron Gidgup , Coordinator Aboriginal Liaison, South Metropolitan Health Services	
9:15am – 9:20am	Conference Welcome Speaker: Monica Taylor , ACMHN WA Chair/Vice President	
9:20am – 10:00am	Opening Address Speaker: Robina Redknapp , Chief Nurse and Midwifery Officer Western Australia	
10:00am – 10:30am	Morning Tea and Exhibition	Level 6 Foyer
Abstract Presenters Session: 10:30am – 12:30pm		Level 5 Plenary
10:30am – 11:00am	Presentation: 'Promoting positive and safe care in forensic mental health inpatient settings: Evaluating critical factors that assist nurses to reduce the use of restrictive practices and improve staff health and safety' Speaker: Lesley Barr	
11:00am – 11:30am	Presentation: 'Stigma in mental health nursing' Speaker: Andrea Lyon	
11:30am – 12:00pm	Presentation: 'The power of believing you can make a difference in youth mental health' Speaker: Patricia Taylor	
12:00pm – 12:30pm	Presentation: 'Adapting frameworks for clinical supervision within a mental health unit to provide sustainability of the Safewards model' Speaker: Richard Bostwick and Jenny Hamilton	
12:30pm – 1:30pm	Lunch and Exhibition	Level 6 Foyer
Plenary Session 2: 1:30pm – 3:00pm		Level 5 Plenary
1:30pm – 2:30pm	Keynote Speaker: Eva Storey , Resilience Coach Presentation: "I don't have time"	



the Australian College
of Mental Health Nurses Inc.

2:30pm – 3:00pm	Presentation: 'Line and clinical supervision enhancement strategy' Speakers: Elizabeth Caulker, Caroline Dyer and Shae Ali	
3:00pm – 3:30pm	Afternoon Tea and Exhibition	Level 6 Foyer
Masterclass Session: 3:30pm – 4:30pm		Level 5 Plenary
3:30pm – 4:30pm	Masterclass: 'Laughing Through The Nursing Journey' Presented by: Marie Boulianne <i>The aim of this workshop is to encourage participants to reflect on the use of humour in their working life and its resulting effect on self and others.</i>	
Closing Plenary – 4:40pm – 5:30pm		Level 5 Plenary
4:40pm – 5:05pm	Keynote Speaker Speaker: Stephen Jackson, CEO, ACMHN	
5:05pm – 5:30pm	Closing Address Speaker: Monica Taylor, ACMHN WA Branch Chair/Vice President	
5:30pm – 6:30pm	Networking Drinks in Restaurant, Anzac House	