A Comparison of the Effects of Mentorship and Self-efficacy on the Career Advancement of Nurses Educated Internationally and in the United States

A Thesis

Submitted to the Faculty

of

Drexel University

by

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In partial fulfillment of the requirements for the degree

of

Doctor of Nursing Practice

Dedications

This dissertation is dedicated to my parents- My late father, Michael Adewale Adekoya, who taught me the value of education early in life and to always aim high and never fail, and my mother Risikat Afolake Adekoya, who taught me the value of perseverance, hard work and humility. Daddy, the confidence and pride you had for me has been the driving force. Without you, Daddy and Mommy, I would not be here.

It is also dedicated to my five children, Anthonia Debby Temitope, Tiffany Anuoluwapo, Prince Anthony Olaoluwa, Justin Ayoola, and Destin Olufeyi; and my darling husband, Anthony A. Adeniran, who redefined women's roles and responsibilities in a family, encouraging and supporting me to be the best I can be.

I would be remiss if I did not include the nurses who voluntarily participated in this study. This study is dedicated to you for your time and honest feedback on the questionnaires. You allowed me to answer some of the deepest questions that I had for the nursing profession, and have helped to expand the knowledge for advancing nurses- I am indebted to you all!

Acknowledgements

"In the race for excellence, there is no finish line" - Rita K. Adeniran

This dissertation would not have been possible without the wisdom, goodwill, and support of many great people- mentors, professors, colleagues, friends and family. My deepest gratitude goes to Dr. Victoria L. Rich, Chief Nurse Executive, University of Pennsylvania Medical Center and Associate Professor of Nursing, University of Pennsylvania School of Nursing, who in the Spring of 2007, while we were in Geneva, challenged me to identify and pursue doctoral education, offering to support me all the way. You have led me to a place I would not have gone by myself. Thanks for your vision. You epitomize true leadership.

I am privileged to have Dr. Mary Ellen Smith Glasgow serve as my supervising chair. She gladly accepted my research interest, and provided me the kind of support every doctoral student needs to succeed. Her diligence, wise counsel and responsiveness is unmatched! Dr. Glasgow carefully reviewed and critiqued numerous versions of my dissertation. She guided me to overcome many of the challenges inherent in doctoral education. It has been my highest honor to know her as my teacher, mentor, co-researcher, and supervising chair. Her belief in my abilities empowered and supported me to reach this professional milestone. She has been the ultimate mentor along this transformational journey. I am indebted to her!

Special thanks goes to my committee members, each one contributed a special strength, willingly sharing their expertise. Dean Donnelly, the thought-provoking questions you asked at each step of the research process helped me think through and focus my ideas and showed me how to reach deeper within myself to achieve excellence. I am humbled by the meticulous editing of the many versions that came across your desk and the ideas for enhancing the work. Sincere gratitude to Dr. Polansky for showing me that I can, indeed learn statistics. Your insight and support have allowed me to apply statistical knowledge, opening for me new ways to make sense of the world. Dr. Xu, your contributions made a huge difference. I appreciate your critical review of my writings and the insights you provided. Your scholarly work and expertise in the areas of internationally educated nurses' transition, adaptation, and integration greatly enhanced this dissertation.

Thanks to the Drexel doctoral faculty, and specifically to Dr. H. Michael Dreher who accepted me into the doctoral program. Your passion for the advancement of the nursing profession, and genuine interest for students' success as professionals and individuals are worthy of emulation. My deepest appreciation to Dr. Elizabeth Gonzales, for teaching me to think and write scientifically. You enhanced my understanding of how concepts are related to theories, strengthened my knowledge of the research process, and buttressed my writing skills. My heartfelt gratitude to Drs.

Vicki Lachman and Louise Ward who believed in my ability and recommended me for the doctoral program. This journey would not have begun without your recommendation. Sincere gratitude to the "Drexel Dozen", the DrNP cohort class of 2007; I learned so much from each one of you!

I acknowledge my colleagues at the Department of Nursing Education, Innovation and Professional Development and the HUP Nursing Cultural Competence Committee at the Hospital of the University of Pennsylvania. Your support, patience, and collegial spirit was instrumental to the completion of my doctoral journey. Special thanks, goes to Christine Capps for all the proof readings and Lisa N. Mitchell for your assistance in many ways, you both are true friends. I am indebted to Anand Bhattacharya for your friendship and expert assistance in data analyses. I learned and benefited greatly from your comments, critical insights, suggestions, and advice. The many hours spent together during the dissertation did not go unnoticed. You are a true friend!

My profound gratitude to hospitals, professional associations and nursing magazines that willingly hosted the study's survey link on their websites or sent the link to their staff or members. This includes: Mary Beth Kingston, Chief Nurse Executive for Albert Einstein Healthcare Network, Philadelphia; Gail Guterl, former Editor, Advance for Nurses; Donna Novak, Editorial Director at Gannett Healthcare Group; Sandra Jost, former Associate Chief Nursing Officer of the Hospital of the University of

Pennsylvania; the leadership team of the Honor Society of Nursing, Sigma Theata Tau International; the Asian American Pacific Islander Nurses Association; and the Filipino Nurses Association, USA. I am extremely grateful for your support.

Most of all, I acknowledge the love and support of my family. Other things in life may change, but we start and end with family. My journey through doctoral education has not been a solo adventure. This journey has been shared and supported by those most dear to me, my family. First, my children: Anthonia Debby Temitope, Tiffany Anuoluwapo, Prince Anthony Olaoluwa, Justin Ayoola, and Destin Olufeyi. You all have been the constant source of my inspiration. If patience is a virtue, each one of you is indeed virtuous. Without you, this dissertation, and many other achievements, would not hold the same meaning. I walk this path for the sake of each one of you. I love you more than you will ever know. My greatest thanks goes to my best friend, darling husband and life partner, Anthony A. Adeniran. Darling was with me at every turn. He gave me things I asked for, things I did not ask for or forgot to ask for and things that I do not have words for. Darling, I am fortunate that a human being of such inner and outer beauty has chosen to share his life with me. Without your unwavering support, unconditional love, patience, understanding, and wit, I would not have had the courage to begin this doctoral journey, let alone complete it. I love you Hubby. Your Wife and Princess-Who Else? Rita K. Adeniran

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Abstract

Introduction: Excellence, professional and personal fulfillment of nurses underscores the need for all registered nurses (RNs) to keep their skills and competencies current through professional development and career advancement opportunities. Professional development is the process by which healthcare professionals keep their skills and competencies current to meet the healthcare needs of their patients. Career advancement serves as a tool that supports nursing excellence. However, emerging evidence suggests that internationally educated nurses (IENs) progress relatively slowly through the career ladder and participate less in professional development opportunities compared to their indigenous counterparts, such as nurses educated in the U.S.(UENs). It is important to understand the factors that influence professional development and career advancement of all nurses, and particularly IENs. Mentorship and self-efficacy are major determinants of career advancement, but the influence of these two variables on professional development, and career advancement of nurses is yet to be explored. This study seeks to understand how mentorship and self-efficacy have influenced nurses' participation in professional development and career advancement activities. **Methods:** This study used a descriptive-correlational survey design and content analysis of open-ended questions to examine differences in levels of mentoring functions and self-efficacy of IENs compared to nurses UENs. It also explores the association among mentorship, self-efficacy, professional development and career advancement of both groups of nurses. A web-designed questionnaire was used to reach potential participants through an online survey. **Results:** Results showed that the socio-demographic characteristics of the respondents closely matched the U.S. nursing workforce reported in other studies. Only the role model subscale score of mentorship was significantly different between the groups. Self-efficacy was similar in both groups. While there were similarities in some professional development and career advancement measures, significant disparities were noted in others. Analysis of the open-ended questions revealed that a healthy work environment is critical for nurses' engagement in professional development and career advancement opportunities. Both groups of nurses face similar professional development challenges; however, some of the factors leading to the challenges differ between UENs and IENs. **Conclusion** Mentorship is essential for nurses' professional development. The socio-demographic characteristics of mentors are equally important, as nurses look up to their mentors as role models. Nurse leaders are challenged to create a healthy work environment and implement a standardized career advancement structure that will promote professional growth and development in nursing. This is essential for nurses to remain vital and leading members of the interdisciplinary care team. Each nurse has the responsibility to engage in self-leadership for personal and professional fulfillment. In comparison to UENs, IENs are only somewhat successful in the U.S. nursing workforce. Considerable work is needed to bridge the gaps in professional development and career advancement between UENs and IENs. This study identifies some of the areas where the differences exist, as well as some of the factors that contribute to these differences. Further research is necessary to validate these findings and understand the mechanisms that underlie these disparities.

Chapter 1: Introduction

Specific Aims

Internationally educated nurses (IENs) constitute a growing proportion of the nursing workforce in the United States (U.S.) and contribute significantly to meeting the healthcare needs of the American public. The percentage of IENs as new entrants to the U.S. nursing workforce grew from 13,000 in 1990 to 181,000 in 2000, a substantial gain from just 8.8% to over 15% of the nursing workforce (Polsky, Ross, Brush, & Sochalski, 2007). Between 2000 and 2003, foreign-born nurses (FBNs) accounted for one third of the increase in employed nurses in the U.S. (Buerhaus, Staiger, & Auebach, 2004). In 2008 alone, over 48,000 nurses who entered the U.S. nursing workforce were foreign-born, elevating the concentration of foreign-born nurses to more than 16% of the U.S. nurse workforce (Buerhaus Auerbach, &Staiger, 2009). These numbers clearly show the expanding role of nurses who were born or educated outside the U.S. in ameliorating the impact of the U.S. nursing shortage. IENs come from diverse cultural and educational backgrounds. The nursing profession needs to adjust to this increasing diversity in its own workforce by supporting all nurses, regardless of birthplace or country of education, to reach their highest potential within the profession. In other words, *professional excellence in healthcare underscores the need for all registered nurses (RNs), regardless of birth place or country of education, to keep their skills and competencies current through ongoing professional development and career advancement.* However, emerging evidence suggests that IENs do not have equivalent access to professional development opportunities and do not progress through career ladders as equals with their indigenous counterparts (Alexis, Vydelingum, & Robbins, 2007; Alexis, Vydelingum, & Robbins, 2006; Edwards & Davis, 2006; Hawthorne, 2001; Henry, 2007; Nichols & Campbell, 2010; Xu & Kwak, 2007; Zizzo & Xu, 2009). It is unknown

why IENs participate less in professional development activities or progress relatively slower through the career advancement ladder compared to their UEN counterparts. Further, with increased recognition of nurses as valuable members and leaders of multi-disciplinary healthcare teams, it is important to understand factors that influence nurse's participation in professional development and career advancement.

Understanding the factors that influence nurses' participation in professional development and career advancement, particularly among IENs, may facilitate the development of programs that can lead to better integration of IENs in the U.S. nursing workforce and facilitate more nurses' participation in professional development and career advancement opportunities. There is clear evidence in the literature supporting the idea that mentorship and self-efficacy are major determinants of career advancement (Abele & Spurk, 2009; Allen, Eby, Poteet, Lentz, & Lima, 2004; Brown, Jones, & Leigh, 2005; Godshalk & Sosik, 2003; Kay, Hagan, & Parker, 2009). However, the influence of these two variables on professional development and career advancement of nurses is not well understood (Day & Allen, 2004; Hayes, 1998; Koberg, Boss, & Goodman, 1998).

This study will begin *to bridge that gap* by exploring the association among mentorship, self-efficacy, professional development, and career advancement of nurses. Research suggests that minorities and women are less likely to be mentored and more likely to encounter barriers in finding mentors (Noe, 1998b; Ragins, 1999). Mentorship is critical for professional growth, as it serves as a mechanism for information exchange and acquisition of new knowledge (Mullen, 1994). Mentors provide mentees access to social networks that include repositories of knowledge not available through normal channels (Burt, 2005; Dreher & Ash, 1990; Dreher, &

Cox, 1996; Palgi & Moore 2004). Mentorship promotes individual self-efficacy by enhancing self confidence, competence, and self-esteem (Day & Allen 2004; Koberg et al., 1998; Kram, 1983). Another important ingredient for professional growth and career development is self-efficacy. Self-efficacy influences how professionals set career goals, influencing not only the initiation of behavior and effort expended, but also the persistence of behavior in the presence of impediments (Bandura, 1982; 1984; Pajares, 2002). Self-efficacy is mediated by individuals' beliefs or expectations about their ability to accomplish certain activities successfully (Bandura, 1984). Self-efficacy has been shown to have a positive influence on an individual's desire to engage in professional development and career advancement (Annelies & Van, 1999; Day & Allen 2004; Schyns, 2004). Lower self-efficacy limits the extent to which individuals participate in progressive endeavors, serving as a barrier to career advancement (Bandura, 1977a, 1977b, 1982; Hackett & Betz, 1981). Similar association is reported between self-efficacy and mentorship. Self-efficacious individuals accept their roles as mentees with greater receptivity and willingness to engage in new activities, learning new skills and enhancing their competencies more so than less efficacious individuals (Poon, 2006). Mentored individuals have higher self-efficacy from vicarious learning and verbal persuasion (Bandura, 1977; Day & Allen 2004). The extent to which mentorship and self-efficacy may influence career advancement and professional development in nurses, specifically IENs, deserves careful study.

The objective of this study is to determine the association of mentorship and self-efficacy with professional *development and career advancement among IENs and UENs.* The overall purpose of this study is to identify how differences in levels of mentorship function and self-efficacy influence participation in professional development and career advancement opportunities among nurses providing evidence for the development of programs to foster

greater participation in professional development and career advancement. The *central hypothesis* is that mentored UENs and IENs will have higher levels of self-efficacy, participating more in professional development activities and advancing faster through their organization career ladder compared to those who receive minimal mentorship and are less self-efficacious.

The specific aims of this study are as follows:

Specific Aim 1: *Determine the differences in the level of mentorship functions and self-efficacy between UENs and IENs.*

Hypothesis 1: IENs will report lower levels of mentorship functions and self-efficacy compared to UENs.

Specific Aim 2: *Determine the differences in levels of participation in professional development activities and career advancement opportunities between IENs and UENs.*

Hypothesis 2: IENs will demonstrate fewer professional development activities and less career advancement opportunities compared to UENs.

Specific Aim 3: *Explore the relationship of mentorship and self-efficacy with career advancement in both IENs and UENs*

Hypothesis 3: The association of mentorship and self-efficacy will be different between UENs and IENs.

The research team at Drexel University was well positioned to conduct this study. The Principle Investigator is a nurse administrator, consultant, educator, and doctoral candidate with over 22 years of combined healthcare experience in clinical, administrative, educational, safety,

and global health issues. She has utilized diversity and inclusion frameworks to promote professional nursing excellence. The co-investigator and supervising chair, Dr. Mary Ellen Smith Glasgow, is a tenured Associate Professor and Associate Dean for Undergraduate Programs, MSN Programs, & Continuing Nursing Education at Drexel College of Nursing & Health Professions and a nationally recognized nurse executive, innovative administrator, educator, and researcher. Dr. Smith-Glasgow is one of 20 regional nursing executives selected in 2009 to participate in an esteemed nurse executives' award fellowship by the Robert Wood Johnson Foundation. The team also included: Dr. Gloria Donnelly, a well accomplished Dean, tenured professor, renowned scholar, editor, nurse executive, and national consultant, with a national reputation; Dr. Marcia Polansky, a tenured Associate Professor in the Department of Epidemiology & Biostatistics in the Drexel School of Public Health; and Dr. Yu (Philip) Xu, a tenured Professor at the University of Nevada, Las Vegas School of Nursing, where his research focuses on the transition, adaptation, and integration of IENs into Western healthcare systems.

This research used two instruments. The first was the Scandura and Ragins (1993) 15-item multidimensional instrument. This instrument measures levels of mentoring functions received by participants with regards to career development, psycho-social support and role modeling dimensions of mentoring. This instrument's Chronbach's alpha = 0.93; content, concurrent and convergent validity has been reported. The second instrument was the New General Self-efficacy (NGSE) scale by Chen, Gully, and Eden, (2001). The NGSE scale assesses levels of self-efficacy. The internal consistency of the scale's item response ranges from .85 to .90. The stability coefficient ranges from r = .62 to r = .65. The NGSE scale is reported to have high content validity. Reliability of the scale has been demonstrated by previous studies.

In addition, this study used a 46-item investigator-generated questionnaire with two additional qualitative questions to determine how mentorship and self-efficacy has influenced the career advancement of nurses. Participants included UENs and IENs practicing in a hospital located in Philadelphia County, part of the Delaware Valley Region. Philadelphia, is located in the Commonwealth of Pennsylvania, it is one of the three original counties, along with Chester and Bucks counties, created by William Penn in November 1682. It is coterminous with the city of Philadelphia. The U.S. Census Bureau (2008) reported the population as 1,540,351 making it the most populous county in Pennsylvania. Philadelphia is one of the flagships of the Greater Philadelphia metro statistical area (MSA) of the Delaware Valley Region. According to the U.S. Bureau of Labor Statistics, the Delaware Valley Region (DVR) refers to the metropolitan area which is centered on the city of Philadelphia in the U.S. The DVR consists of the Philadelphia–Camden–Wilmington Metropolitan Statistical Area. It comprises several counties in southeastern Pennsylvania and southern New Jersey, one county in northern Delaware and one county in northeastern Maryland (Office of Management Budget, 2008). Study participants were invited to complete an online survey that collected information related to demographics, mentorship, self-efficacy, professional development activities, and rate of career advancement in nursing. The study used a descriptive correlational design in conjunction with content analysis of the open-ended questions. This study is innovative because this is the first nursing study to determine the association of mentorship and self-efficacy with nurses' professional development and career advancement activities.

Summary of Introduction

Professional development of nurses is vital for the individual nurse, healthcare organizations, and the status of the nursing profession among multidisciplinary care teams (Happell, 2004; Whyte, Lugton, & Fawcett, 2000). Professional development enhances skills acquisition, clinical competence, and role performance with the ultimate outcome of protection of the public and the provision of safe-quality care (American Nurses Association (ANA) & National Nursing Staff Development Orgnanization (NNSDO), 2010; Yoder-Wise, 2008). Career advancement serves as a tool that supports nursing excellence through the conferment of higher clinical status to those nurses who meet the requirements. In order for nurses to advance through the career ladder, they must show evidence of enhanced or new competency in their practice. More importantly, with emerging evidence to suggest that disparities exist in levels of participation in professional development and career advancement among nurses based on their region of nursing education, it is imperative for the nursing profession to identify the factors responsible for these differences and address them. Mentorship and self-efficacy have been identified in the literature as essential ingredients for professional growth and development. This study has been useful in addressing questions about some of the causes of disparities between UENs and IENs in their levels of participation in professional development and career advancement opportunities. Study outcomes have provided research evidence to support the development of appropriate interventions to promote active engagement in professional development and career advancement opportunities by all nurses.

Chapter 2: Literature Review

Background

Healthcare organizations use career advancement programs to support nurses to enhance their skills for professional excellence on an ongoing basis. These programs are intended to enhance nurses' participation in professional development activities and to strengthen their competencies (Buchan & Thomson, 1999; Nelson & Cook, 2008). The literature identifies mentorship and self-efficacy as key elements in career advancement (Allen, Eby, Poteet, Lentz, & Lima, 2004; Brown, Jones, & Leigh, 2005; Godshalk & Sosik, 2003; Kay, Hagan, & Parker, 2009). Thus, the effects of mentorship and self-efficacy on career advancement deserve a careful study. It is quite evident that IENs participate less in ongoing professional development activities and progress more slowly through nursing career ladders compared to UENs (Alexis, Vydelingum, & Robbins, 2007; Alexis, Vydelingum, & Robbins, 2006; Edwards, & Davis, 2006; Hawthorne, 2001; Henry, 2007; Nichols & Campbell, 2010; Xu & Kwak, 2007; Zizzo & Xu, 2009). The reasons for these disparities are unknown. For example, it is not well understood if IENs have less access to mentors or if the mentoring relationship is of poorer quality, or if IENs lack the level of self-efficacy required for seeking a mentor or for participating in career advancement activities. In fact, one study in the United Kingdom (U.K.) reported that migrant nurses were found to be concentrated in lower grades or levels with over 61% of overseas-trained nurses employed on Grade D, the entry grade level for qualified nurses, compared with 14% of all U.K-trained nurses (Ball & Pike, 2005). The U.K. National Health Service (NHS) utilizes a grading structure for advancing professional nurses through the nursing career ladder. The ladder spans six grades from D to I. Grade D is the entry and lowest possible grade for initial

hiring of newly qualified nurses. With experience and more educational attainments, nurses can advance to Grades E, F, G, H, and I. Grade I is the highest grade, which is reserved for nurses who are in leadership roles, such as ward managers and supervisors (Pudney & Shields, 2000).

Career advancement in professional nursing. Career advancement refers to the process professionals undergo to achieve changes in performance, job roles, and promotions, and to develop a better relationship with management (Ismail & Arokiasamy, 2007). Career advancement is greatly influenced by interpersonal, intrapersonal, and human capital determinants. Interpersonal determinants of career advancement include concepts of self-efficacy, personality traits, and other psychological factors. Intrapersonal determinants of career advancement include concepts of mentorship, supportive work environment, and peer network Human capital determinants of career advancement include personal investment in education, family support, and participation in professional development (Apospori, Nikandrou, & Panayotopoulou, 2006). Career advancement in nursing constitutes any form of professional promotion that recognizes and rewards talent in clinical or administrative nursing practice (Walker, 2005).

The need for a strategy that would recognize, reward, and retain expert nurses at the bedside was acknowledged as early as the 1960s (Creighton, 1964). However, it was not until the 1970s that formal career advancement programs were implemented for nurses and referred to as either clinical ladders or career advancement programs. Until the advent of career advancement programs, the only way a nurse was recognized, rewarded, or promoted was to move further away from the bedside by taking a nonclinical role, such as nurse manager or educator (Walker, 2005). Career advancement provides opportunities for nurses to enhance their competencies

through ongoing professional development. Professional development denotes a learning process where competency is the outcome (Solveig & Bjork, 2007). In order for nurses to advance through the career ladder, they must show evidence of enhanced or new competencies in their practice (Joel, 1990). Thus, career advancement serves as a tool that supports nursing excellence through the conferment of higher clinical status to those nurses who meet certain requirements.

The connection between ongoing professional development and career advancement and nursing practice excellence has been empirically confirmed (Hsu, Chen, Lee, Chen, & Lai, 2005). The 1981 American Academy of Nursing's study identified clinical ladders or career advancement programs as a structure for promoting nurses' increased participation in professional development activities, which lead to clinical excellence, and for promoting better outcomes for patients (McClure, Poulin, Sovie, & Wandelt, 2002). In addition to facilitating prospects for clinical nurses, Hsu et al. (2005) reported that career advancement programs promote an environment of clinical learning and quality patient care. Nurse leaders' concurred that well-educated nurses who participate in ongoing professional development and career advancement programs are invaluable to achieving nursing goals for improving the quality of patient care. Further, they declare that ongoing professional development enhances clinical skills and professional growth of new nurses, increasing nursing staff productivity, resulting in successful recruitment and retention of competent, clinical nursing staff (Joel, 1990; Franker, 2003; Kurgan, Smith, & Goode, 2000; Schultz, 1993; Vestal, 1984).

Other positive outcomes of career advancement discussed in the literature include increased income for nurses, improved nurse and patient satisfaction, cost savings from decreased use of temporary staff and sick time, decreased nurse turnover, enhancement of

professional image and advancement of the discipline, and most importantly, higher quality patient care (Buchan & Thomson, 1999; Drenkard & Swartwout, 2005; Robinson, Eck, Keck, & Wells, 2003; Schmidt, Nelson, & Godfrey 2003; Shapiro, 1998). Despite the overwhelming advantages of career ladder or advancement programs in promoting nurses engagement in professional development and career advancement activities and improving patient care, only scant research has focused on the evaluation of these programs (Buchan & Thomson, 1999; Goodrich & Ward, 2004; Nelson & Cook, 2008). There is a gap in the literature with regards to identifying factors that influence nurses' participation in professional development and career advancement activities (Bjørk, Hansen, Samdal, Solveig & Hamilton, 2007).

In most professions, income or salary increase has been identified as a career advancement measure (Abele & Spurk, 2009). Although registered nurses' income can change dramatically from switching job roles or positions (Reineck & Furino 2005), it is usual for nurses' income to increase with more experience (Lee, 2006). Income also increases with advancement through a career ladder (Shermont, Krepcio, & Murphy, 2009); added increases also occur with higher educational qualifications or specialty certifications (Lee, 2006). Due to the nature of the profession, nurses may also engage in additional part-time work to increase their income (Reineck & Furino 2005). A nurse's salary may serve as an objective career advancement measure (Abele & Spurk, 2009; Riley, Rolband, James, & Norton, 2009); however, it is important to distinguish between regular work hour's income and overtime income or salary, especially in clinical practice.

Registered nurses in the U.S. workforce. Registered Nurses (RNs) constitute the single largest group of healthcare professionals in any healthcare system in the world, with almost 3

million RNs in the U.S. in 2006 (Aiken, 2007). Inadequate numbers of RNs to care for patients in any country threatens even the most stabilized healthcare delivery system. The U.S. could not operate an effective healthcare system unless the country educates, recruits, and retains sufficient numbers of RNs (Aiken, 2007; Adeniran et al., 2008; Cohen, 2009). U.S. Bureau of Labor Statistics (U.S. Department of Labor, 2009) projects RN jobs to be second among the top ten largest job growth categories in the U.S. in the next decade. In addition, an estimated 703,000 new RN jobs will be created between 2004 and 2016, and more than one million new and replacement nurses will be needed by 2016 (The U.S. Department of Labor). There is a looming projected shortage of 260,000 RNs by 2025 (Buerhaus, Auerbach, & Staiger, 2009). Ongoing changes in models of healthcare delivery, population dynamics, market forces, and technology in the U.S. have resulted in a recurring imbalance in the demand and supply of RNs over the last forty years; thus, the cyclical shortages and surpluses of RNs in the U.S. workforce (Aiken, 2008; Brush, Sochalski, & Berger, 2004; Elgie, 2007; Health Resources and Services Administration, 2004). In order to meet the healthcare needs of the American public, U.S. healthcare organizations and recruitment agencies have reached beyond the U.S. borders to recruit IENs to increase the RN supply (Adeniran et al., 2008; Brush & Berger, 2002; Buerhaus et al., 2009). Furthermore, the U.S. is the choice destination for a majority of migrating IENs (Adeniran et al., 2008).

IENs in the U.S. are mainly Asians, with 75% of IENs coming from the Philippines until the mid-1980s. The percentage of Philippine nurses among IENS in the U.S. workforce diminished to 52% in 2001, as nurses from other countries started to emigrate (Brush, et al., 2004). The top six nurse-exporting countries to the U.S. in 2001 were: Philippines (52%),

Canada (12%), Korea (6%), India (4.5%), United Kingdom (3.0%), and Nigeria (2.0%) (Brush et al., 2004; Xu & Kwak, 2005).

In a report of an analysis of the characteristics of the U.S. nursing workforce, IENs were found to have more clinical experience with higher nursing educational entry level preparation than UENs. (Polsky, et al., 2007; Xu & Kwak, 2007). IENs are more likely to have a Bachelor's degree than UENs, but are less likely than UENs to advance through the professional nursing career ladder (Xu & Kwak, 2007). IENs are somewhat younger with an average of 43.7 years compared to UENs at 45.1 years (Xu & Kwak, 2007). The latest reported statistics on the number of RN licenses issued to IENs was in 2003; it showed an upward trend as IENs' RN licensure steadily increased from 6,000 annual licensures in 1990 to 8,000 in 1994, to nearly 10,000 in 1995 (Buerhaus, Staiger, & Auerbach, 2003). Also, the numbers of IENs grew exponentially producing more than a tenfold increase within 10 years from 13,000 in 1990 to 181,000 in 2000 (Polsky, et al., 2007). From 1990 to 2001, the number of IENs in the workforce increased by 6% annually, while IENs accounted for almost one third of the increase in employed nurses between 2000 and 2003-faster than UENs as a whole (Edwards & Davis, 2006). It is important to note that trends of IEN concentration in the U.S. workforce may change due to some procedures enacted by the U.S. Congress in response to the tragic event of September 11, 2001. As one protective measure against terrorism, new policies exercising increased control, restrictions, and scrutiny of potential labor migrants, including nurses are now in place (U.S. Department of Home Land Security, December 5, 2008; Shusterman, 2005). However, the impact of these policies in reducing the numbers of IENs in the U.S. workforce is yet to be determined and reported. Current analytical findings of the U.S. nursing workforce at the time of this study acknowledged 42% of the increase of IENs in the U.S. workforce occurred after 1996.

In 2008 alone, 48,000 nurses who entered the U.S workforce were foreign-born. With globalization, population dynamics, a projected looming nursing shortage, and the U.S. as the choice destination for most migrant nurses, it is likely that IENs will continue to increase in the U.S. workforce (Buerhaus, et al., 2009).

Mentoring

Mentoring occurs when a more experienced person (mentor) guides, teaches, and protects an inexperienced person (mentee) (Sands, 2006). The concept of mentoring is used in a variety of applications that enhance personal, professional, career, and organizational developments (Hunt & Michael, 1983; Kram, 1985; Stewart & Krueger, 1996; Yoder, 1990). The term mentor originated from Greek mythology (Bell, 1996; Oliver & Aggleton, 2002; Prestholdt, 1990). Mentor was the name of a trusted friend and tutor who had the responsibility of teaching and giving wise counsel to Odysseus' son, Telemachus (Apospori, et al., Bell, 1996; Davidhizar, 1988; Prestholdt, 1990). Mentor's role was to prepare Telemachus for his future position as King while his father was away fighting in the Trojan War (Apospori, et al., 2006; Bell, 1996; Davidhizar, 1988; Prestholdt, 1990).

The literature offers numerous definitions of mentoring. Ragins and Cotton (1999) defined mentoring as a process where a high-ranking, influential individual, who has advanced experience and knowledge in the profession, makes a commitment to provide upward mobility and support to the mentee's career. Mentors are powerful advocates for their mentees, helping them progress in the profession by giving them the opportunity to share, observe, discuss, and learn from an experienced practitioner (Alboim, 2002). A good mentor acts as a wise consultant to support and promote the mentee's career journey (Wills & Kaiser, 2002). Mentoring has also been defined g as a relationship in which a senior and influential person with advanced experience and knowledge

provides support and mobility in advancing the career and professional development of a mentee, thus optimizing work performance (Allen & Poteet, 1999; Fagenson, 1989; Kram, 1985; Scandura, 1992; Scandura, & Ragins, 1994).

Some scholars have defined mentoring in terms of function, roles, and relationship between the mentor and the mentee (Burke, 1984; Kram, 1985; Schockett & Haring-Hidore, 1985). Others have grouped mentoring functions, roles, and relationships by categories. For example, as a result of findings from content analysis of interview data obtained from mentors and mentees in a study of a business organization, Kram (1985) classified mentoring functions into two broad categories of career and psycho-social mentoring. Noe (1988b) conducted a factor analysis of data obtained from school teachers and administrators reporting two functions of mentoring to be career and psychological mentoring. Olian, Carroll, Giannantonia and Feren (1998) reported instrumental and intrinsic mentoring as the two main categories of mentoring functions. Schockett and Haring-Hidore (1985) discussed two functions of mentoring as psycho-social and vocational and suggested that the psycho-social function of mentoring accounted for four times as much variance in mentoring outcomes compared with vocational functions. Burke (1984), through a factor analysis of a study of 80 managers who participated in a professional development course, reported three distinct functions of mentoring as: career development, psycho-social function, and role model functions, thus adding the role model function of mentoring as a third and distinct component of mentoring. Scandura and Ragins (1993), through factor analysis, also reported three distinct mentoring functions-psycho-social supports, career development, and role modeling-asserting that each component of the mentoring functions has a different level of impact on mentees' work effectiveness, work performance, career advancement, and job satisfaction. Barker,

Monks, and Buckley (1999) confirmed the three mentoring functions described by Scandura and Ragins.

Researchers also discussed factors that influenced mentor/mentee relationships and their relevance on mentees' career advancement and other mentoring benefits (Hunt & Michael, 1998; Ismail & Arokiasamy, 2007; Koberg, et al., 1998; Koberg , Boss, Chappell, Ringer, 1994; Lyons & Oppler, 2004; Ragins, 1999, 2000). Minorities and women are more likely to encounter barriers in finding mentors (Kammeyer-Mueller & Judge, 2008; Ragins & Cotton, 1999; Thomas,1990). Characteristics such as ethnicity, race, gender, and education were found to influence mentoring outcomes, and men were found to receive more mentoring than women (Ismail & Arokiasamy, 2007; Koberg, et al., 1998; Koberg et al., 1994; Lyons & Oppler, 2004). Findings on the influence of mentee/mentor gender composition on mentoring relationships have produced mixed results (Allen & Eby 2004; Hunt & Michael, 1983; Ragins 1999; Ragins & Cotton 1999). For example, Allen and Eby (2004) did not find support for their hypothesis that gender composition would influence career or psychological outcomes of mentoring. Similarly, Fowler, Gudmundsson, and O'Gorman (2007), in a study that examined the impact of gender on distinct mentoring functions, found that gender had no influence with regards to mentoring functions and outcomes. However, other studies found female mentees to be more likely than male mentees to report receiving more psycho-social and role modeling mentoring functions from their mentors (Allen, Day & Lentz, 2005; Burke, 1984; McGuire, 1999; Noe, 1988b; Stonewater, Eveslage, & Dingerson, 1990). Stonewater, Eveslage, and Dingerson (1990) found that women described their mentor/mentee relationship in terms of personal connection and support, while men described their relationship in the objective sense of encouragement related to their career. The influence of age on mentoring relationships was also explored in the literature, with mixed findings. Allen, Poteet, Russell, and

Dobbins (1997) reported a negative relationship between age and intentions to mentor, while Allen (2003) informed that a willingness to mentor correlates positively with age. The influence of race and ethnicity on mentoring outcomes were studied and reported in the literature (Kalbfleisch & Bach, 1993; Thomas, 1990). Thomas (1990) studied cross-racial dynamics in mentoring relationships and found that White mentees rarely formed cross-racial mentoring relationships, while Black mentees often formed cross-racial relationships. Thomas also suggested that same-race relations provided more psycho-social support than cross-racial relationships. These findings support the assertion that attraction due to some form of similarities between mentor and mentee is associated with positive mentoring outcomes, particularly in developing informal mentoring relationships (Darling, 1984; Berscheid, 1994). Contrarily, Tillman (2001) challenged the claim that same-race mentoring relationships positively influenced mentoring outcomes and reported that the most important predictor of positive mentoring outcomes is whether mentors provide mentees with the type of career support needed. Other factors reported to influence the mentor-mentee relationship in the literature includes mentees' job reward values, organizational commitment, and satisfaction (Kalbfleisch & Bach, 1998). Mentees' communication, competence, and self-esteem are reported to also have direct and indirect influence on mentee participation in mentoring relationships (Kalbfleisch & Davies, 1993).

Despite the polarity in constructs, concepts, definitions, roles, and functions of mentoring among researchers and scholars, researchers have agreed that mentoring has a positive personal, career, and organizational influence (Kram, 1985; Noe, 1988a,b; Scandura, 1992; Vance, 2002).

Mentoring in nursing. Mentoring first began to appear in the nursing literature in the 1970's (Vance, 1977; Yoder, 1990). Earlier development of the concept was in the field of

organizational behavior, business psychology, and organizational development (Stewart & Krueger, 1996). Currently, the nursing literature is replete with articles about mentoring, but deficient in empirical research (Stewart & Krueger, 1996; Yoder, 1990). In the nursing literature, mentoring has mainly been described as a relationship that can positively influence career outcomes, psycho-social outcomes, and organizational and professional outcomes (Greene & Puetzer, 2002; Oliver & Aggleton, 2002; Rawl & Peterson, 1992; Vance, 2002). Oliver and Aggleton (2002) described mentoring as a pedagogical approach, where learning occurs through relationships in which individuals engage in dialogue and experiences that enhance the development of critical thinking capacities. Owens, Herrick, and Kelley (1998) defined mentoring as a "supportive and nurturing relationship between an experienced professional and an aspiring protégé" (p. 78). Mentoring is a developmental, empowering, and nurturing relationship that extends over time, resulting in mutual sharing, learning, and growth in an environment of respect, collegiality, and affirmation (Vance & Olson, 1998). "A mentor is a wise and trusted advisor, counselor or teacher, who has something to offer that meets the immediate needs and/or future needs of another" (Dorsey & Baker, 2004, p. 260). Mentors offer knowledge, insight, perspective, and wisdom intended to be useful to mentees, creating and facilitating an environment for self-development and self-reflection (Parse, 1998; Kullman, 1998). A good mentor serves as a wise consultant during a mentees' career journey (Wills & Kaiser, 2002). Mentoring is an effective mechanism for providing systematic support for nurses in general practice, thereby facilitating professional development and enhancing care coordination (Gibson & Heartfield, 2005).

The benefits of mentoring in nursing cannot be overemphasized. Mentorship facilitates critical thinking and a connection to practice which supports knowledge development that can influence society (Meleis, Hall, & Stevens, 1994). Mentoring is a teaching-learning

process that promotes scientific competencies (Fitzpatrick & Abraham, 1987). Mentoring accelerates the process of learning (Davidhizar, 1988), elevating higher education beyond technical expertise (Weekes, 1989). Mentors support protégé nurses to make new decisions and gain new competencies, providing them challenges and opportunities to grow (Dracup & Bryan-Brown, 2004). Mentorship contributes to the career development of nurse educator administrators (Rawl & Peterson, 1992). Stewart and Krueger (1996) discussed mentoring outcomes in nursing to include career progression, development of new investigators, and empowerment. They also reported other outcomes of mentoring to include expansion of professional knowledge, generativity, increased numbers of minority nurses in graduate programs, institutional stability, continuity, and professional socialization. Vance (2002) stated: "the research and anecdotal literature supports the idea that the mentor component is an important element of every career stage, and each requires different types of mentoring" (p. 5). Williams and Blackburn (1998) studied faculty mentoring in eight nursing colleges and found that mentoring types of role specific teaching and encouragement were related to the mentees' research productivity. Nurse executive teams identified mentoring as a major factor that influenced integration and collaboration in a study that examined nurse executives' perceptions of factors the influence success (Dalley & Smith, 2000). Koberg, Boss, and Goodman (1998) found that those who received mentoring reported higher levels of self-esteem and confidence than non-mentored healthcare professionals. Mentoring influences promotion, compensation, and organizational and career successes (Koberg et al., 1994). Douglas and Schoorman (1988) found career-oriented mentoring accounted for more of the variance in positive outcomes of mentoring towards career development in a small sample of registered nurses. Although empirical research using the concept of mentoring in nursing is relatively scant, just as in other fields, most study

findings suggest that mentoring had a positive influence on mentees' career advancement (Dalley & Smith, 2000; Koberg, et al., 1998; Williams & Blackburn, 1998).

Models, theories, and framework to guide mentoring research. While no comprehensive, integrated theoretical framework exists to guide mentoring research, scholars and researchers concur that mentor-mentee relationships benefit the mentee in many ways, including career advancement (Kay, Hagan, & Parker, 2009; Koberg, et al., 1998; Noe, 1988a; Vance & Olson, 1998). Numerous theories, models, and frameworks were found to have relevance to mentoring research in the literature. Some articulated social learning theory (Bandura 1982) accentuating mentoring as a developmental process occurring from role modeling and vicarious reinforcement (Eby, Lockwood, & Butts, 2006). Others posit the usefulness of social exchange theory in guiding mentorship and developing mentoring relationships. They claim that mentors and mentees initiate a relationship based on the perceived benefits and losses involved in the relationship (Ensher, Thomas, & Murphy, 2001; Vance & Olson, 1998). Social exchange theorists have utilized one-time case studies to report mentoring experiences as compared to grounded theories used by other researchers (Gibb, 1999). Professional State Development Theory (PSDT) is another framework used as a model for guiding mentoring research. This model describes mentoring as a career development tool (Benner, 1984). Benner discusses nursing professional advancement trajectory as a five-stage model that expands from novice to expert from the aspect of PSDT. An expert nurse in the fifth stage of Benner's model can serve as a mentor, passing his or her knowledge and expertise to nurses in any of the remaining lower four levels of career development. Some nurse researchers supported Benner's model and have utilized it to guide their research (Dracup & Brown, 2004; Oliver & Aggleton, 2002). Johnson, Geroy, and Griego (1999) discussed a mentoring model that

encompasses human development with other dimensions of mentoring such as socialization, task development, and life span development, suggesting the benefit of the model is in its usefulness as a diagnostic tool for training and research inquiry.

It has been argued that a clear vision of a conceptual model, framework, or theory is important and fundamental to guide mentoring research inquiries. Some researchers have criticized that assertion claiming that there is no need for a comprehensive, integrated theoretical framework, because mentoring is multidimensional (Gibb, 1999; Kay, Hagan, & Parker, 2009; Koberg, et al., 1998; Noe, 1988a; Vance & Olson, 1998; Wallace & Haines, 2004). Several researchers described mentoring as a one-dimensional relationship where help comes from a single leader who influences the mentee's career advancement (Little, 1991). Others have argued that mentorship is a multidimensional concept, emphasizing that mentoring takes a variety of forms such as role modeling, coaching, guidance, truth telling, and teaching (Apospori, et al., 2006; Burke & McKeen, 1990). Researchers have therefore adapted existing frameworks or developed a model to guide their research inquiries.

Researchers have also used a framework or model that discusses mentoring in terms of the mentoring functions and outcomes of the relationships between the mentee and mentor (Barker, et al., 1999; Scandura & Ragins, 1993). Scandura and Ragins (1993) described mentoring highlighting three distinct mentoring functions: career development, psycho-social support, and role modeling. According to Scandura and Ragins, the career support functions of mentoring advances the mentee's career through engagement in activities that promote skill development and competency enhancement; the psycho-social support function offers mentees friendship benefits by giving mentees a platform to share their feelings and personal challenges

with their mentors. The third function of mentoring¸ role modeling expresses how well-accomplished and experienced professionals are able to motivate mentees through observation and emulation. The three mentoring functions-career development, psycho-social support, and role modeling cover most of the benefits that mentors provide their mentees (Kwan, Liu, & Yim, 2011). Scandura and Ragins also suggested that certain characteristics, such as gender and role orientation, may impact the dynamics of mentoring relationships.

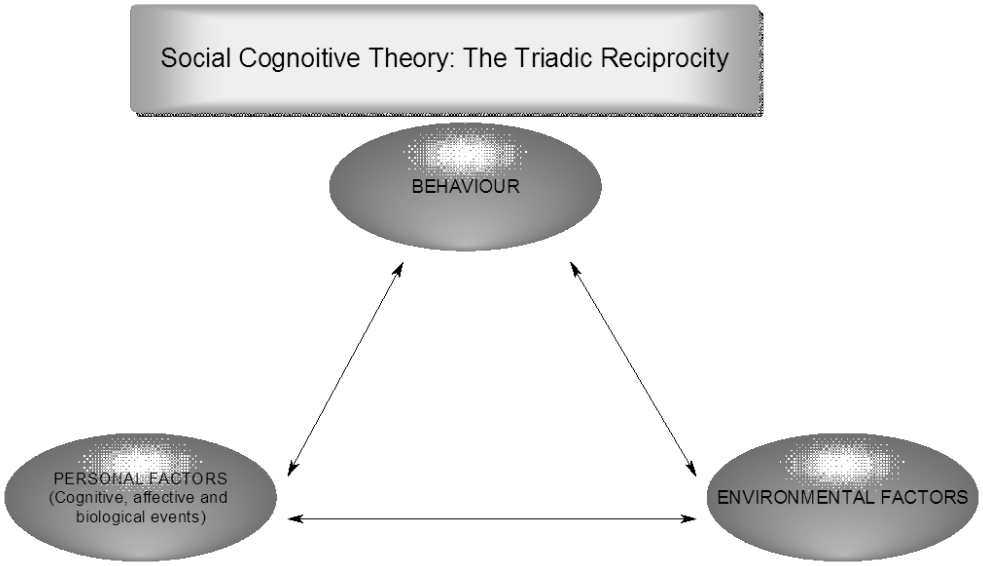
While nurse researchers concur about the importance of mentoring in promoting competence, critical thinking of inexperienced nurses, and career development of all nurses (Vance & Davidhizar, 1996; Vance, 2002; Vance, 2003 Vance 2007), the nursing profession and nurse researchers are yet to subscribe to any particular model of mentoring. The mentoring functions described by Scandura and Ragins can provide a suitable framework towards the development of a professional development and career advancement model that is relevant to nursing research. Not only will the model allow for accountability of every piece of the mentoring function received by mentees, it would also provide more specific information and promote clearer understanding of how each dimension of mentoring moderates the effects of mentoring outcomes. Such a model may help gain accurate understanding of the impact of mentoring on nurses' participation in professional development and career advancement.

Self-efficacy

Self-efficacy as a concept evolved from Albert Bandura's Social Cognitive Theory (SCT) of behavior (Bandura, 1977a). Bandura began his work in the field of Social Learning Theory (SLT) in the early 1960s before publishing his Social Cognitive Theory (Bandura, 1986). SCT asserts that learning occurs from a process of continuous reciprocal interaction- of personal,

behavioral and environmental factors- the triadic reciprocity which determines human behaviors and motivation (Crothers, Hughes, & Morine, 2008).

Figure 1. Social Cognitive Theory (SCT)



Bandura, 1982

Description of the triadic reciprocity of social cognitive theory. According to Bandura (1982), human motivation and achievement are a result of the interaction of the triadic reciprocity. Factors of the triadic reciprocity may occur concurrently or at different times, but personal and environment factors certainly influence human behavior. For example, an individual's performance at work can be influenced by their personal and environmental factors. Mentorship is conceived to have both personal and environmental factors that can influence behaviors of the nurse's engagement in professional development and career advancement. SCT emphasizes that teaching and learning are highly social activities and that the interaction with

learning sources, such as mentors, influences both the affective and cognitive development of learners (Bandura, 1982).

According to Zimmerman (2002), SCT includes four interrelated processes that affects human motivation toward life achievements. These are 1) self-observation that speaks to the observation of oneself as a souce of motivation. 2) self-evaluation, involving how an individual compares his or her current perofrmance with a desired goal, 3) self-reaction which discusses how the reaction to ones own performance can cause one to reevaluate themself to determine a course of action and lastly 4) self-efficacy that explains one's belief in his or her own ability to complete a given task (Zimmerman, 2002).

Self-efficacy is the "belief in one's capabilities to organize and execute the courses of action required for managing prospective situations" (Bandura, 1982, p. 122). An individual's perception plays an essential role in behavioral outcomes since there is personal efficacy in exercising influence over what is done and the outcome of the events (Bandura, 1982). An individual's level of confidence or perceived self-efficacy influences how that individual sets professional goals, influencing not only the initiation of behavior, the expended effort, and also the persistence of behavior in the presence of impediments (Bandura, 1982; Bandura, 1984). The concept of self-efficacy has been used in several arenas of research, such as smoking cessation, weight control, depression, academic achievement, and professional development. These studies explored how individuals choose what to engage in and how they utilize resources available to them (Buchanan & Likness, 2008; Heale & Griffin, 2009; Lin & Wang, 1997; Martin, et al., 2008; Pajares & Valiante, 1999; Pekmezi, Jennings, & Marcus, 2009; Weng, Wang, Dai, Huang, & Chiang, 2008). The findings from these studies have demonstrated the critical

importance of self-efficacy in life achievements. Generally, people will avoid activities they believe exceed their capabilities and engage in activities they judge themselves competent to handle (Bandura, 1977b).

Self-efficacy is identified as one of the most powerful motivational predictors of performance in almost any human endeavor (Busch, 1995). An individual's self-efficacy is a strong determinant of his or her effort, fortitude, and job performance (Heslin & Klehe, 2006). Bandura describes self-efficacy as a mediating mechanism with individual beliefs having an impact on expectations (Bandura, 1977a). Bandura (1977b) underscored the importance of differentiating between efficacy expectations and outcome expectations as individual's self-appraisal is a critical component of how they make decisions and what activities they select.. Efficacy expectation is the belief that a specific behavior will lead to a specific outcome. Outcome expectation is the belief in one's own ability to perform activities that would lead to an aspired outcome. For instance, an individual may believe that obtaining a doctoral degree would lead to more job opportunities, which represents efficacy expectation, whereas it is the individual's belief in his or her own ability to complete a doctoral education that is an outcome expectation. If individuals do not believe in their ability to complete a doctoral education, they may not pursue the course of action necessary to complete the task; thus there may be an efficacy expectation, but not outcome expectation. This nuance accentuates the need to distinguish "efficacy expectations" from "outcome expectations" in understanding self-efficacy theory (Appendix A). Efficacy and outcome expectations are different in that a person may believe that a particular course of action will produce certain outcomes. However, any doubts about whether they can perform the necessary activities could impede their ability take action or move forward (Bandura, 1977a). "A capability is only as good as its execution" (Bandura, 1982, p. 122).

Bandura (1984) also highlights the importance of differentiating between self-esteem and self-efficacy concepts. Although these concepts positively relate to task performance, they are empirically and conceptually distinguishable (Chen, et al., 2004). The distinctions on both variables fall along the lines of motivational and affective traits and states.

Self-efficacy is more closely related to motivational variables suggesting that how individuals judge their own capabilities arouses certain cognitive actions; whereas, self-esteem is more closely related to affective traits (e.g., how they feel about themselves) (Chen et al., 2004). In a study that explored the interrelationship of self-esteem and self-efficacy in predicting job performance within an organizational setting, Gardner and Pierce (1998), differentiated and clarified the relationship between the two concepts (Appendix B).

Bandura (1982) also discusses four sources of self-efficacy (Appendix C) that are important and relevant to understanding how individuals acquire the motivational will to learn, make appropriate decisions, and engage in challenging activities. They are: 1) mastery experience, 2) vicarious experience, 3) verbal or social persuasion, and 4) physiological and emotional states. Mastery experience involves how past success influences self-efficacy of future activities (Schyns & von Collani, 2002). Role modeling explains the vicarious source of self-efficacy through observation of others (Schyns & von Collani, 2002). Verbal or social persuasion speaks to the effect of verbal empowerment from a more experienced person to a mentee in increasing self-efficacy (Bandura, 1982). Conversely, rejection or disapproval of mentees' behavior can decrease self-efficacy through disempowerment (Bandura, 1982). The physiological and emotional sources of self-efficacy speak to how individuals judge their own

ability, strength, and vulnerability to dysfunction during a stressful or taxing situation (Bandura, 1982).

Although no study was found to have examined the influence of nurses' self-efficacy on career advancement, several studies explored the influence of self-efficacy on career advancement in other fields. Noticing the under-representation of women in leadership and professional roles, Hackett and Betz (1981) argued that women lack strong expectations of personal self-efficacy to many of the career-related behaviors, and thus, fail to fully realize their capabilities and talents in career pursuits. Following the above assertions, these researchers examined the influence of self-efficacy on a diverse array of career advancement opportunities between men and women. Their findings suggested a significant difference in the levels of self-efficacy related to gender, which corresponds with respondents' career choice, job growth, and satisfaction. Female respondents demonstrated higher self-efficacy for traditional female professions, such as social worker, secretary, and home economist. Concomitantly, male respondents demonstrated higher self-efficacy for male-dominated professions, such as engineer, accountant, and mathematician. Further, an Australian study found female academicians to be less confident than male academicians in research tasks, but more confident in teaching (Schoen & Winocur, 1988). Vasil (1992) reported that male faculty had higher self-efficacy than female faculty in developing research and thus conducted more research than their female counterparts. Female faculty in a female-dominated departments reported lower self-efficacy in developing research than women in a male-dominated academic environment, validating vicarious sources for developing self-efficacy.

The findings from the above studies demonstrate that self-efficacy is related to professional development and career advancement, and support the need to assess the influence of self-efficacy on nurses' participation in professional development and career advancement opportunities.

Conceptual framework for professional development and career advancement in nursing

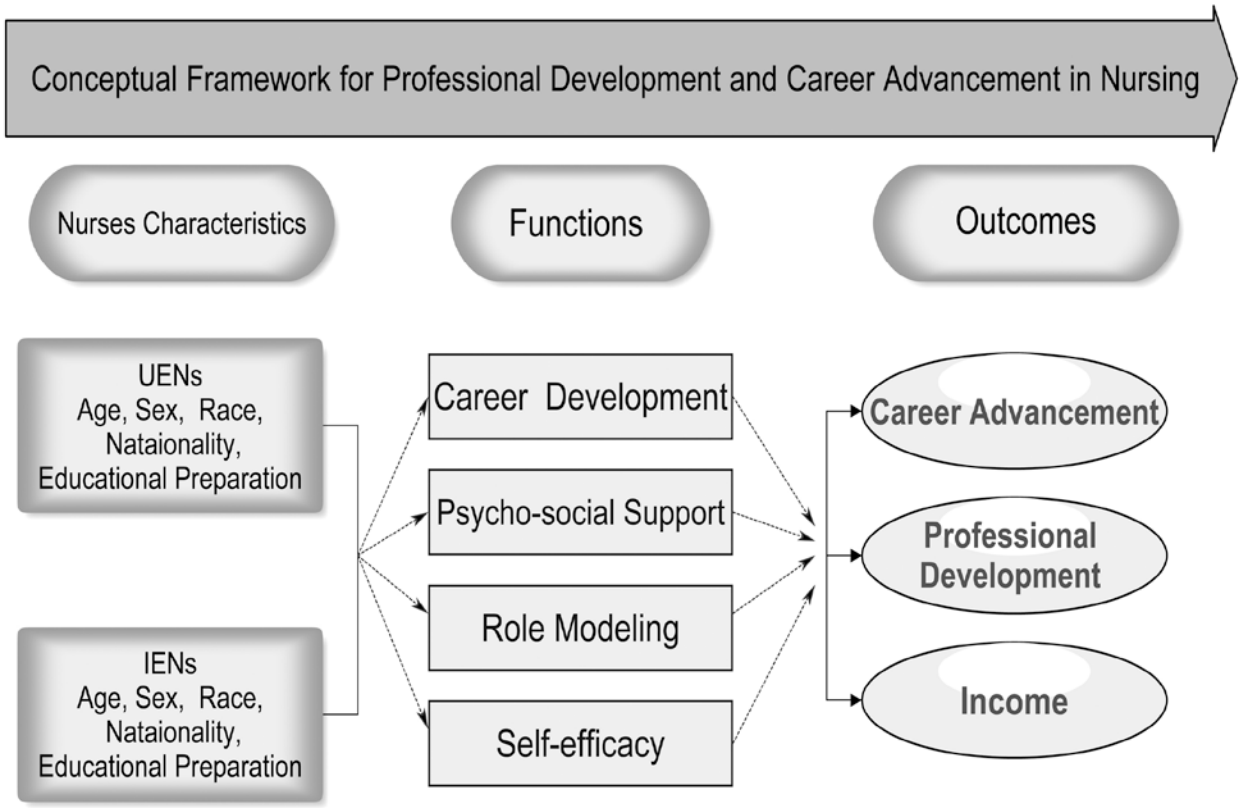
Social Cognitive Theory (SCT) contends that individuals learn from the observation of others in a shared social environment. Learning occurs if the role model is relevant, credible, and knowledgeable. Additionally, verbal persuasion and reinforcement are necessary to maintain learned behavior. In the context of mentoring, mentees benefit from mentors who have the expert knowledge, social reference, credibility, and authority which can lead to mentees' empowerment (Bandura, 1977a). Mentors can also provide verbal persuasion and reinforcements necessary to strengthen their mentees self-efficacy. Likewise, the absence of a mentor often has a negative influence on an individual's self-efficacy (Noe, 1988b). A self-efficacious individual, under the tutelage of a credible mentor should be able to progress professionally and realize career goals.

Figure 2 illustrates the conceptual framework use to guide this research study. Based on empirical evidence discussed above, this framework postulates that a relationship exists among nurses' demographic characteristics, the level of mentoring they receive, their self-efficacy and their accomplishments in terms of professional development, career advancement, and income. The framework applied the three mentoring functions proposed by Scandura and Ragins (1993) and self-efficacy component of the SCT.

According to the framework, nurses' demographic characteristics, such as gender, age, race, educational level and country of education, impacts the mentoring function received, and in

turn influences their level of self-efficacy. The level of mentoring received in each of the mentoring functions is directly correlated to the amount of professional development, career advancement, and income of the nurse. Higher mentoring in each of the mentoring functions would result in greater professional development, career advancement, and income and vice-versa. However, lack of mentoring in any of the three mentoring functions will adversely impact the outcomes of professional development, career advancement, and income. Likewise, the framework proposes that individuals with high level of self-efficacy will have greater professional development and career advancement and vice-versa.

Figure 2. Conceptual Framework



Source: Adapted from Scandura and Ragins, 1993 and Bandura, 1982

Summary of Literature Review

Excellence underscores the need for all nurses to engage in professional development. IENs will continue to be part of the U.S nursing workforce. It is important that research be conducted to learn why IENs progress more slowly through the career ladder compared to their UEN counterparts. It is also essential to learn how mentorship and self-efficacy influence the professional development and career advancement of all nurses. The reason that IENs are concentrated on the lower levels of the professional nursing career ladder may be related to lack of mentoring and/or lower self-efficacy, similar to the findings that women were under-represented in leadership and professional roles (Hackett & Betz, 1981). Mentoring theory suggests that mentors can help mentees develop a sense of competence, self-esteem, self-efficacy, and confidence required to increase their skills and progress professionally (Kram, 1983). Mentoring also enhances self-efficacy (Day & Allen, 2004). Although the influence of mentoring and self-efficacy on career advancement of nurses has been examined in separate studies, no study has explored the relationship of these two complementary concepts towards nurses' career advancement. This study has attempted to address the gap in the nursing literature.

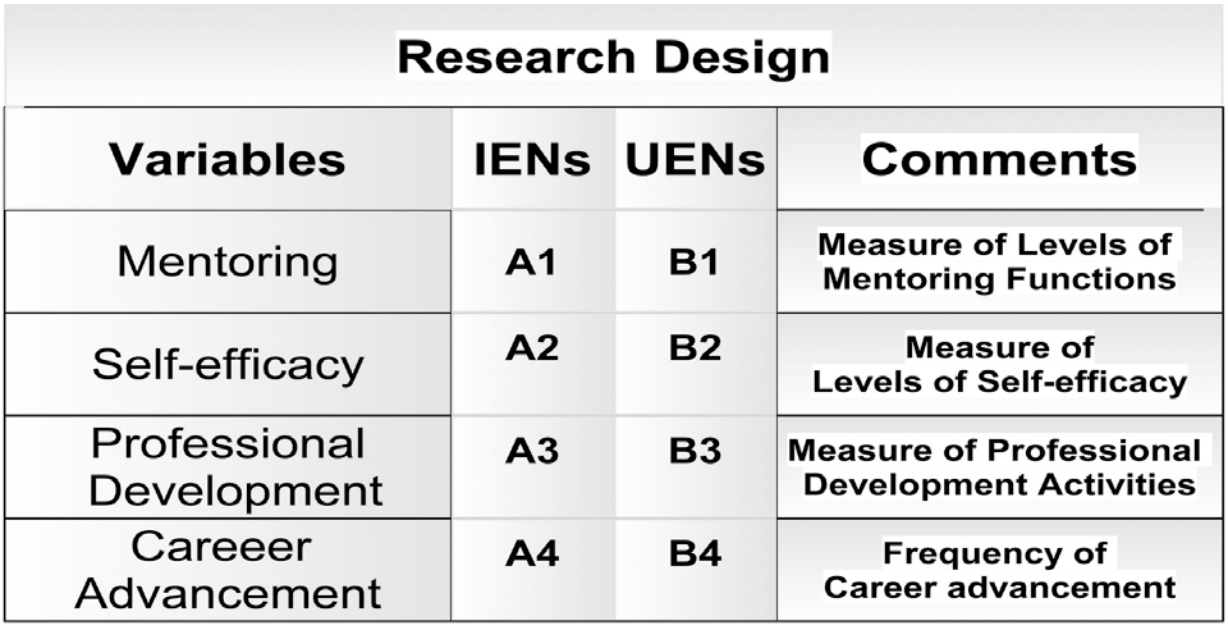
Chapter 3: Research Design and Methods

Research Design

This study used a descriptive-correlational survey design and content analysis of open-ended questions to examine differences in levels of mentoring functions and self-efficacy of internationally educated nurses (IENs) compared to nurses educated in the United States (UENs). It also explored the association among mentorship, self-efficacy, professional development and career advancement of both groups of nurses. A web-designed questionnaire was used to reach potential participants through an online survey.

A cross sectional design uses measurement at a single time point to draw conclusions from the research data. A schematic representation of the research design of this study is presented in Figure 3. The four dependent variable constructs-mentorship, self-efficacy, professional development, and career advancement-are tabulated under the variables column. The next two columns present the two groups in this study,Internationally Educated Nurses (IENs) and U.S. Educated Nurses (UENs). The comment column briefly explains the dependent variables. The notations A1-A4 and B1-B4 under IENs and UENs respectively signify the measurement of respective dependent variables at one time point during the study.

Figure 3: Research Design of This Study.



Procedural Assumptions for the Research Study

The underlying procedural assumptions of the study include, but are not limited to, the following:

1. Study participants will respond honestly to all questions posed in this study.
2. Study participants will provide accurate information regarding their mentorship experience, self-efficacy, demographic characteristics, professional development activities and career advancement.
3. Study participants will represent the U.S. nursing workforce

Sample

The sample size for this study comprised a total of 200 licensed RNs, UENs (n = 145) and IENs (n =55). Study's inclusion criteria included nurses who have practiced in hospitals located in the Philadelphia County of the Delaware Valley Region of the U.S. for a minimum of 3 years. These nurse participants were between 22 and 65 years old. Over 97% of licensed registered nurses in the U.S. are between 23 and 64 years (Auerbach, Buerhaus, & Staiger, 2007); thus this age range was selected in order to have participants reflect the actual age range of practicing nurses in the U.S. nursing workforce; the 3 year minimum practice experience requirement was utilized to be able to assess career advancement trajectory. Nurses generally advance through a career ladder between the first, second and third years of practice (Nelson & Cook, 2008; Nelson, Sassaman, & Phillips, 2008; Winslow & Blankenship, 2007). For the purpose of this study, UENs were defined as nurses who received basic nursing education within the United States, regardless of birth place, while IENs were nurses who received basic nursing education outside the United States, regardless of birth place. To participate, all study participants were comfortable with using the internet and able to speak, read, write and understand English. The reason for inclusion criteria of comfort with the internet is because the study is an online survey; and the English literacy requirement is because the study materials, including survey instruments, are written in English.

Inclusion Criteria for the participants are described as follows:

1. RNs actively practicing in an hospital located in the Philadelphia County of the Delaware Valley Region of the U.S. for a minimum of 3 years;
2. RNs between the ages of 22 and 65 years old;
3. RNs who completed basic nursing education outside the U.S. for IENs;
4. RNs who completed basic nursing education within the U.S. for UENs;

5. RNs must be comfortable using the internet;
6. RNs have willingness to devote a minimum of 30 minutes to an hour to complete the research surveys and questions;
7. RNs have the ability to speak, read, write, and understand English.

Exclusion Criteria were:

1. RNs not working as an RN in an hospital located in the Philadelphia County of the Delaware Valley Region of the U.S for a minimum of 3 years;
2. RNs is younger than 22 years and older than 65 years;
3. Excluded as a UEN if RN did not complete formal basic nursing education within the U.S;
4. Excluded as an IEN if RN did not complete formal basic nursing education outside the U.S;
5. RNs is not comfortable with using the internet
6. RNs not willing to devote a minimum of 30 minutes to an hour to complete the research surveys and questions;
7. RNs do not have the ability able to speak, read, write, and understand English.

Sample Size Estimation

The sample size required for this study was guided by a power analysis using the software program G*Power (Version 3.1, Dusseldorf, Germany).The analysis was based on a linear multiple regression analysis (MRA) that tested whether the three independent variables (i.e mentorship, self-efficacy, and region of education significantly predict the dependent/criterion variable-career advancement. Following the recommendation of Green (1991), the a priori analysis evaluated both: (a) the overall significance of the MRA model, and (b) the unique contribution of individual predictors. The significance level for both analyses was set to $p = .05$, as per standard scientific conventions. Small to medium effect sizes were postulated in keeping with Cohen's (1992) recommendations for MRA (i.e., both f^2 values = .10). The effect size is considered to be the smallest immediate effect that is clinically meaningful in the target

population for the outcome measure of, in this case, career advancement. In addition, power was set to .80, meaning there would be an 80% probability of reaching statistical significance if the predictors have an effect in the population.

In this study, for a significance level of alpha = .05 with an effect size of .10 to achieve a power of .80 with three predictor variables, a total sample size of 114 was required to evaluate the overall model; 81 subjects required to evaluate each individual predictor. The sample size of 114 was selected in order for the MRA to be sensitive to the least powerful comparison. Subjects will be stratified into two groups of 57 each: IENs and UENs.

It was anticipated that only one in three respondents would meet the inclusion criteria for this study based on evidence on web-research response rates (Cook, Heath, & Thompson, 2000; Kaplowitz, Hadlock, & Levine, 2004). To account for those who would be excluded from the study by not meeting the inclusion criteria, the number of participants needed for the study response would be open to 350 participants. The PI would monitor enrollment periodically to ensure that the total number of participants did not exceed 350. If the total number of eligible participants did not reach 114 at the 350 responses, an amendment to the IRB application was to be made to recruit additional subjects.

Measurement of Variables

The study used four distinct instruments in addition to an initial screening questionnaire. The initial screening questionnaire consisted of five questions with Yes/No responses related to the inclusion and exclusion criteria of the study. They are:

1) Are you an RN practicing in a hospital located in the Philadelphia County of the Delaware Valley Region of the U.S for the past three years?

2) Are you between the ages of 22 and 65 years?

3) Do you speak, read, write, and understand English?

4) Are you comfortable using the internet and willing to devote 35-minutes to an hour to completing this study?

5) Is this the first time you are completing this survey?

If the respondents answered No, to any of the above five screening questions, they were directed to exit the survey by clicking submit. If the respondents answered yes to the five screening questions, they were able to continue with the study survey that consists of a four multi-part questionnaire. See appendix D for the study questionnaires and screening questions.

Section 1: Mentorship instruments. The mentorship instruments encompass three sub-sections of the survey, 1A, 1B and 1C. The mentorship instruments help to identify participants who had a mentor during their nursing career. It also obtained some demographical information about the identified mentor, as well as information about the level of mentoring functions that that xparticipants received. (See Appendix D, Section 1). Section 1A is a*" yes" or" no"* screening question *that asks if participants have had a mentor.* Only participants who answered yes to section 1A were asked to complete Sections 1B and 1C. Participants who answered "no" to question 1A were classified as not having experienced a mentoring relationship in nursing and skipped questions 1B and IC. Section 1B: This is an investigator generated question that was used to gather the mentor's demographical information. Section 1C: This section of the survey uses the Scandura and Ragins (1993) 15-item multidimensional mentoring measure (items 3-17). It is a 5-point Likert scale instrument where participants are asked to indicate their agreements from response categories ranging from *strongly disagree = 1, to strongly agree* = 5. These items included statements about three mentoring relationship functions: 1) career development; 2)

psycho-social support; and 3) role modeling. Questions 3-6,8, and 16 represent the career advancement function of mentoring, questions 7, 9, 12, 14 and 17 represent the psycho-social support, and questions 10, 11, 13, and 15 represent the role-model functions of mentorship. The Scandura and Ragins scale measures the level of mentoring received by participants on the above three mentoring functions. Although this instrument has been used primarily in organizational research studies, the content focuses on general mentoring functions. Castro, Scandura, & Williams (in press) reported the tool to be highly reliable with a Chronbach's alpha = 0.93 and valid for content validity, concurrent validity, and convergent validity. Barker et al. (1999) also reported the tool to be highly reliable. The instrument has been used in Ireland and in the U.S. with replicated findings on the factor loadings (Barker et al.; 1999; Castro, et al., in press).

Section 2: New general self-efficacy scale (NGSE).

The NGSE was developed and validated by Chen, Gully, and Eden (2001). It is an 8-item, 5-point Likert type scale, with response categories ranging from *strongly disagree = 1 to strongly agree* = 5. This scale appears as survey item 18-25 and was used to measure the level of self-efficacy of the participants (see Appendix D, Section 2). The NGSE scale is suitable for this study, as it was developed using Eden's (2001) definition of general self-efficacy "one's belief in one's overall competence to effect requisite performance across a wide range of achievement situations" (p. 75). Reliability of the scale has been demonstrated in previous studies (Chen, Gully, & Eden, 2001). The short version of the NGSE scale has been reported to have internal consistency of the items ranging from .85 to .90. The stability coefficient ranges from r = .62 to r = .65. The NGSE scale has a high content validity from the findings of two independent college student studies with validity at 98% and 87% respectively. The NGSE is reported to have higher predictive validity compared to other general self-efficacy scales. In a hierarchical regression

analysis, the NGSE scale demonstrated a predictive relationship between previous and subsequent performances (Chen et al., 2004).

Section 3: Open-ended questions.

Two open-ended questions was used to gather narrative information about the positive and barrier factors that have influenced participants' engagement in professional development and career advancement (Appendix D, Section 3, questions 26-27). The qualitative data obtained from the responses to the two open-ended questions was used to complement the quantitative measures and provide additional information that would be used to guide the interpretation of the quantitative information.

Section 4: Demographic information. The demographic data questionnaire was an investigator-generated form designed to collect three forms of data (Appendix D, Section 4). This section was sub-categorized as sections 4A, 4B, and 4C. Participants responded to questions about socio-demographic characteristics (items 28-38) in section 4A, nursing education and professional development activities (items 39-52) in section 4B, and employment and financial information (items 53-72) in section 4C.

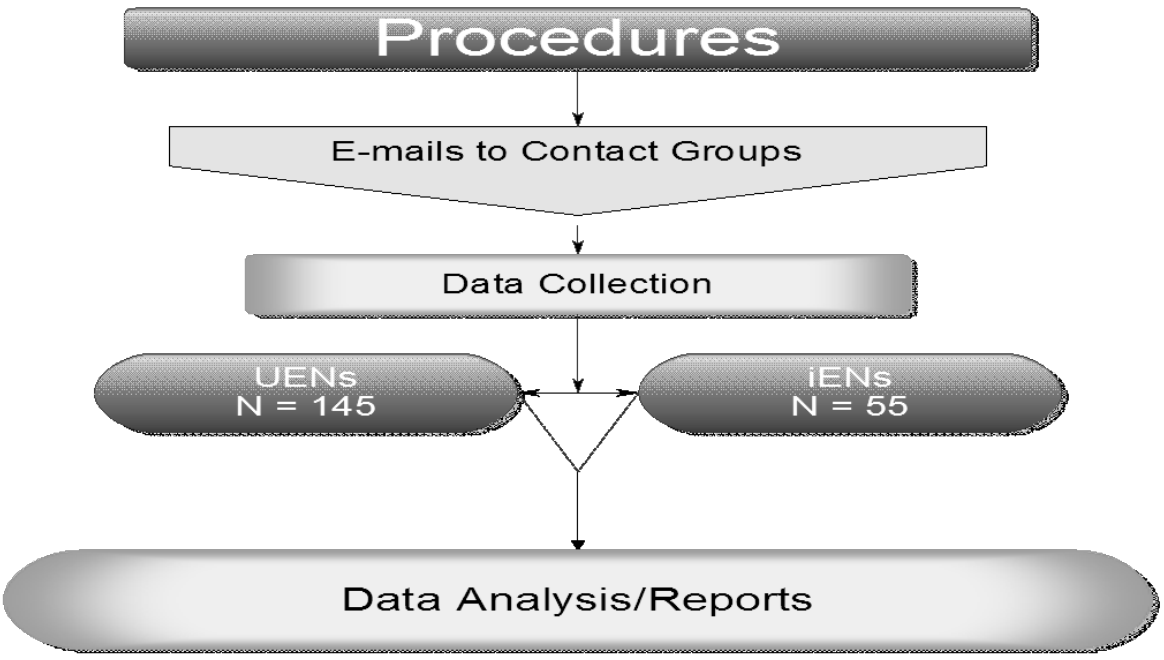
Procedures

Following authorization from the Institution Review Board (IRB), this study surveyed comparable numbers of IENs and UENs. Data was collected from participants through an online, web-based survey medium-Survey Monkey. Survey Monkey allows for spontaneous tally of responses and weekly reports of survey analyses, which were sent to the PI of the study via encrypted e-mails to provide updates regarding the progress of enrollment in the study. This was to ensure effective monitoring and compliance with standard human subject protection. The

online medium of the survey was preferred because of its economical value, ability to ensure anonymity, and rapid turnaround in data collection. Emails containing survey flyers and web-links to the website where the study's survey was hosted were distributed to registered nurses through the following mediums: local chapters of professional nursing organizations' list-serves, local nursing magazines' websites, local hospitals, and professional nursing organizations' websites, and any other RNs' list-serves that would reach and recruit study participants who would meet inclusion criteria. Weekly email reminders were sent to the list-serves requesting those who had not completed the survey to participate and those who had already taken the survey to forward the survey link to their colleagues. This was intended to create a snowball effect that could expedite the recruitment process. When potential participants accessed their emails that contained the survey link or clicked on the survey links that were hosted on hospital and professional nursing magazines' websites, they first saw and read a brief description of the study which included the average amount of time required to complete the survey. They then provided consent by clicking on the link that took them to the first part of the survey, which consisted of five screening questions related to the inclusion and exclusion criteria for the study. Only those who met the inclusion and exclusion criteria were instructed to proceed with the full study survey. Those who did not meet the criteria were instructed to submit the screening questions without proceeding further. After eligible participants submitted their completed study survey, they were re-directed to a raffle application. Interested participants had the option to enter their name, telephone number, and e-mail to be eligible for a raffle. To maintain respondents' anonymity, the raffle application was hosted on a separate database and was not linked to the original survey. An "honest broker" who was not a member of the research team was responsible for collecting the raffle application data and for selecting the five winners of the

one hundred dollar VISA gift cards. A total of 5 VISA gift cards, each in the amount of $100.00 available through a raffle draw was used as an incentive for nurses in the Philadelphia County of the Delaware Valley Region to participate in this study. The honest broker was also responsible for drawing the raffle and notifying the winners. The research team did not have access to the information from the raffle application. Figure 4 shows a diagrammatic representation of the survey procedure, Appendix E is the sample email letter to participants. Appendix F is the sample recruitment flyer, and Appendix G, is the sample raffle-draw application. Appendix H is the sample letter requesting hospitals, professional associations, and local magazines to email the survey links to their nurses and host the survey link on their organizations' intranet. Appendix I , J and K are sample support letters from organizations that agreed to host the survey link on their respective websites or e-mail the link to their nurses. Appendix L is sample of the notification letter that the honest broker sent to the five winners of the one hundred dollars VISA gift cards.

Figure 4: Procedure Diagram



Data Management and Analysis

The PI was responsible for collection and management of all research data. After initial collection, data was transferred from the online survey into a secured computer intended for research purposes only. The statistical package SPSS-PC 18.0 (Chicago, IL) was used to perform the statistical tests on the three research hypotheses. Descriptive statistics were obtained for demographic characteristics and survey measures. These included frequency and percentage estimates for categorical variables, measures of central tendency (mean, medians), measures of variation (standard deviations, interquartile range, range) and derived moments of skewness and kurtosis for continuous variables. Data was checked to meet the assumptions of normal distribution and parametric statistics. Outliers were assessed by visual inspection of the distribution of the dependent variables and excluded from the final analysis. T tests for continuous data and chi square analyses for categorical data were conducted to compare demographic variables to ensure that groups would be similar demographically.

Specific Aim 1: *Determine the differences in the level of mentorship functions and self-efficacy between UENs and IENs*

Hypothesis 1: IENs will report a lower level of mentorship functions and self-efficacy compared to UENs.

Statistical Test: An independent sample test was conducted to test the differences in mentorship functions and self-efficacy between groups of UENs and IENs.

Specific Aim 2: *Determine the differences in levels of participation in professional development activities and career advancement opportunities between IENs and UENs.*

Hypothesis 2: IENs will demonstrate fewer professional development activities and less career advancement opportunities compared to UENs.

Statistical Test: Chi-square analyses were conducted to compare differences between UENs and IENs for professional development activities and career advancement opportunities for categorical variables. Independent t tests were used to assess differences of professional development and career advancement between the groups of nurses for continuous variables.

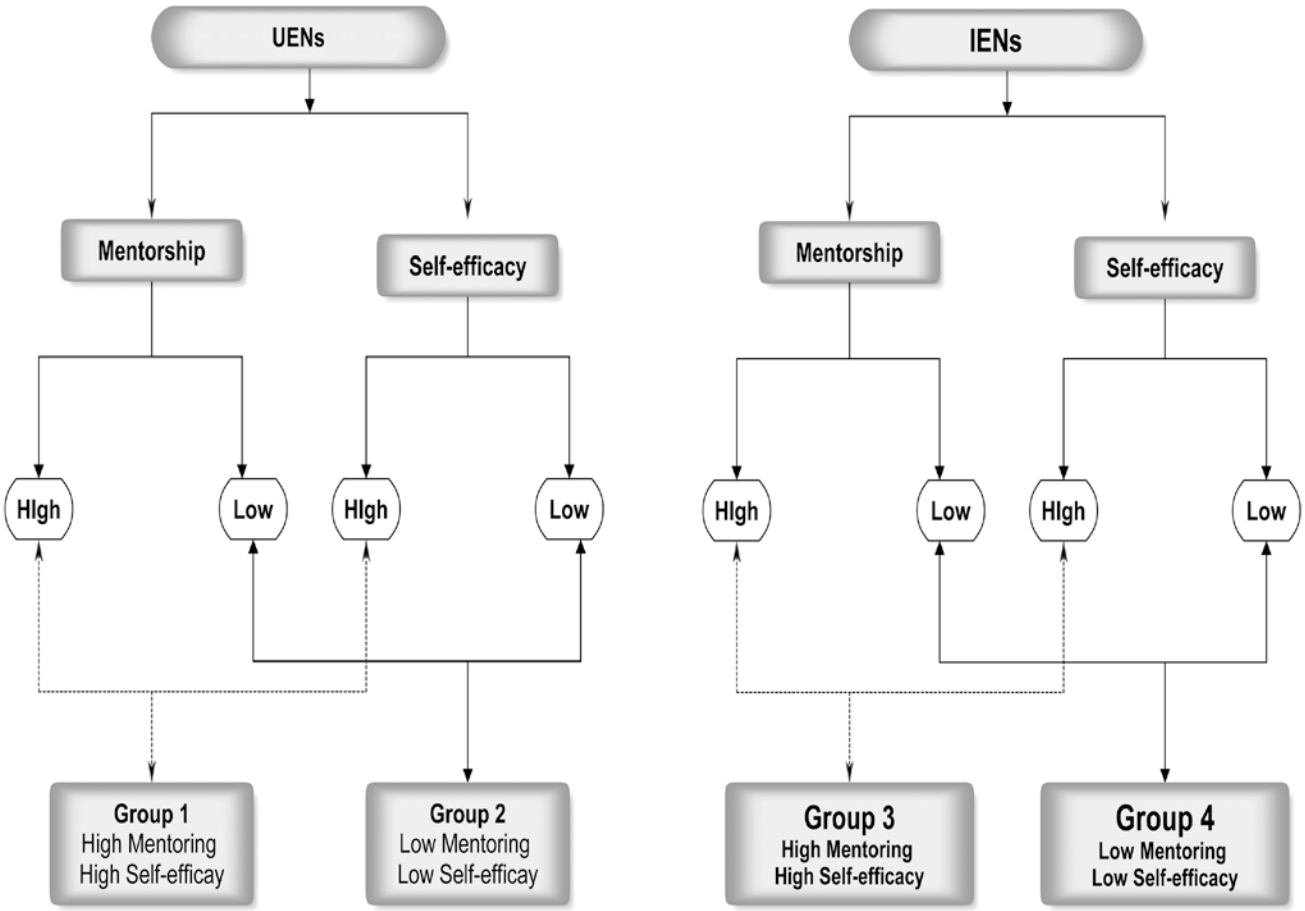
Specific Aim 3: *Explore the relationship of mentorship and self-efficacy with Career Advancement in both internationally and U.S. educated nurses.*

Hypothesis 3: The association of mentorship and self-efficacy will be different between UENs and IENs.

Statistical Test: Linear multiple regression analyses were conducted to assess whether the combination of mentorship, self-efficacy, and region of education (UEN vs. IEN) can predict levels of Career Advancement in nurses. Annualized income and hourly income were used as a criterion for separate regression analyses. The final variable representing career advancement was number of times promoted through the career ladder. Before testing this variable, the sample was stratified into groups based on levels of mentorship, self efficacy and region of education. The median score for mentorship and self efficacy in each group was used as a cut off for the stratification. Participants with scores below the median were classified as having low level of mentorship and self-efficacy while participants with median scores and higher were classified as having high level of mentorship and self efficacy. Figure 5 below provides a diagram of the stratification based on sample median values. The four groups created from the stratification were: 1) UENs with high level of mentorship

and high level of self-efficacy, 2) UENs with low level of mentorship and low level of self-efficacy, 3) IENs with high level of mentorship and high level of self efficacy, and finally 4) IENs with low level of mentorship and low level of self efficacy. A chi square analysis was used to compare the groups and to test whether the combination of mentorship, self-efficacy, and region of education (UEN vs. IEN) was related to number of times participants advanced through the professional career ladder. Level of significance for all tests is set at alpha = 0.05.

Figure 5: UENs & IENs Stratified by Levels of Mentorship & Self-Efficacy.



Analysis of two open-ended questions. Participants' responses to the two open-ended questions were analyzed using content analysis research methodology. Content analysis is a flexible research method used for analyzing text data (Cavanagh, 1997). It includes both the quantitative and qualitative approach to data analyses (Graneheim & Lundman, 2004; Jinks & Chalder, 2007, Kondracki, Wellman, & Amundson, 2002). Kondracki, Wellman, & Amundson (2002) defined content analysis as "a set of qualitative and quantitative methods for collecting and analyzing data from verbal, print, or electronic communication" (p. 224). According to Duncan (1989), content analysis lies at the crossroads of quantitative and qualitative methods of research. Content analysis entails a process where text data are systematically and objectively described and quantified (Downe-Wamboldt, 1992; Elo & Kyngäs, 2008; Krippendorff, 2004). The process allows quantitative analysis of qualitative data (Smith, Heady, Hamilton, & Phillips, 1996). In order to accomplish quantitative content analysis of qualitative data, objective inferences are made out of subjective information through coding of text, visual images, or any other forms of communication (Elo & Kyngäs, 2008; Kondracki et al., 2002; Smith et al., 1996).

The basic or meaning unit of analysis in content analysis consists of variables within the study that are recorded, categorized, coded, or analyzed. Examples of unit of analysis include: individual participants; groups of participants; an organization, a classroom; a community; a state or county; part or full records of interviews, diaries of collected data for a study or parts of the texts that have been abstracted and coded (Graneheim & Lundman, 2004; Rourke, Anderson, Garrison, & Archer, 2000). For this study, each participant response to the two open ended questions constituted the unit of analysis.

The process of content analysis is not linear, as analysis involves a back and forth process. The approach may be inductive or deductive and manifest or latent. Researchers may use the inductive and deductive approach simultaneously (Hsieh & Shannon, 2005; Kondracki et al., 2002). With inductive approach, data are examined without any pre-conceived notions about categories or codes to be found in the data to be analyzed. Inductive content analysis is used when there is little knowledge about the phenomenon of study. Analysis moves information from a specific area of knowledge found in the data to the general (Elo & Kyngäs, 2008). This is in contrast to a deductive approach that allows researchers to have pre-conceived categories or codes about the data to be analyzed (Elo & Kyngäs, 2008; Kondracki et al., 2002). Deductive approach is used to test existing data in a new context or to test categories, concepts, or hypothesis that other researchers have put forth. Data are interpreted from the general information found in the literature to the specific information found in the study data that is being analyzed (Catanzaro, 1988; Elo & Kyngäs, 2008). The inductive approach was appropriate to analyze the open-ended questions because of the explorative nature of this study where little evidence exists in the literature to support any pre-conceived subthemes or themes for analysis testing.

The manifest strategy of content analysis describes research data at the surface level, analyzing only the information present in the data (Downe-Wamboldt, 1992; Graneheim & Lundman, 2004; Kondracki et al., 2002). It is the obvious and visual content abstracted from the data (Downe-Wamboldt, 1992; Krippendorff, 2004; Polit & Hungler, 1999). In contrast, latent strategy interprets data in the context of the data source and other variables, taking into consideration the underlying meanings of the texts (Downe-Wamboldt, 1992; Graneheim & Lundman, 2004; Kondracki et al., 2002). The researchers of this study used the manifest content analysis. The manifest approach was deemed appropriate since the purpose of the open-ended questions was to

complement and serve as a context for interpreting the quantitative results of this study. Thus, the study used the inductive-manifest content analysis approach to analyze the feedback to the two open-ended survey questions.

Objectivity and Rigor in Analyzing the Open-ended Questions

The Primary Investigator, (PI) used the following procedures to assure objectivity and rigor of the analyses of the responses to the two open-ended questions. Using the inductive-manifest content analysis strategy, the PI reviewed the reponses by classifying each meaning unit into subthemes, and subsequently themes, and worked conscientiously to achieve objectivity during the coding process. Objectivity is important in qualitative research and refers to the standardized process by which coded categories are achieved (Kolbe & Burnett, 1991). Coded categories that were derived from using an objective approach served as a condensed representation of the facts described in the data (Seidel & Kelle, 1995). To enhance objectivity, themes and subthemes were operationally defined to facilitate accurate and reliable coding of the responses to the open-ended questions (Kolbe & Burnett, 1991). The definitions for each subtheme and theme, as identified by the PI, were based on an extensive review of the literature. During the coding, the PI ensured that: 1) a subtheme provided an unambiguous representation of a segment of the meaning unit that it represented; 2) a particular subtheme was used consistently where applicable; and 3) all meaning units that could be associated with a particular subtheme were identified and counted. Subthemes were eventually condensed to derive the emergent themes of the study.

Following this exercise, the PI's chair evaluated the enitre meaning unit and its coding into subthemes and themes, including the definitions of each subthmene and theme. Afterwards,

the PI and chair met to review and finalize the subthemes and themes via consensus. After reaching consensus on the subthemes that were agregated to themes, they counted the number of times each subtheme was coded in the data in each group for the positive and barrier factors.

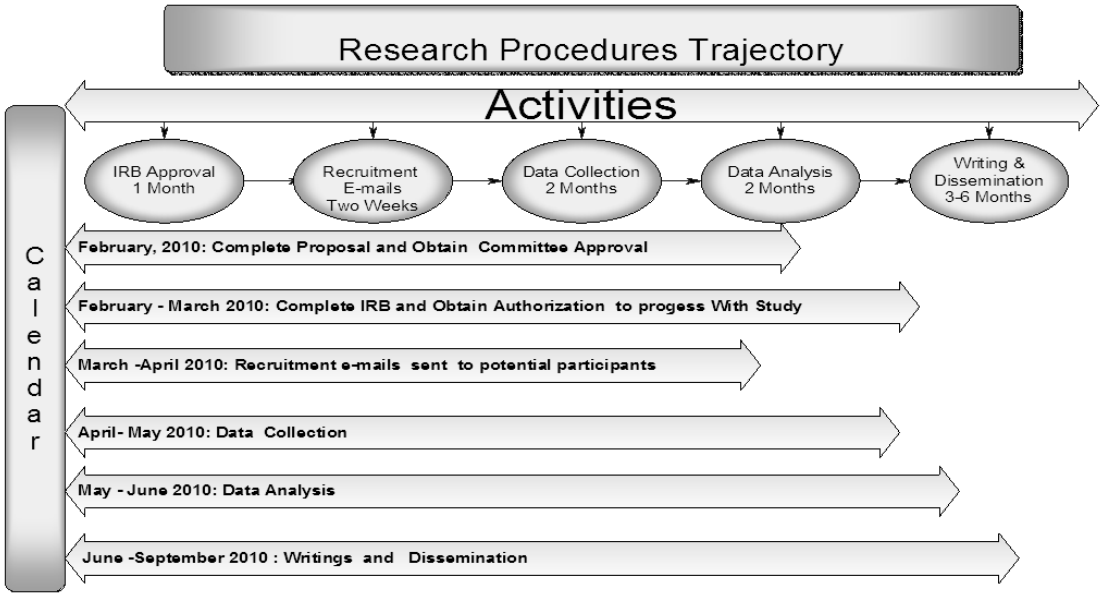
A triangulation strategy was used to verify and validate the subthemes and themes and the number of times each subtheme appeared in the entire data. An independent external expert qualitative researcher also reviewed this process to enhance the internal validity (Barbour, 2001; Mays & Pope, 1995; Seale & Silverman, 1997). Triangulation describes a technique whereby two known or visible points are used to plot the location of a third point (Knafl & Breitmayer, 1989). It is an approach to data analysis in which evidence is deliberately sought from independent sources (Barbour, 2001, Mays & Pope, 1995). Investigator triangulation decreases the potential of bias in gathering, reporting, and analyzing data by opening the coding process to scrutiny to other researchers, thereby keeping it honest and objective (Lincoln & Guba, 1985; Thurmond, 2001). Triangulation has been used extensively for various purposes in research and credited for its contribution to the body of knowledge found in the literature. For example, Risjord, Dunbar, and Moloney, (2002) reported the benefit of methodological triangulation in yielding completeness in studies where qualitative findings offer details to supplement quantitative research findings, thus providing knowledge that would otherwise be unavailable from one research method alone. Methodological triangulation adds completeness, abductive inspiration, and confirmation to research findings (Knafl & Breitmayer, 1991; Risjord et al., 2002). Along the same lines, researchers speak to the benefits of triangulation in validating findings of qualitative research studies. For example, Barbour (2001) reported that triangulation could address concerns of internal validity by confirming findings through corroboration and refinements or refuting through rejection of findings.

For this study, an investigator triangulation approach was used where the three coders confirmed the data coding among themselves without engaging in any prior discussions (Thurmond, 2001). In this analysis, the PI, who is also the primary researcher, first reviewed each response to the open-ended questions, line by line, ensuring objectivity. Next, the meaning units were condensed, coded, labeled, and organized into subthemes and eventually themes. After the PI and Chair completed the coding and classification into subthemes and themes, the chair and PI's committee evaluated the enitre meaning unit and its coding into subthemes and themes, along with the definitions of each subtheme and theme. Afterwards, the PI and the chair met to review the findings, corroborating the subthemes and themes via consensus.

Once the PI and the chair reached consensus on the subthemes and themes, the coded data and definitions of subthemes and themes were sent to the external qualitative researcher for further validation. This process of cross-checking and verification by multiple analysts served to amplify and increase both the validity and the reliability of the findings (Banik, 1993).

After receiving feedback from the external qualitative researcher, the PI and the Chair made a final review of the data to resolve any contradictions with the external qualitative researcher to reach a final consensus. The corroboration of the subthemes and themes to reach a consensus between the PI, the chair and the external qualitative researcher, demonstrated methodological rigor and established a level of inter-rater reliability (Barbour, 2001; Brookes, 2007; Patton, 1999).

Figure 6: Planned Study Trajectory



Human Subjects Research

Registered nurses who are between the ages of age 22 years to 65 years. are not considered a vulnerable population by the criteria established by the human subjects regulation. However, appropriate precautions were taken to ensure protection of human subjects. Authorization for the study was obtained from the Drexel University Institutional Review Board (IRB) before collecting data from participants. Protective measures were taken to ensure confidentiality and participants' anonymity. This study used an online data collection strategy (Survey Monkey) to gather data from professional nurses, age 22 to 65 years, who are practicing in hospitals located in the Philadelphia County of the Delaware Valley Region of the U.S. It was estimated that the sample would be representative of the demographic composition of the nursing workforce of the Philadelphia County hospitals or the U.S. Nursing workforce. In 2008, the U.S. nursing workforce was comprised of 83.2% non-Hispanic Whites, 3.6 % Hispanic/Latino,

5.4% Blacks/African Americans, 5.8% Asians, Native Hawaiian or Pacific Islander; 0.3% American Indian/Alaska Native, and 1.7% two or more races (Health Resources and Services Administration (HRSA), 2010). In the U.S. approximately 6% of nurses are men and 94% women with the mean age of 44 years (Buerhaus, Auerbach, & Staiger, 2009). The criteria to participate in the study included having an active license to practice nursing in the U.S. and experience as a registered nurse in the U.S. for a minimum of three years. Regardless of place of birth, nationality, ethnicity, race or any other demographic variable, only participants who had their basic nursing education outside the U.S. qualified as IENs, and those who had their basic nursing education in the U.S. qualified as UENs. Other study inclusion criteria included the potential participants' comfort with using the internet, willingness to devote a minimum of 30 minutes to an hour to complete the survey questions, and age range between 22 and 65 years of age, reflecting the age of the U.S. nursing workforce. Proactive steps were taken to address ethical issues that are associated with online data collection. These included ensuring appropriate consent and security mechanism for online data collection, protection of participants' privacy, maintaining cyber security of survey site, as well as for the PI's and research team's personal computers. Each research team member's personal computer is password protected. Cyber security measures, such as password and McAfee network firewalls and virus protection were taken against all three forms of potential data security issues, such as unauthorized internal access to data, external access to data, and malicious intent to destroy data and computer systems (Whitehead, 2007). Emails containing survey flyers and web-links to the website where the study's survey was hosted were distributed to registered nurses through mediums such as: professional nursing organizations' list-serves, local nursing magazines, hospitals, professional nursing organizations' websites, and any other RNs' list serves that would reach and recruit

study participants who would meet the inclusion criteria. Weekly email reminders were sent to the list-serves requesting those who had not completed the survey to participate and those who had already taken the survey to forward the survey link to their colleagues.

Data source. All study information is self-reported.

Potential risk. The risk for this study was minimal. The probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life, during the performance of a routine physical or psychological examination or test, or the potential risk of invasion of privacy by working with a public acessible computer. The risk of possible privacy invasion from a public computer was addressed by recommending that particpants use a private or personal computer. If they must use a publicly accesible computer, they were asked to clear the browser history post survey completion.

Inclusion of women and minority subjects. There is no exclusion for women or minorities. It is estimated that the sample was a representation of the demographic composition of the nursing workforce of nurses who are practicing in the Philadelphia County of the Delaware Valley Region or the U.S. nursing workforce. In 2008, the U.S. nursing workforce comprised of 83.2% of non-Hispanic Whites; 3.6 % Hispanic/Latino; 5.4% Blacks/African Americans; 5.8% Asians, Native Hawaiian, or Pacific Islander; 0.3% American Indian/Alaska Native; 1.7% two or more races (HRSA, 2010). Nursing workforce statistics indicate 6% of nurses to be men and 94% women (Buerhaus, et al., 2009).

Inclusion of children. The population of interest is registered nurses licensed to practice in the U.S., this requirement excludes children without any form of discrimination to them.

Compensation to participants. All participants were eligible to win one of five VISA gift cards in the amount of $100.00 by completing both the study survey, as well as a second survey collected for the purpose of the raffle drawing. An honest broker drew the raffle from the information provided on the second, separate survey. To maintain respondents' anonymity, the survey that collected participants' personal information for the raffle drawing was hosted on a separate database, not linked to the original survey. The study research team did not have access to the information on the second survey.

Summary of Research Design and Methods

This study used a descriptive-correlational survey design and content analysis of open-ended questions to examine differences in levels of mentoring functions and self-efficacy of internationally educated nurses (IENs) compared to nurses educated in the U.S (UENs). It also explored the association among mentorship, self-efficacy, professional development, and career advancement of both groups of nurses. The sample size comprised a total of 200 licensed RNs, UENs (n = 145) and IENs (n =55). The study's inclusion criteria included nurses who have practiced in hospitals located in the Philadelphia County of the Delaware Valley Region of the U.S. for a minimum of 3 years. The study used four distinct instruments in addition to an initial screening questionnaire. The four distinct instruments were: a 15-item multidimensional mentoring measure developed by Scandura and Ragins (1993), the New General Self-efficacy Scale (Chen et al., 2001), an investigator developed questionnaire to gather information on

demographics, professional development, and career advancement, and a set of open-ended questions to complement the quantitative measures.

Following authorization from the Institution Review Board (IRB), data was collected from participants through an online survey medium. After initial collection, data was transferred from the online survey into a secured computer intended for research purposes only. The statistical package SPSS-PC 18.0 (Chicago, IL) was used to perform the statistical analyses of the three research hypotheses. Descriptive statistics were obtained for demographic characteristics and survey measures. They included frequency and percentage estimates for categorical variables, measures of central tendency (mean, medians), measures of variation (standard deviations, interquartile range, range), and derived moments of skewness and kurtosis for continuous variables. Data was checked to meet the assumptions of normal distribution and parametric statistics. Outliers were assessed by visual inspection of the distribution of the dependent variables and excluded from the final analysis. T tests for continuous data and chi square analyses for categorical data were conducted to compare demographic variables and test the first two research hypotheses. Separate multiple regression analyses and chi square tests were performed to test the third analyses. Participants' responses to the two open-ended questions were analyzed using an inductive-manifest content analysis research methodology. Standard procedures were used to code the data to meaning units, subthemes and eventually themes. Findings of the open-ended questions were triangulated among investigators and crosschecked with an independent external expert qualitative researcher for objectivity and rigor of the analytical findings.

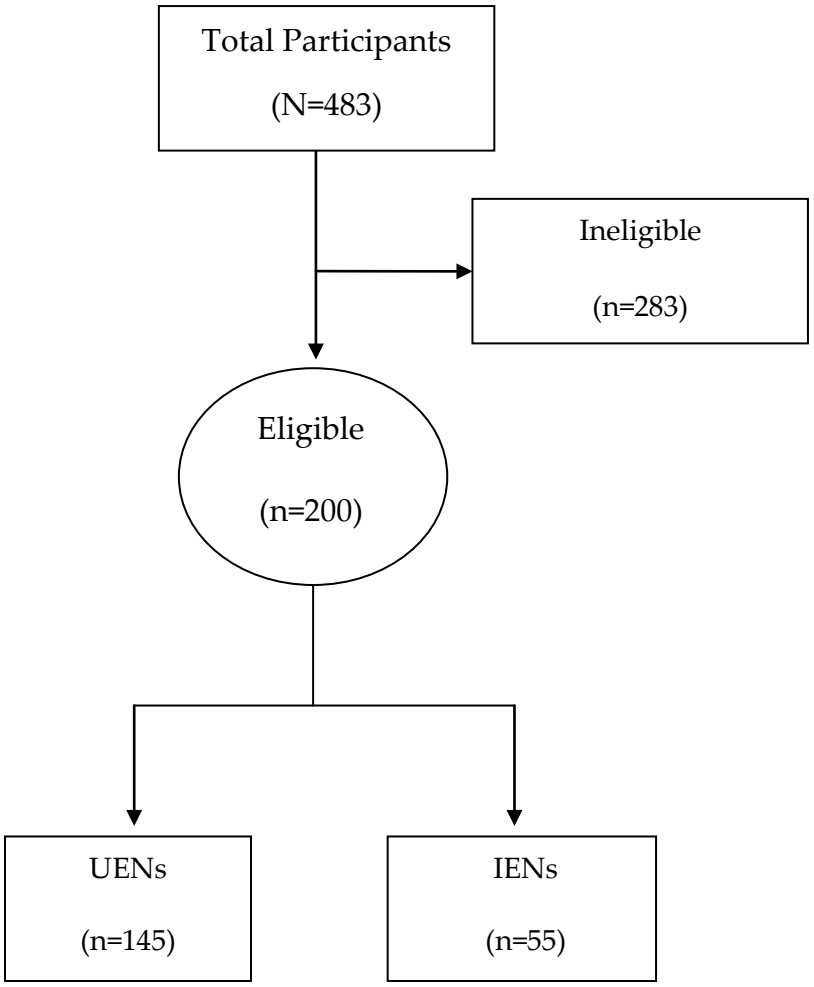
Chapter 4: Results

This chapter presents the results of this study. A brief overview of the online survey response is discussed, followed by a comprehensive description of the socio-demographics of the study population. Thereafter, the results are presented on the analytic testing of each of the research hypotheses and content analysis of the open-ended questions.

Survey Response

Figure 6 shows the participant flow chart for this study. A total of 483 nurses initiated the online survey. Of these, 210 respondents met the inclusion criteria of the study and proceeded to take the full survey. The other 273 respondents were prompted to submit the survey completed to that point without further responses and were excluded from the study. Eligible responses were then gleaned for missing data, and individual responses with more than 10% missing data were excluded from the analysis (Wittman-Price & Bhattacharya, 2009). A total of 200 were eligible for further analyses. Among these, most (n = 145) were U.S. educated nurses (UENs), while the rest (n = 55) were internationally educated nurses (IENs). For any missing data among the eligible participants, a pair wise deletion approach was adopted, whereby all available data from the subjects were used in the analyses. If the subject had missing data for a particular variable, the person was excluded from the analyses involving that variable, but considered in analyses involving other variables. The relatively low response rate among the IENs was in large part reflective of the percentage of IENs in the US nursing workforce; however it could also be attributed to their being less familiar with electronic media. The survey was kept open for an additional two weeks to the IENs until the total 55 responses were received.

Figure 7. Participant Development Flow Chart



Socio-demographic Characteristics

The socio-demographic characteristics of all the participants are summarized in Table 1. In those instances where data were missing, statistics were reported for available data. U.S. educated nurses (UENs) were middle aged (Mean = 41 years, *SD* = 10.6), predominantly Caucasian (*n* = 110,

77%) and women (*n* = 130, 91%). Almost all identified themselves to be Catholic (*n* =125, 97%), and were either married, living with a significant other (*n* = 99, 68%) or single, divorced or widowed (*n* = 46, 32%). At the time of participation, IENs were similar in age (Mean = 42.4 years, *SD* = 10.3) to the UENs (Mean = 41, *SD* = 10.6), but had significantly more number of men (*n* = 11, 20%) compared to women (*n* = 44, 80%). IENs were more diverse in religious affiliation and reported more non-Catholics (*n* = 6, 11%) compared to UENs (*n* = 4, 3%). IENs in this study were mostly Asians (*n* = 46, 87%) while majority of UENs were Caucasian (*n* = 110, 77%). More of the IENs were married or living with a partner (*n* = 46, 84%) while one third of UENs reported being single, divorced or widowed (*n* = 46, 32%). Many more IENs had dependents at home (*n* = 42, 79%) compared to UENs (*n* = 82, 57%). The number of dependents at home was also significantly different. On average, UENs had two dependents (*SD* = 1.4) living with them; while IENs had three dependents (*SD* = 2) at home. Just over half the UENs (*n* = 80, 57%) indicated having a B.S. in nursing at the time of taking the NCLEX compared to three out of four IENs (*n* = 42, 76%). As far as work experience as a nurse was concerned, IENs had an average of 19.3 (SD = 8.6) years of work experience compared to an average of 16.1 (*SD* = 10.3) years of work experience of UENs. With respect to experience specifically working in the US as a nurse, UENs had worked around 15.3 (*SD* = 10.4) years compared to IENs at 11.8 (*SD* = 10) years. Both groups showed similar levels of satisfaction with their job and had access to a formal career ladder system at their workplace. Both groups also had held their current jobs for similar duration of time. However, significantly more number of IENs (*n* = 40, 72%) held licensure at another state compared to UENs (*n* = 57, 39%). As shown in Table 1, an independent t-test revealed that the two groups were not statistically different for age (*p* = 0.40) and years worked at their current position (*p* = 0.26), but significantly different for years of overall work experience (*p* = 0.04), work experience in the U.S. (*p* = 0.04) and number of dependents at home (*p* = 0.04). A chi-square test comparing the other socio-

demographic characteristics revealed that the two groups were similar for presence of a formal career ladder, and job satisfaction. However, gender, ethnicity, religious affiliation, education, marital status, dependents at home, and licensure in another state were significantly different between the two groups.

Table 1. Socio-demographic Characteristic of the Participants (N = 200)

Variable	UEN n = 145	IEN n = 55	p value
	Mean (SD)		
Age	41 (10.6)	42.4 (10.3)	0.4
Years worked as a nurse	16.1 (10.3)	19.3 (8.6)	0.04*
Years worked as a nurse in US	15.3 (10.4)	11.8 (10)	0.04*
Years employed at current position	6.2 (5.7)	7.6 (7.7)	0.26
No. of dependents at home	2 (1.4)	3 (2)	0.04*
	Frequency (%) **		
Gender			0.05*
Female	130 (91%)	44 (80%)	
Missing	2	0	
Ethnicity			0.001*
African-American	17 (12%)	4 (8%)	
Asian	15 (10%)	46 (87%)	
Caucasian	110 (77%)	3 (5%)	
Multi-racial	2 (1%)	0(0%)	
Missing	1	2	
Religion			0.03*
Catholic	125 (97%)	46 (89%)	
Other	4 (3%)	6 (11%)	
Missing	16	3	
Marital Status			0.03*
Single, Divorced or Widowed	46 (32%)	9 (16%)	
Married, living with significant other	99 (68%)	46 (84%)	
Education at time of NCLEX			0.04*
Diploma	23 (16%)	8 (15%)	
Associate's	35 (25%)	5 (9%)	
Bachelor's	80 (57%)	42 (76%)	
Master's	3 (2%)	0 (0%)	
Missing	4	0	
Job Satisfaction			0.22
Extremely/somewhat Satisfied	80 (55%)	24 (45%)	
Satisfied	51 (36%)	28 (50%)	
Extremely/somewhat Dissatisfied	14 (9%)	3 (5%)	
Formal Career ladder at work place	128 (89%)	51 (92%)	0.42
Missing	1	0	
Licensed in another state	57 (39%)	40 (72%)	0.001*
Dependents			0.004*
Yes	82 (57%)	42 (79%)	
Missing	1	2	

*$p < 0.05$

** Percentages were calculated based on eligible data.

Specific Aims

Specific Aim 1: *Determine the differences in the level of Mentorship and Self-efficacy between UENs and IENs.*

Hypothesis 1: IENs will report a lower level of mentorship and self-efficacy compared to UENs.

The study measured the level of mentoring received by participants on three mentoring relationship functions: 1) career development; 2) psycho-social support; and 3) role modeling. The study used the Scandura and Ragins (1993) 15-item multidimensional mentoring measure, which is a 5-point Likert scale instrument where participants are asked to indicate their agreements from response categories from *strongly disagree = 1* to *strongly agree* = 5. Higher scores indicate stronger agreement. The Reliability Coefficient (Cronbach's Alpha) for the mentorship and self-efficacy instruments were computed to determine the internal consistency reliability of the items that were aggregated to derive the scores. Internal consistency reliability is a useful measure as it is a reflection of the correlation among items and the correlation of each individual item with the total score. As with other correlational statistics, this index ranges from 0.00 to 1.00. A value that approaches 0.90 is considered high, and the scale can be considered reliable (Portney & Watkins, 2009). Results from the data analysis of this study indicated a Chronbach's alpha of 0.88 for the Mentorship scale and 0.94 for the Self-efficacy scale. Therefore, for the current study, both the scales were highly reliable.

Before conducting data analysis, the data were tested and found to meet the assumption of parametric statistics. These were: a) independent observation, b) continuous level data, and c) normal distribution. Consequently, an independent t-test was appropriate. Results from the

comparison are summarized in Table 2. The first hypothesis was only partially supported by the results. No statistically significant differences were noted between the groups for Career Development ($p = 0.80$) and Psycho-social Support ($p = 0.90$); however, the score of the function of Role Model was significantly different ($p = 0.02$) between the groups. As evident from the means scores, IENs were less likely to look up to their mentors as role models.

No statistically significant difference was reported in self-efficacy as measured by the New General Self-efficacy Scale (NGSE) that was developed and validated by Chen, Gully, and Eden (2001). It is an 8-item (items 18-25), 5-point Likert type scale with response categories ranging from *strongly disagree = 1* to *strongly agree* = 5. Higher scores indicate a higher level of self-reported self-efficacy. Both groups reported similar levels of self-efficacy.

Table 2. Comparison of Mentorship and Self-Efficacy Between the UENs and IENs (N = 200)

Variable	UEN (n= 145) Mean (SD)	IEN (n =55) Mean (SD)	p value
Mentorship subscales			
Career Development	24.3 (4.3)	24.4 (3.5)	0.8
Psycho-social Support	16.2 (3.7)	16.1 (4)	0.9
Role Model	17 (2.7)	16 (2.2)	0.02*
Self Efficacy	34.3 (3.1)	34.4 (3.7)	0.9

* $p < 0.05$

In order to further explain the differences in the Role Model function of the Mentorship instrument, participants' responses to the questions asking to identify the socio-demographic characteristics of their mentors were analyzed. These included the mentors' gender, ethnicity and position at work.

A chi-square test was performed to identify differences in mentor's socio-demographic characteristics between the two groups. The following assumptions were tested: a) independent observation, b) categorical level data, and c) expected count in each cell greater than five. The Fisher's exact test was used for the comparison of the mentors' race, since the third assumption was violated. All other assumptions were met.

As evidenced from the comparisons in Table 3, mentors for both groups were mostly women; however significant differences exist in race and position of the mentors ($p < 0.001$) between the two groups. Almost all UENs were mentored by Caucasians ($n = 126$, 90%) while the mentors for IENs were more ethnically diverse. They included Caucasians ($n = 34$, 67%), Asians ($n = 10$, 20%), and African-Americans ($n = 5$, 10%). With respect to the position of the mentor at work, while over half of the mentors ($n = 77$, 53%) for the UENs were currently in a position of leadership at their respective organizations, only a few ($n = 12$, 22%) of the mentors who were mentoring IENs held a position that required leadership. Leadership positions included nurse managers, clinical nurse specialists, nurse educators, clinical directors, and patient care coordinators. In contrast, most IENs participating in this study were mentored by clinical staff nurses ($n = 24$, 44%).

Table 3. Comparison of Mentor's Profile (N = 200)

Variable - Frequency (%)	UEN n = 145	IEN n = 55	p value
Mentor's Gender			0.3
Female	124 (86%)	50 (91%)	
Mentor's Position			0.001*
Staff Nurse	30 (21%)	24 (44%)	
Leadership	77 (53%)	12 (22%)	
Unclassified	38 (26%)	19 (34%)	
Mentor's Race			0.001*
Caucasian	126 (90%)	34 (67%)	
African-American	13 (9%)	5 (10%)	
Latin-American	1 (1%)	2 (3%)	
Asian/Pacific Islander	0 (0%)	10 (20%)	
Missing	5	4	

*$p < 0.05$

Specific Aim 2: *Determine the differences in levels of participation in professional development activities and career advancement opportunities between IENs and UENs.*

Hypothesis 2: IENs will demonstrate fewer professional development activities and less career advancement opportunities compared to UENs.

Prior to testing, data were tested and met the assumptions of an independent t-test and chi-square test. Results from the independent t-test and chi-square analyses revealed that the second hypothesis was also only partially supported for both professional development and career advancement.

Professional Development

Quantitative measures of professional development and results from the group comparison are presented in Table 4. No significant differences were noted between the groups for continuing education

credits taken per year (p = 0.08) and the frequency of nurses that were certified in their nursing practice specialties (p = 1.0). However, UENs were significantly different from IENs in their enrollment to another degree program since obtaining licensure (p = 0.01), as well as their pursuit of an advanced academic degree (p = 0.02). As evident from the frequencies and percentages in Table 4, overall, less than half of all nurses that participated in this study received another degree since completing their education that qualified them to take the NCLEX. Moreover, less than half were currently pursuing an academic degree. However, twice as many UENs (n = 54, 38%) received another degree since receiving their licensure compared to IENs (n = 10, 19%). Moreover, IENs (n = 10, 18%) were also half as likely to pursue another degree at the time of participation in this study compared to UENs (n = 51, 36%).

Table 4. Comparison of Professional Development Between UENs and IENs

Variable	UEN (n= 145)	IEN (n=55)	p value
	Mean (SD)		
Continued education credits/year	33.2 (26.9)	27.9 (12.9)	0.08
	Frequency (%) **		
Received formal degree since last education	54 (38%)	10 (19%)	0.01*
Missing	3	3	
Currently pursuing academic degree	51 (36%)	10 (18%)	0.02*
Missing	2	1	
Professional certification completed	61 (50%)	17 (50%)	1.00
Missing	23	20	

*****p < 0.05
** Percentages were calculated based on eligible data.

A comparison of previous and current education between the two groups is illustrated by Figures 8 and 9. As seen in Figure 8, greater proportion of IENs (n = 42, 76%) had a BSN degree at the time of

licensure compared to UENs (*n* = 80, 56.7%). However, compared to IENs, approximately twice the proportions of UENs had either obtained or were pursuing another degree since licensure. More importantly, as evident from Figure 9, IENs that do go on to obtain another degree since getting their licensure, a smaller percentage (*n* = 10, 22%) are likely to pursue an advanced degree compared to UENs (*n* = 54, 38%).

Figure 8. Comparison of Previous and Current Education Between UENs and IENs (N = 200)

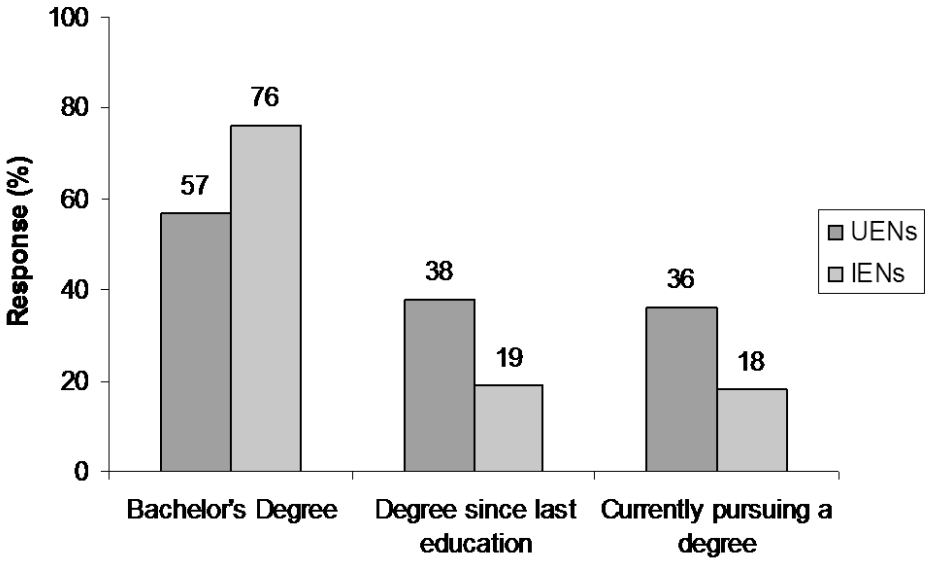
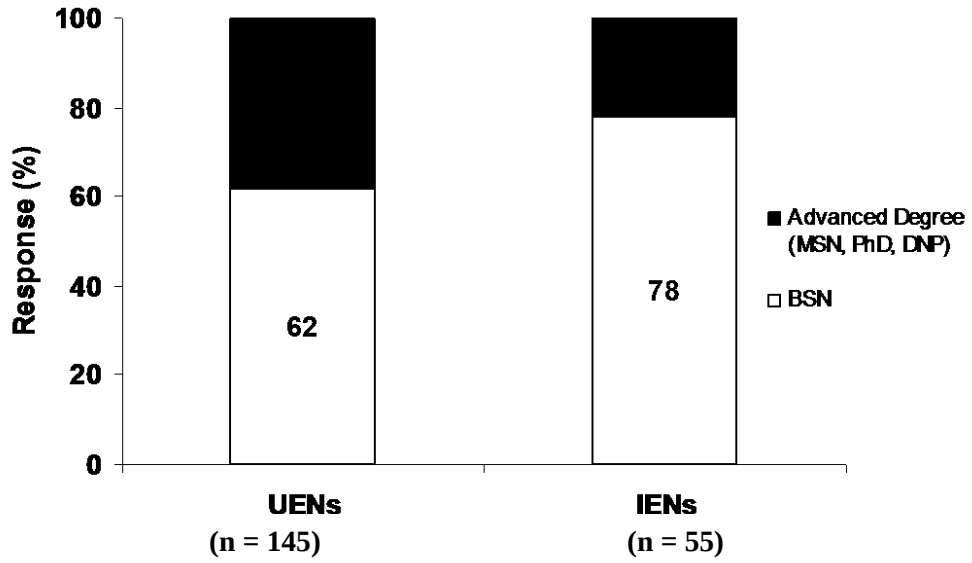


Figure 9. Comparison Between UENs and IENs Type of Degree Obtained Since Licensure.



Career Advancement

Measures of career advancement and results from the group comparison are summarized in Table 5. Data met the assumptions of the chi-square analysis. In specific instances, where expected count per cell was less than five, a Fisher's exact test was used in place of a chi-square test.

There were no significant differences between UENs and IENs for practice area ($p = 0.60$), certification ($p = 1.0$), type of pay ($p = 0.28$), number of hours worked per week ($p = 0.50$), hourly income ($p = 0.30$) and annual income ($p = 0.60$). However, UENs were significantly different from IENs in their practice role ($p = 0.03$). IENs also reported receiving promotions significantly less frequently than UENs ($p = 0.04$). Interestingly, despite the fact that average work experience reported by the participants was well over 10 years (Table 5), approximately one third of all participants had never received a promotion during their career ($n = 58$, 31%). Also, as seen in Table 5, compared to

UENs (*n* = 38, 28%), a higher proportion of IENs (*n* = 20, 41%) never received any promotion. Further, two out of every five UENs (*n* = 56, 42%) received a promotion within the last three years. In contrast, only one in four IENs (*n* = 13, 26%) received a promotion within the last three years. Additionally, despite the fact that both UENs and IENs reported similarity in practice area, their practice roles were vastly different. IENs work predominantly as staff nurses (*n* = 52, 98%), with a mere one person reporting working in an area of leadership (*n* = 1, 2%). None of the IENs participating in this study were working as a nurse manager, clinical nurse specialist, nurse educator, clinical director or as nurse practitioner (NP). In contrast, practice role among UENs was more diverse. Over one in five UENs were working in an executive role, or a nurse manager, clinical nurse specialist, or NP (*n* = 28, 21%). Although mean annual income was similar between the groups, the standard deviation for the mean was higher in the UENs ($15,000) compared to IENs ($8,000). In addition, annual income ranged between $54,000 to $125,000 for UENs and between $69,000 to $92,000 among IENs. This demonstrates that UENs have a wider range of income compared to IENs.

Table 5. Comparison of Career Advancement Between UENs and IENs

Variable	UEN n=145	IEN n=55	p value
	Mean (SD)		
Work Hours/week	37.6 (9.9)	36.6 (5.4)	0.5
Hourly Income	$40.4 (5.3)	$39.5 (2.8)	0.3
Annual Income	$86,200 (15,000)	$80,200 (8,000)	0.06
	Frequency (%) **		
Last promotion through career ladder			0.04*
At least once in last 2 years	16 (12%)	8 (16%)	
At least once in last 3 years	40 (30%)	5 (10%)	
At least once in last 5 years	41 (30%)	16 (33%)	
Never promoted	38 (28%)	20 (41%)	
Missing	10	6	
Practice area			0.6
Administration	11 (8%)	2 (4%)	
Acute care-Med-surg	42 (31%)	21 (39%)	
Ambulatory/Outpatient	11 (8%)	2 (4%)	
Speciality Nurs. Unit	67 (48%)	27 (51%)	
Skilled care facility	1 (1%)	0 (0%)	
Education	5 (4%)	1 (2%)	
Missing	8	2	
Practice role			0.03*
Staff Nurse	110 (78%)	52 (98%)	
Nurse Manager	11 (8%)	0 (0%)	
Clinical Nurse Specialist	9 (7%)	0 (0%)	
Nurse Practitioner	4 (3%)	0 (0%)	
Executive leadership	4 (3%)	1 (2%)	
Missing	7	2	
Pay type			0.28
Hourly	110 (76%)	44 (83%)	
Salaried	35 (24%)	9 (17%)	
Missing	0	2	

*$p < 0.05$

** Percentages were calculated based on eligible data.

To gain further insight into factors that may be associated with the nurses' ability to engage in professional development and pursue career advancement opportunities, participants were asked to rate five "situations" in order of importance to their life. These situations were: family, financial remuneration, career advancement opportunities, work-life balance, and leadership opportunities. The rating scale ranged from 1 to 5; 1 being "least important" and 5 being "most important" Table 6 presents the combined percentage of respondents in each group who selected the top two ratings (scale value 4 and 5) for each situation. Also presented is the difference between the percentages of responses between the two groups for each situation. The situations are listed in the order of largest to smallest difference between UENs and IENs. It is clear from the table that both UENs and IENs rate family to be the most important priority in their lives. However, IENs rated family to be most important much more frequently compared to UENs. This was evident from family having the largest difference between the groups with 19% more IENs rating it to be most important compared to UENs. The next largest difference that IENs rated as more important was work-life balance. In contrast, UENs rated financial remuneration and career advancement opportunities a lot more frequently than IENs to be the most important priority in their life. An almost equal percentage of UENs and IENs rated leadership opportunities to be most important.

Table 6. Ratings of the Situations Associated with Nurses' Ability to Engage in Professional Development and Career Advancement (N = 148)

Situation	UENs n = 109	IENs n = 39	Difference in % (UENs - IENs)
	Frequency (%)		
Family	60 (55%)	29 (74%)	-19%
Work life balance	46 (42%)	22 (56%)	-14%
Leadership opportunities	30 (28%)	12 (31%)	-3%
Career advancement	37 (34%)	7 (18%)	16%
Financial remuneration	45 (41%)	9 (23%)	18%

Specific Aim 3: *Explore the relationship of mentorship and self-efficacy with career advancement in both IEN and UEN participants.*

Hypothesis 3: IENs with lower levels of mentorship and self-efficacy will report lower levels of CA than UENs with higher levels of mentorship and self-efficacy.

For testing hypothesis 3, the outcome variables representing career advancement were gross annualized income, hourly pay, and number of times promoted through the career ladder. A general linear model approach to multiple regression analysis was used to test whether the relationship of mentorship and self-efficacy to income and hourly pay differed by group (UEN vs. IEN). Results indicated no significant interaction between mentorship, self-efficacy, and group for gross annualized income ($p = 0.91$) and hourly rate ($p = 0.38$). This implied that the associations of mentorship and self-efficacy with annualized and hourly income were not significantly different between IENs and UENs (Tables 7-8).

Table 7. Regression Analysis Using the General Linear Model Indicating No Significant Interaction Between Mentorship, Self-efficacy, and Group (UEN or IEN) for Gross Annual Income

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Interaction of Group with Mentorship and Self Efficacy	8.5	23	3.7	.5	.91
Error	7.1	10	7.1		

Table 8. Regression Analysis Using the General Linear Model Indicating No Significant Interaction Between Mentorship, Self-efficacy and Group (UEN or IEN) for Hourly Income

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Interaction of Group with Mentorship and Self Efficacy	2000.1	83	24.1	1.1	.38
Error	649.9	30	21.7		

Career Ladder

The third outcome variable of interest in the analysis was the number of times the participant was promoted through the career ladder. Since this variable is categorical, a chi-square analysis/Fisher's exact test was conducted. Before conducting the chi-square analysis, mentorship and self-efficacy were dichotomized based on observed sample median values. Scores below the median were classified as low level of mentorship and less self-efficacious while those above the median were classified as having received a high level of mentorship and having been more self-efficacious. The sample was then stratified into four groups: 1) high level of mentorship and high self-efficacy, for UENs; 2) high level of mentorship and high self-efficacy, for IENs; 3) low level of mentorship and low self-efficacy, for UENs; and 4) low level of mentorship and low self-efficacy; for IENs. Comparing the distribution of

number of promotions among the four groups tested whether the association of mentorship and self-efficacy with career advancement would be different between IENs and UENs. If a participant fell under the category of high mentorship but low self-efficacy or vice versa, the participant was not classified under any group and was excluded from the analysis. Since the expected count was less than five for some cells, a Fisher's exact test was used in place of a chi-square test. Results from the Fisher's exact test revealed no statistically significant association between the groups and number of times advanced through a career ladder ($p = 0.14$). Frequencies and percentages from this analysis are presented in Table 9. Although the groups were not statistically different, the distribution of promotion in the group of IENs with low level of mentorship and low self-efficacy was lower compared to the rest of the groups. Half of the IENs ($n = 8$, 50%) with low level of mentorship and self-efficacy had never received a promotion in their nursing career. This is almost double the number of nurses who had not received a promotion in any other groups. Moreover, IENs with a low level of mentorship and self-efficacy also had not received a promotion in the last two years. Despite these differences, the small sample size in each group of the IENs may have led to a Type II error, whereby the results failed to reach statistical significance.

Table 9. Comparison of Promotion Through the Career Ladder Between UENs and IENs with High and Low Levels of Mentoring and Self-efficacy.

Promotions through the formal career ladder – Frequency (%)	UEN Low Mentoring and low self-efficacy (n = 39)	UEN High Mentoring and high self-efficacy (n = 36)	IEN Low Mentoring and low self-efficacy (n = 16)	IEN High Mentoring and high self-efficacy (n = 11)
Never	11 (28%)	9 (25%)	8 (50%)	3 (27%)
At least once in last 2 years	8 (21%)	4 (11%)	0 (0%)	3 (27%)
At least once in last 3 years	7 (18%)	13 (36%)	1 (6%)	2 (19%)
At least once in last 5 years	13 (33%)	10 (28%)	7 (44%)	3 (27%)

Results from the Open-Ended Questions

This study used an inductive, manifest quantitative and qualitative content analysis approach to analyze the feedback to the two open-ended survey questions. This section describes the results of the open-ended survey questions.

Table 10 presents the quantitative summary of the numbers of responses of all the participants for the question that requested them to discuss the positive and barrier factors that influenced their professional development and career advancement. UENs (*n* = 145) provided a total of 100 responses while 42 responses were received from IENs (*n* = 55) to the first open-ended question that asked participants to discuss the positive factors that influenced professional development and career advancement. To the second open-ended question that asked participants to discuss factors that have served as barriers towards their professional development and career advancement, 124 responses were received from UENs (N = 145) while 48 IENs (N = 55) responded.

Table 10. Quantitative Summary of Number of responses received from UENs and IENs

Open-ended questions	UENs n = 145	IENs n = 55
"Please discuss the positive factors that have influenced your professional development and career advancement"	100 (69%)	42 (76%)
"Please discuss the factors that have served as barriers towards your professional development or career advancement"	124 (86%)	48 (87%)

Results of the Themes and Sub-themes in the Context of the Research Study

This section presents the operational definition of the themes and subthemes used in the coding of the meaning units. Three positive themes emerged for both UENs and IENs. These

were Healthy Work Environment, Commitment to the Profession, and External Support and Engagement. Operational definition of the positive themes and sub-themes of the study are presented in the following section in alphabetical order.

Healthy work environment. Healthy Work Environment is the first of the three themes found in the analysis of participants' responses to the positive factors that have influenced participation in professional development and career advancement. It comprises the following subthemes for both UENs and IENs: 1) career advancement opportunities, 2) mentorship, 3) role modeling, 4) supportive colleagues, 5) supportive leadership, and 6) tuition support. In addition, there were two other subthemes that were only found in the UENs' responses: 1) access to education and 2) nursing excellence. In contrast, the inclusion subtheme that was only found in the IENs responses.

Healthy work environment refers to the positive organizational attributes reported by participants to have been present in their organizations, which have empowered or facilitated their participation in professional development and career advancement. These attributes, as reported by the study participants, are consistent with Kanter's Theory of Structural Empowerment which underlines the factors that create and sustain healthy work environments for professionals. These attributes are also reported to facilitate employees' engagement in professional development and career advancement opportunities (Smith, Andrusyszyn, & Spence Laschinger, 2010). The literature discussed components of healthy work environment to include opportunity, information, resources, support, and formal and informal power (Smith, et al., 2010; Wagner, et al., 2010). Various empirical studies have provided support for the indispensable role of these factors in creating healthy work environments for nurses (DeCicco, Laschinger, & Kerr,

2006; Havens & Laschinger, 1997; Miller, Goddard, & Laschinger, 2001; Smith, et al., 2010; Spence Laschinger, 2008; Stewart, McNulty, Griffin, & Fitzpatrick, 2010; Wagner, et al., 2010).

Access to education. Access to education is a subtheme that referring to responses suggesting that the availability of educational opportunities, infrastructures and/or educational support and resources within the participant's organization contributed or facilitated participation in professional development and career advancement opportunities. According to Urbano and Jahn (1988), a nurse's participation in educational activities is an outcome of purposeful interaction between the individual nurse and her work environment. Participation in ongoing education is moderated by educational opportunity and structures in the work environment (Penz, et al., 2007). The subtheme to education was found to be as a positive professional development and career advancement characteristic for only UENs in this study.

Career advancement opportunities. The Career Advancement Opportunities subtheme represents participants' responses that suggest that the availability of a career ladder or/and the prospect for advancement in their organizations positively influenced engagement in professional development and career advancement opportunities. Evidence in the literature illustrates that nurses are most apt to engage in professional development and career advancement opportunities in organizations that have a career or advancement trajectory (Nelson et al., 2008; Walker, 2005; Wurmser, 2006). Career advancement opportunities were identified as an important positive attribute for participating in professional development and career advancement opportunities for both UENs and IENs in this study.

Inclusion. Inclusion is one of the subthemes found in the analysis of only IENs participants' responses as one of the positive factors that has influenced participation in

professional development and career advancement opportunities. It described responses that indicated how their colleagues and/or leadership staff intentionally included and engaged them in activities of the organization, which consequently served as a positive factor towards facilitating their participation in professional development and career advancement activities. The benefits of an inclusive environment for employees and organizational advancement are widely reported in the literature (American Association of Colleges and Universities, 2010; Lombe & Sherraden, 2008).

Mentorship. Mentorship is one of the subthemes found in the analysis of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities. It described participants' responses that suggested the presence of an influential individual with advanced experiences and knowledge in nursing helped provide opportunity and support for their engagement in professional development and career advancement. These mentors may have served as their educator, manager, overseer, and/or coach. The mentor may also be a preceptor, who is teaching and helping them transition from school to practice, or from one practice area to another (Milton, 2004; Ragins & Cotton, 1999; Vance, 1995). Both group of study participants' reported the importance of a relationship with a mentor facilitated engagement in professional development and career advancement.

Nursing excellence. Nursing Excellence is one of the subthemes found in the analysis of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities. It encompassed responses where participants suggested that their commitment to the highest standards of nursing practice or their passion for safe-quality patient care in an environment where they could achieve excellence

facilitated engagement in professional developmental and career advancement. Nursing excellence drove them to seek and acquire new knowledge, skills, and competencies necessary to provide compassionate, safe, quality and/or evidence-based care (Jasovsky, Grant, & Lang, 2010; Lash & Munroe, 2005). Nursing excellence was only found in UENs responses to the open-ended questions that required participants to reports factors that have positively influenced their career development

Role modeling. Role Modeling is one of the subthemes found in the analysis of both group of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities. It encompasses responses where participants indicated that the positive examples set by their mentors or individuals they have admired facilitated engagement in professional development and career advancement opportunities. Role models often have earned a status of recognition for their skill set that serves as a catalyst to transform those who admire and relate to them. These individuals are able to facilitate professional development and advancement for those who admire and relate to them (Perry, 2009; Holton, 2004).

Supportive colleagues. Supportive Colleagues is one of the subthemes found in the analysis of both group of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities. It describes responses that suggested that the behaviors, actions, or attitudes of professional colleagues promoted participants' participation in professional development and career advancement opportunities. Supportive colleagues have been identified as an important characteristic of a healthy work environment (Alspach, 2009; Graham & Ben, 2010) Supportive colleagues

promote a collaborative work environment and nurses have identified supportive colleagues as a critical component of their work (Button, 2008; DeCicco et al., 2006; McDonald, Vickers, Mohan, Wilkes, & Jackson, 2010; Pilette, 2006).

Supportive leadership. Supportive Leadership is one of the subthemes found in the analysis of both group of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities. It describes responses where participants indicated that their leadership was enabling; it supported their engagement in activities that promoted professional development and career advancement. Supportive leadership is characterized by effective communication, behaviors, and actions that create a practice environment where nurses feel supported to learn and work effectively, productively, and appropriately (Muller, Maclean, & Biggs, 2009). Supportive leadership is a characteristic of an empowered organization or nursing department, facilitating a healthy work environment (Beaulieu, Shamian, Donner, & Pringle, 1997; Kanter, 1993; Laschinger, Almost, & Tuer-Hodes, 2003; Wagner, et al., 2010).

Tuition support. Tuition Support is one of the subthemes found in the analysis of both group of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities**.** This subtheme describes participants' responses suggesting that engagement in professional development and career advancement opportunities was facilitated by organization reimbursement or support of tuition or to attend conferences, symposiums, continuing educational activities, and/or formal degree earning programs.

Commitment to the profession. The Commitment to the Profession is the second of the three positive themes found in this study. The theme encompasses the experience and self-leadership subthemes for UENs and IENs, along with the resilience subthemes found in the IENs group only. Subthemes aggregated to the commitment to the profession themes illustrate participants' willingness to advance the profession, loyalty to and pride in the nursing profession, perseverance or self-leadership attitudes, and actions as evidenced by self-direction. Scholars have written about how the subthemes are an important ingredient for career success (Becker, 1960; Gardner, 1992). For example, Reilly and Orsak (1991) found professional commitment to be significantly greater among nurses who have been practicing for a longer time. Drey, Gould, and Allan (2009) further confirmed this finding. Drey et al. (2009) stated: "While other factors may influence career commitment in the early stages, it subsequently became harder for the learners to ignore their day-to-day experiences when contemplating their commitment to nursing" (p. 299). It is difficult for people to ignore jobs they do not like, thus experience is seen as evidence of commitment in nursing where highly committed professionals usually stay in their chosen field for a long time (DeGroot, Burke, & George, 1998). Hallmarks of commitment to a profession include pride in the profession, enthusiasm for optimal performance, personal and professional engagement, hard work, resilience and an interest to advance within the profession (Colarelli & Bishop, 1990; Friss, 1983).

Experience. Experience is one of the subthemes identified in analysis of both groups of participants' responses to the positive factors influencing participation in professional development and career advancement opportunities. Experience speaks to the participants' responses indicating the professional wisdom that comes with longevity in practice or the acquisition of a specific knowledge and skill in nursing that has positively influenced

participation in professional development and career advancement opportunities. Experience encompasses actions, opportunities, or specific occurrences that have enhanced their wisdom in practice overtime. Experience is viewed as a prized possession and a process to treasure. Those who hold, share, and exemplify a specialized body of knowledge and a particular skill set (Arbon, 2004; Benner, 1984; Truglio-Londrigan, 2002) deem it as an outcome achievable. Both UENs and IENs identified experience as a positive factor that had influenced their participation in professional development and career advancement.

Self-leadership. Self-Leadership is one of the subthemes found in analysis of participants' responses to the positive factors influencing participation in professional development and career advancement opportunities. This subtheme contained participants' responses that self-direction and motivation facilitated engagement in professional development and career advancement opportunities. Self-leadership involves leading oneself by utilizing behavioral and mental techniques to self-regulate actions (Baumeister & Vohs, 2007). Research suggests self-leadership to be mediator between organizational culture and nurses' professional development, where individuals assume responsibility and control over their behavior. However, the environment in which they function is equally important to success (Kim, 2009; Roberts & Foti, 1998).

Resilience. Resilience is one of the subthemes found in the content analysis of IEN participants' responses to the positive factors influencing participation in professional development and career advancement opportunities. It referred to responses where participants indicated that their perseverance in accommodating difficulties served as a positive factor

facilitating their professional developmental and career advancement (Earvolino-Ramirez, 2007: Nolan, 2010)

External support and engagements. External Support and Engagements is last of the three themes found in the analysis of participants' responses to the positive factors influencing participation in professional development and career advancement opportunities. This theme comprised two subthemes: 1) supportive family and 2) outside engagements. UENs and IENs shared the supportive family subtheme; however the second subtheme, outside engagements, was only found in the UENs' responses. This theme encompassed participants' responses indicating that some form of support from family, family values, or/and engagement in activities outside the nursing profession positively influenced their engagement in professional development and career advancement activities. Scholars have alluded to the role of family support in influencing career success, especially for women, and also to leisure activities as an effective source of relief or buffer against stress for individuals in demanding professions (Ng et al., 2005; Pachulicz et al., 2002; Rokeach, 1973; Schwartz, 1992, 1994).

Supportive family. Supportive Family is one of the subthemes found in the analysis of both group of participants' responses to the positive factors that have influenced participation in professional development and career advancement opportunities. This subtheme describes responses where participants indicated that support from family members empowered them to engage in professional development or/and career advancement opportunities. Scholars have reported on how professionals with extensive family support are more likely to advance their careers compared to those with littler no family support (Featherstone, 2006; Penn & Gough,

2002). In this study, participants identified supportive family to be a key ingredient facilitating engagement in professional development or/and career advancement opportunities

Outside engagements. Outside Engagements is one of the subthemes found in the analysis of UEN participants' responses to the positive factors influencing participation in professional development and career advancement opportunities. It constituted responses indicating that certain activities outside their organization supported or empowered them to actively engage in career development opportunities. Outside engagements include, but are not limited to, volunteerism, goodwill, social, pleasurable, or leisure activities (Ng, Eby, Sorensen, & Feldman, 2005; Pachulicz, Schmitt, & Kuljanin, 2008).

A summary of the themes and sub-themes for positive factors that have influenced participation of UENs and IENs in professional development and career advancement are reported in Table 11. Both groups shared the three positive themes to professional development and career advancement. However, the subthemes and the number of subtheme counts from which they were derived were somewhat different. While UENs had eight subthemes for Healthy Work Environment, IENs had seven. UENs had 132 subtheme counts for Healthy Work Environment compared to only 37 subtheme counts for IENs. In comparison, for the theme of Commitment to the Profession, IENs had three subthemes compared with two for UENs. Moreover, IENs had 25 subtheme counts for this theme compared to only 18 for UENs. The final positive theme, External Support and Engagement was also different between the groups in the underlying subthemes and their counts. While IENs had only one subtheme count for External support, UENs had 2. This shows that support from family was a more frequent positive factor among UENs compared to IENs. The total subtheme count for positive factors was 165 among UENs, almost three times more to the IENs count of 65.

Table 11. Quantitative Counts of the Subthemes and Themes Found in the Responses to the Open-ended Question: "Please discuss the positive factors that have influenced your professional development and career advancement"

UENS Positive Subthemes	**Counts**	**UENS Positive Themes**	**IENs Positive Subthemes**	**Counts**	**IENs Positive Subthemes**
Access to education	20	Healthy work environment	N/A	N/A	Healthy work environment
Career advancement opportunities	8		Career advancement opportunities	2	
Mentorship	28		Mentorship	5	
Nursing excellence	10		N/A	N/A	
Role modeling	8		Role modeling	2	
Supportive colleagues	38		Supportive colleagues	14	
Supportive leadership	16		Supportive leadership	6	
Tuition support	4		Tuition support	2	
N/A	N/A		Inclusion	5	
Subtotal Count Healthy Work Environment = 132			**Subtotal Count Healthy Work Environment = 37**		
Experience	9	Commitment to the profession	Experience	4	Commitment to the profession
Self leadership	9		Self leadership	18	
N/A	N/A		Resilience	3	
Subtotal Count Commitment to Profession = 18			**Subtotal Count Commitment to the Profession =25**		
Supportive family	10	External support and engagement	Supportive family	1	External support and engagement
Outside engagement	2		N/A	N/A	
Subtotal Count External Support & Engagement = 12			**Subtotal Count External Support & Engagement = 1**		
Cannot code	1	Unable to classify	Cannot code	2	Unable to classify
Total Counts =163			**Total Counts =65**		

For the barriers to professional development and career advancement, three identical themes emerged for both UENs and IENs. These were Poor Work Environment, Competing Priorities, and Complacency/Contentment. Unlike the positive factors, the subthemes for barriers were similar between the groups with the notable exception of the 'Cultural Barrier' subtheme among IENs.

Poor work environment. Poor Work Environment is the first of the three themes found in the analysis of participants' responses to the barriers towards participation in professional development and career advancement opportunities for both UENs and IENS. Both groups of nurses shared the following subthemes for this theme: 1) Bias/Discrimination/Exclusion 2) Lack of Career Advancement Opportunities 3) Unsupportive Leadership 4) Unsupportive Colleagues, and 5) Work Overload. In addition, IENs identified Culture/Language Difference as a barrier. The subthemes that were aggregated to the Poor Work Environment theme described responses that suggested barriers to participants' participation in professional development and career advancement opportunities are related to hindrances from the work environment, encompassing poor leadership behaviors, organizational policies and procedures, and infrastructures including the level of control nurses have over their practice. Several researchers have alluded to these same factors as characteristics of poor work environments (Baernholdt & Mark, 2009; Kanai-Pak, Aiken, Sloane, & Poghosyan, 2008; Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005).

Bias//discrimination/exclusion. The Bias/Discrimination/Exclusion/ subtheme speaks to participants' responses suggesting some form of unfair, differential treatment and/or exclusion experienced in their organizations that prevented or served as a barrier to their engagement in professional development and/or career advancement opportunities.

Bias/Discrimination/Exclusion is recognized in the literature as a factor that has the potential to stagnate professionals' engagement in professional development and/or career advancement opportunities (Allan, Cowie, & Smith, 2009; Ensher, Grant-Vallone, & Donaldson, 2001; O'Gorman, Wilson, & Miller, 2008). Bias/Discrimination/Exclusion subtheme was found as a barrier factor to professional devlopment and career advancemnet for both UENs and IENs of this study.

Culture/language difference. Culture/Language Difference is one of the barrier subthemes found only among IENs. It describes responses where participants indicated that their cultural or language differences hindered their ability to engage in professional development and career advancement opportunities. It included responses suggesting that a difference in culture and language exists between the study's participants and the majority of their organization members, serving as a barrier to professional advancement. Research and anecdotal evidence reports have identified how difference in culture and language between IENs and host countries poses barriers to full engagement of IENs in host countries' workforce (Adeniran, et al., 2008; Takeno, 2010; Xu, 2005, 2007).

Lack of career advancement opportunities. The lack of career advancement opportunities is one of the subthemes found in the analysis of participants' responses to the barriers that have hindered their participation in professional development and career advancement opportunities. It described responses where participants reported that the absence of a career ladder or advancement structure in their organization or in the nursing profession served as a barrier or hindrance to participating in professional development and career advancement opportunities. Scholars in nursing have called for the indispensable need for career

advancement opportunities in nursing to insure that clinical nursing secures the place of primacy it deserves in the hierarchy of professional standards (Bullough & Bullough, 1971; Walker, 2005).

Unsupportive colleagues. Unsupportive Colleagues is one of the subthemes found in the analysis of participants' responses to the factors that present barriers towards participation in professional development and career advancement opportunities. It describes responses suggesting that behaviors, actions, or attitudes by professional colleagues served as barriers to participants' participation in professional development and career advancement opportunities. This subtheme was illustrated by poor work relationships among colleagues, as well as in the organization and characterized a poor work environment. Unsupportive Colleagues are described as those who are unhelpful; and do not work collaboratively with their colleagues. Supportive colleagues have been reported to be a key element of the nurses' work environment, as nurses' relationships with colleagues are crucial to individual success (Button, 2008; DeCicco, et al., 2006; McDonald et al., 2010).

Unsupportive leadership. Unsupportive Leadership is one of the subthemes found in the analysis of participants' responses to the factors that present barriers towards participation in professional development and career advancement opportunities. It describes participants' responses highlighting the characteristic of poor, or lack of, leadership in their organization in the form of abusive, aggressive, punitive, or passive behaviors, which hindered them from engaging in professional development and career advancement opportunities. Empirical and anecdotal evidence suggest that Unsupportive Colleagues or lack of leadership is detrimental to both employees and organizational progress (Kelloway, Sivanthan, Francis, & Barling, 2005).

Work overload. Work Overload is one of the subthemes found in the analysis of participants' responses to the factors that present barriers towards participation in professional development and career advancement opportunities. It describes responses demonstrating participants' need to function at an excessively high performance level, in addition to a lack of control of their work environment, as a barrier to participating in professional development and career advancement opportunities. The total demand on participants' time and energy exceeded their capability to meet their responsibilities. This finding has also been discussed by several other researchers (Brown & Benson, 2005; Carayon & Gurses, 2008; Gaudine, 2000; Pellico, Djukic, Kovner, & Brewer, 2009; Slan-Jerusalim & Chen, 2009).

Competing priorities. The Competing Priorities theme is the second of the three barrier themes identified in this study. It encompasses subthemes suggesting that tension existed in making decisions between participating in professional development and career advancement opportunities and other equally important life responsibilities. This theme denotes that a conflict exists between the participants' interest to participate in professional development and career advancement opportunities and the participants' personal responsibilities. This theme encompasses three subthemes from the analysis for both UENs and IENs respectively: 1) family obligations, 2) financial issues, and 3) lack of time. Evidence in the literature identified lack of time, financial support, scheduling difficulties, and family responsibilities as the barriers most often reported related to nurses' participation in professional development activities (Harper, 2000; Penz et al., 2007).

Family obligations. The Family Obligations subtheme is one found in the analysis of both group of participants' responses to the factors that presented barriers towards participating

in professional development and career advancement opportunities. It describes participants' responses suggesting that family obligations such as caring for a sick parent, taking care of children, or the level of the participant involvement in family activities served as a hindrance to engaging in professional development and career advancement opportunities. Research has shown that family involvement, especially for women, is a major interference to career advancement (Greenhaus & Beutell, 1985; Grzywacz et al., 2007; Mayrhofer, Meyer, Schiffinger, & Schmidt, 2008)

Financial issues. Financial Issues is one of the subthemes found in the analysis of both groups of participants' responses to the factors that presented barriers towards participation in professional development and career advancement opportunities. It refers to participant responses suggesting that limited financial resources are the main hindrance to engaging in professional development and career advancement opportunities. It may have been the need for money for tuition, the cost of working less, and making less money in order to go to school. Several researchers have reported financial limitations to be one of the main barriers to nurses' participation in continuing education (Beatty, 2001; Silverman, Goodine, Ladouceur, & Quinn, 2001).

Lack of time. Lack of Time is one of the subthemes found in the analysis of participants' responses to the factors that present barriers towards participating in professional development and career advancement opportunities. It described participants' responses suggesting that the barrier to engaging in professional development and career advancement opportunities was due to lack of time from other life commitments and responsibilities that were not related to work. Since this was self-reported data, it is not known if lack of time for the participant meant actual

lack of time (Heesch & Mâsse, 2004). Additionally, researchers have alluded to lack of time as a barrier to nurses' engagement in continuing education for professional advancement (Beatty, 2001; Penz, et al., 2007).

Complacency/contentment. Complacency/Contentment is the last of the three themes found to serve as a barrier for nurses' participation in professional development and career advancement opportunities. The two subthemes that were aggregated to the complacency/contentment theme in both UENs and IENs were: 1) lack of motivation/interest, and 2) satisfaction. Complacency occurs when an individual's behavior interferes with taking action, exhibited by procrastination, indecisiveness, and/or the lack of motivation. Complacent individuals may be unaware of any potential risk of their complacency (Girard, 2003). Contentment is a state of satisfaction, happiness, or pleasure achieved after reaching a set goal (Carson, 1981). Complacency would be distinguished from contentment based on the motivation or stagnation in the participants' current position. However, for this study, there was not enough information in the participant responses to determine whether participants "lacks motivation" which can be attributed to complacency, or if the participants are satisfied because they have reached a set professional career goals, providing contentment. Thus, both contentment and complacency were considered as one theme.

Lack of motivation/interest. Lack of Motivation/Interest is one of the subthemes found in the analysis of participants' responses to the factors presenting barriers towards participation in professional development and career advancement opportunities. It described responses indicating that there were no reasons for their lack of participation in professional developmental and career advancement opportunities other than avoidance, a lack of desire, or interest to

engage. These responses suggested that participants had no aspiration to participate in any activities that would advance them in their profession. Motivation and interest are key to self-regulation and an important ingredient of professionals' career success (Aryee & Tan, 1992; Baumeister & Vohs, 2007).

Satisfaction. Satisfaction is one of the subthemes found in analysis of responses to the factors that present barriers towards participation in professional development and career advancement opportunities for both UENs and IENs. It speaks to responses where participants suggest engagement in professional development and career advancement opportunities has the potential to pull them away from the bedside or frontline clinical nursing practice, and therefore they decided against its pursuit. The nursing profession has been challenged to institute gradations in the form of clinical ladders to allow career advancement opportunities for clinical staff who would otherwise be denied adequate recognition and remuneration for their work. However, the limitations of such gradations across longevity in practice have resulted in satisfaction for some nurses who want to remain at the bedside or frontline staff (Bullough & Bullough, 1971; Walker, 2005).

Table 12 presents the quantitative summary report of the barrier themes and sub-themes that influenced participation of UENs and IENs in professional development and career advancement. The numbers of subtheme counts were vastly different. There were eleven subtheme counts for cultural barriers among IENs, while this subtheme was absent among UENs. The number of subtheme counts for Poor Work Environment was 64 for UENs and 36 for IENs. Given that the sample size of IENs in this study was one third of the UENs, it is evident that Poor Work Environment was a much more frequent subtheme among IENs' responses compared to UENs'. Subtheme counts for Competing

Priorities and Complacency/Contentment were also higher among UENs compared to IENs, however, they were consistent with the larger sample size of UENs in the study.

Table 12. Quantitative Counts of the Subthemes and Themes Found in the Responses of UENs and IENs to the Open-ended Question: "Please discuss the factors that have served as a barrier to your professional development and career advancement"

UENS Barrier Subthemes	**Counts**	**UENs Barrier Themes**	**IENs Barrier Subthemes**	**Counts**	**IENS Barrier Themes**
Bias/discrimination/ exclusion	19	Poor work environment	Bias/discrimination/ exclusion	12	Poor work environment
Lack of career advancement opportunity	6		Lack of career advancement opportunity	2	
Unsupportive leadership	20		Unsupportive leadership	3	
Unsupportive colleagues	11		Unsupportive colleagues	6	
Work over load	8		Work over load	2	
N/A	N/A		Cultural/language difference	11	
Subtotal Count Poor Work Environment = 64			**Subtotal Count Poor Work Environment = 36**		
Family obligations	15	Competing priorities	Family obligations	4	Competing priorities
Financial issues	14		Financial issues	7	
Lack of time	50		Lack of time	16	
Subtotal Count Competing Priorities = 89			**Subtotal Count Competing Priorities = 27**		
Lack of motivation/interest	19	Complacency/ contentment	Lack of motivation/interest	6	Complacency/ contentment
Satisfaction	3		Satisfaction	1	
Subtotal Count Complacency/ contentment = 22			**Subtotal Count Complacency/ contentment = 8**		
Cannot code	**6**	Unable to classify	Cannot code	1	Unable to classify
Total Count = 181			**Total Count = 72**		

Cannot code /unable to classify. This code classification refers to ambiguous responses that the researchers were unable to code and analyze for meaning.

Tables 1 and 2 in Appendix M present sample responses (meaning unit) of the positive factors that have influenced participants' professional developmental and career advancement including examples of participants narratives that were analyzed, categorized, and condensed into the different sub-themes and then finally aggregated to themes for UENs and IENs, respectively. Tables 3 and 4 in Appendix M present the sample responses (meaning unit) of the barrier factors.

In each table, the first column is labeled meaning unit, showing sample data as reported by the participants. The content of this column is the original script written by the study participants. Scholars have used several terms to describe meaning units including: idea unit (Kovach, 1991), textual unit (Krippendorff, 2004), keyword or phrase (Lichstein & Young, 1996), and unit of analysis (Graneheim & Lundman, 2004). The second column of the table shows the sub-themes of how the original scripts were coded, known as the condensed meaning unit. It represents a word or phrase used to interpret the content of the meaning unit. Condensation refers to the abridging of the meaning unit by researchers. In essence, it is shortening of the meaning unit captured in a word or phrase. Terms used to describe condensation in qualitative data analysis includes reduction and distillation (Cavanagh, 1997; Coffey & Atkinson, 1996; Graneheim & Lundman, 2004). The information in the sub-themes column of the Tables 1- 4 in Appendix M shows the underlying themes of the study findings (Graneheim & Lundman, 2004).

The last and third column of the tables shows how the subthemes were abstracted and interpreted. Some researchers describe this process as aggregation, or grouping together

(Barroso, Buchanan, Tomlinson, & van Servellen, 1997; Burnard, 1991). Themes are the re-occurring regularity developed from condensation, interpretation, aggregation and abstraction of the data provided by the participants.

Summary of Results

A total of 483 nurses attempted the online survey. Of these, 210 respondents met the inclusion and exclusion criteria of the study and proceeded to take the full survey. The remaining 273 respondents were prompted to submit the survey without further responses and were excluded from the study. Finally, a total of 200 responses were eligible for further analyses. Among these, 145 were UENs while the remaining 55 were IENs.

UENs were middle aged, mostly Caucasian women. The majority of UENs identified themselves as Catholic and either married or living with a significant other at the time of participation. IENs were similar in age to the UENs, but had more men in the sample. IENs were also more diverse in religious affiliations and significantly different ethnically compared to UENs. More than half of the participants from either group indicated having a Bachelor's degree in nursing at the time of taking the NCLEX, although a higher portion of IENs entered the profession with Baccalaureate degree preparation than UENs. More IENs also had dependents at home compared to UENs, a difference that was significant. IENs had more work experience on average compared to UENs; however, UENs had significantly more experience working in the U.S. healthcare system. Both groups showed similar levels of satisfaction with their job and had access to a formal career ladder system. Both groups also had held their current jobs for similar duration.

An independent t-test revealed that the groups were statistically similar for age ($p = 0.40$) and years worked at their current position ($p = 0.26$); however, they were significantly different

for years of overall work experience ($p = 0.04$), work experience in the U.S. ($p = 0.04$), and number of dependents at home ($p = 0.04$). A chi-square test comparing the other socio-demographic characteristics revealed that the two groups were similar for presence of a formal career ladder and job satisfaction. However, gender, ethnicity, religious affiliation, education, marital status, dependents at home, and licensure in another state were significantly different between the groups.

The first hypothesis was only partially supported by the results with statistically significant differences noted between the groups only in the function of the Role Model subscale of mentorship ($p = 0.02$). The second hypothesis was also only partially supported by the results. Compared to IENs, UENs were significantly more likely to enroll into another degree program since completing their education for eligibility to take the NCLEX ($p = 0.01$), as well as when it came to pursuing an academic degree at the time of study participation ($p = 0.02$). UENs were also significantly different from IENs in their practice roles ($p = 0.03$). IENs also reported receiving a promotion significantly less frequently than UENs ($p = 0.04$). Results did not support the third and final hypothesis stating that-"IENs with lower levels of mentorship and self-efficacy will report lower levels of CA than UENs with higher levels of mentorship and self-efficacy."

The qualitative findings from the content analysis of the narrative data supported the quantitative results. UENs provided a total of 100 responses to the first open-ended question that requested participants to discuss the positive factors that have influenced their professional development and career advancement while 42 responses were received from IENs. To the second open-ended question that asked participants to discuss the factors that have served as

barriers towards their professional development and career advancement, 124 responses were received from UENs while 48 IENs responded.

Subthemes that emerged from the responses were further aggregated into themes. Three positive themes emerged for both UENs and IENs. These were Healthy Work Environment, Commitment to the Profession, and External Support and Engagement. However, the subthemes and the number of subtheme counts from which they were derived were different. Similarly, for barriers in professional development and career advancement, three identical themes emerged for UENs and IENs. These were Poor Work Environment, Competing Priorities, and Complacency/Contentment. Unlike the positive factors, the subthemes for barriers were mostly similar between the groups. However, the numbers of subtheme counts were different. For Poor Work Environment, the number of IENs subtheme counts were disproportionately higher, indicating that this theme emerged much more frequently in the IEN responses compared to UENs. Other subtheme counts were comparable.

Chapter 5: Discussion, Conclusion, and Recommendations

This study used a descriptive-correlational survey design and content analysis of open-ended questions to examine differences in levels of mentoring functions and self-efficacy of internationally educated nurses (IENs) compared to nurses educated in the United States (UENs). It also explored the association among mentorship, self-efficacy, professional development, and career advancement of both groups of nurses. The discussion of the major findings of this study is presented below.

Generalizability of the Sample

Registered Nurses (RNs) are recognized as the linchpin of all healthcare systems of the world. As of 2008, RNs numbered over 3 million in the United States (U.S.) (HRSA, 2010). In general, approximately 75 % of RNs work in frontline positions as staff nurses or equivalent titles while the remaining 25% work in leadership positions, such as management, administration, coordination, nurse practitioners, nurse educators, instructors in colleges or faculty (HRSA), 2010). Over 62% of the 3 million RNs work in hospitals. The sample of this study was drawn from hospitals located in the city of Philadelphia, a major urban city of the northeastern region of the U.S.

In order to have some idea of the generalizability of the findings of this study, the demographics of study participants were compared with the latest available data on the national demographics of the U.S. nursing workforce reported in the 2004 and 2008 National Sample Survey of Registered Nurses (NSSRN). Just as with this study, the NSSRN was a self-reported survey. The NSSRN was designed to assess the demographic, educational and employment

characteristics of RNs in the U. S. (Xu, Zaikina-Montgomery, & Shen, 2010). The 2004 survey was the eighth in a series of the NSSRN study that started in 1977; it provides the most updated information of RN's characteristics, most useful for analyzing the data to compare the characteristics of IENs to UENs in the U.S. nursing workforce. Although the findings of the ninth NSSRN study conducted in 2008 had been released recently, not all characteristics of UENs and IENs in the workforce had been reported, and thus both the 2004 and 2008 NSSRN were used as comparative benchmarks for this study sample.

This study's findings share many striking similarities with the NSSRN, along with a few differences. Similar findings of this study to the 2004 or 2008 NSSRN include the participants' demographics, such as the age, gender, marital status, children, adult dependents, and IENs' main countries of origin. Analogous to the 2004 NSSRN, this study found no significant difference in mean age and gender composition between IENs and UENs in the U.S. workforce. The mean age of both groups of nurses in this study was four years younger than the 2004 NSSRN findings. Explanation for a decrease in the mean age of both groups of nurses may be related to the increasing number of new young nurses entering the profession. A study conducted by Buerhaus, DesRoches, Donelan, and Hess (2009) reported a two year decrease in the mean age of RNs in the U.S. workforce from 2006 to 2008. It was also noted in the same study that IENs have more racial, ethnic, and gender diversity compared to UENs-a finding that was also reflected in this study. Consistent with the findings from the 2004 NSSRN survey, this study also found higher proportions of UENs to be single, never married, and with less numbers of dependents living with them compared to IENs.

Origin countries of IENs in this study mirror the reported data of origin countries of IENs in the 2008 NSSRN, meaning that IENs who participated in this study are representative of the origin countries of IENs in the U.S. workforce. Until recently, the Philippines constituted about 75% of IENs in the U.S., with Canada, U.K, and Nigeria comprising another 15%, and all other countries comprising 10% with no one country reaching 1%. This study demonstrated an increasing diversity from countries like India, Nigeria, Korea, Canada, and the U.K. This is congruent with the 2008 NSSRN study that reported the six main IENs' origin countries: Philippines (48.7%), Canada (11.5%), India (9.3%), United Kingdom (5.8%), Korea (2.6%), and Nigeria (2.0%). Even though the NSSRN showed an increasing diversity of the U.S. nurse workforce, the percentage of a non- Hispanic White majority in the U.S. nursing workforce is still at 83.2% in 2008, compared to 74 % of this study's participants who identified themselves as non-Hispanic Whites. Further analysis of the study data demonstrated that some UENs who participated in the study completed their basic nursing education that qualified them as UENs after migrating to the U.S. after reaching adulthood. This caveat is important for research that examines the state of the U.S. RN workforce. It illustrates the differences between IENs and foreign-born nurses (FBN). IENs are nurses who received their basic nursing education outside the Unites States, while FBNs are nurses born outside the U.S., but who completed their basic nursing education in the U.S after emigrating to the U.S. FBNs may have migrated after reaching adulthood, meaning that they have their formative years in a different country and are most likely to maintain some of the culture and values from their formative years when practicing as nurses in the U.S.

Nurses' Education

This study's findings revealed that IENs entered the nursing profession with higher educational preparations than UENs. This finding mirrors both the 2004 and 2008 NSSRN data. On the other hand, disparate findings exist between the 2004 NSSRN and this study's findings regarding the pursuit or acquisition of an advanced degree. While this study found that UENs are twice as likely to have earned an advanced degree or pursue an advanced degree in comparison to IENs, the 2004 NSSRN reported that both groups of nurses were equal in their level of pursuit or acquisition of advanced degrees. Similar to the 2004 NSSRN findings, both groups of nurses were equal in their level of participation in ongoing professional development and specialty certifications in nursing. The finding of having equal participation in professional development and specialty certifications may have been related to the homogeneity of this study sample, drawn mainly from a region that is considered an academic medical center, where nurses have numerous opportunities, access, and support for professional development opportunities. Further, the relatively recent thirty-hour mandatory continuing education requirement of the Pennsylvania State Board of Nursing, requiring all Pennsylvania RNs to show evidence of completing 30 continuing education credits within a period of two years in order to renew their RN license, (PA State Board of Nursing, Janury 4, 2010), may have influenced these equivalent findings.

Employment, Practice, and Financial Analysis

This study invited only nurses who were actively working in Philadelphia hospitals to participate. Data used for the analysis was obtained from participants who were actively working in a hospital when they participated in the study. In congruence with the 2004 NSSRN findings,

this study found UENs to be twice as likely as IENs to work in settings that offer better work-life balance schedules in areas such as administration, education, and ambulatory practice. (Shermont et.al., 2009). Nurses working in areas such as administration, education, and ambulatory practice have more control over their work and schedules. Further, with regards to the nurses' roles, IENs lacked representation in leadership positions, with over 98% (n= 54) of IENs compared 80% (n=123) of UENs in staff nurse positions. According to the 2008 NSSRN report, approximately 75 % of nurses worked as staff nurses and 25% in management, administrative and/or leadership roles (HRSA,2010). Clearly, a disproportionately low number of IENs were in leadership positions.

Similar to the 2004 NSSRN findings, this study found IENs to have had more nursing practice experience, counting years practiced as a nurse from their countries of origin, while UENs had more experience than IENs, counting only years of practice experience within the U.S. Despite this fact, the data revealed that annual and hourly income were comparable among IENs and UENs. It was unclear whether previous work experience had any bearing on compensation levels, although it is important to point out that UENs had a wider range of salaries compared to IENs.

Licensure. Another significant finding of this study is the disparity in the number of states where the participants were licensed to practice nursing. IENs were licensed in more U.S. states in comparison to UENs. It appears that IENs were searching for more work opportunities and consequently applying and securing licenses from other states as a protective job security measure or for job competitiveness or because they are more accustomed to relocation. Perhaps having a license to practice in another state provided them with flexibility and a sense of security

towards being employable, especially during a period when the nursing shortage has been ameliorated.

Worked hours. This study found that both groups of nurses worked equivalent hours per week, a disparate finding from the 2004 NSSRN, where IENs reported working significantly more hours than UENs. Perhaps, this anomaly is related to the current U.S. economic situation, which has somewhat alleviated the nursing shortage and significantly reduced available overtime hours, an area where IENs had previously gained more work hours (Benson, 2010; Cho & Cooley, 1994). In addition, emerging evidence is discouraging hospitals and other health care organizations from allowing nurses to work overtime hours. Healthcare organizations, more than ever before, are charged and held accountable to improve patient safety and deliver quality care. These requirements have further discouraged hospitals from encouraging nurses to work overtime hours (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Rogers, Hwang, Scott, Aiken, & Dinges, 2004).

Job satisfaction. This study found higher proportions of UENs being extremely satisfied with their jobs compared to their IENs counterparts. In addition, more UENs also reported being somewhat or extremely dissatisfied with their jobs. Over all, analysis of the degree of job satisfaction of both groups of nurses demonstrated equivalent satisfaction levels in their jobs.

In summary, the sample from this study closely mirrored the population of UENs and IENs working in the U.S. healthcare system, and, as such, is generalizable to the nursing workforce in the U.S. Some differences exist with the NSSRN studies from 2004 and 2008 and reflect changes in the socio-demographic characteristics of the nursing workforce in the past two years.

Specific Aims

This section presents the discussion of the findings from the specific aims of the study. The results from the testing of each research hypothesis are discussed. Also, a comparison and contrast of the findings with the literature is provided.

Specific Aim # 1: Determine the difference in the level of mentoring functions and self-efficacy between IENs and UENS.

Hypothesis 1: IENs will report a lower level of mentoring functions and self-efficacy compared to UENs.

The results of this study partially supported Hypothesis 1, as both IENs and UENs were able to identify a mentor in their nursing career. Mentors were operationalized as high ranking, influential individuals with advanced experience and knowledge in the profession, who make a commitment to provide upward mobility and support to the mentees or inexperienced individuals' careers (Ragins & Cotton, 1999). While results of the study revealed that both groups were similar in the psycho-social support function and the career development functions of mentoring, disparities existed in the role model function of mentoring. According to Scandura and Ragins (1993), the psycho-social support function of mentoring encompasses friendship activities of mentoring, where mentees consider their mentors as friends. The career development function of mentoring involves one to one career coaching activities between a mentor and a mentee. It is not surprising to observe equivalence in the psycho-social support and career development functions of mentoring because of the nature of the nursing profession, where

preceptors are routinely used to integrate newly-hired nurses to healthcare organizations (Crim & Hood, 1995; Skees, 2010). This applied to the participants of this study who were primarily from an academic medical center. Academic medical centers tend to offer several forms of structured programs to support integration of newly recruited nurses into the organization. An example of such a program is the nurse residency program (Ricker, 2008). The nurse residency program is a one-year program that uses a series of learning and work experiences to support new-to-practice nurses in direct patient care to successfully transition into their first professional positions in the hospital acute care setting (Berube et al., 2010; Ricker, 2008).

Another explanation for the equivalent findings in the psycho-social support and career development functions of mentoring in both groups is the use of charge nurses and preceptors to mentor newly hired nurses. The use of charge nurses and preceptors to support integration of newly recruited nurses in the organization also serves as a nurse retention strategy in an era of nursing shortage. Preceptor programs have been identified as a successful strategy that hospitals use to mitigate some of the challenges presented by the nursing shortage that includes staff nurse attrition and safety issues (Crim & Hood, 1995; Lockwood-Rayermann, 2003). Hospitals are better able to retain their nurses and decrease nurse attrition when they assign preceptors to work with their newly hired nurses. Preceptors work with newly hired nurses on a one-to-one basis and socialize and familiarize newly hired nurses to the hospital's clinical environment, practice standards, policies and procedures and may continue to work with them for longer periods (Hyrkäs & Shoemaker, 2007). Several studies have reported how these preceptors, more often than not, support newly hired nurses personally and in their professional growth, specifically on the clinical unit, thus preceptors often become the mentees' 'go-to-person,' helping them to integrate, while serving as their mentors within the specific unit or practice area for a long period

of time (Barber, 2006; Mills & Mullins, 2008). The preceptor and mentee may continue to develop their careers and not only maintain their friendship, but often go on to develop a peer mentoring relationship where both nurses learn from each other, a concept referred to as "learning partners" (Crim & Hood, 1995). Consequently, it is not surprising that both UENs and IENs reported similar levels of mentorship function on the psycho-social and career development subscales.

The role model function of the mentorship instrument sought to learn if participants had feelings of respect and identification with their mentor, and if they tried to model their behaviors after their mentor (Scandura, 1992). The demographic profile of the mentors in Table 3 shows that IENs mostly identified preceptors as their mentors. These mentors are primarily clinical nurses themselves who have helped the IENs survive on various units, having served as their go-to-person until such a time as they successfully integrate to the new practice environment (Adeniran et al., 2008; Chege & Garon, 2010; Xu, 2007). In contrast, UENs' mentor profiles comprised of nurses in leadership positions. It is logical to conclude that the differences in the role model function of mentorship between IENs and their UEN counterparts is associated with the differences in the mentor profiles of both groups of nurses. It can be argued that IENs did not see their mentors as role models, as they are most often their peers who have come to be their mentor through preceptorship in the clinical practice areas. According to Bandura (1989a), for a mentee to see a mentor as a role model, the mentor must have attributes or qualities that mentees aspire to achieve. Basically, IENs do not have mentors that they aspire to model after. As written in Robert K. Merton's biographical memoir, Holton (2004) defined a role model as an individual who exemplifies a positive example worthy of imitation. Role models serve as transformational catalysts by instructing, counseling, guiding, and facilitating the development of

others (Bartz, 2007). In accordance with one of the three principles of social learning theory in relation to observational learning, Bandura (1977c) stated: “Individuals are more likely to adopt a modeled behavior if the model is similar to the observer and has admired status” (p. 30).

Role modeling represents the mentor’s influence as someone the protégé wishes to be like (Scandura, 1992). Perceived similarities between the mentor and mentee are important to promoting a mentee’s interest to role model a mentor. It is possible that IENs did not perceive their preceptors as role models, as they could not offer them professional guidance beyond clinical practice. Another factor influencing the disparities in the role model function of mentoring between the two groups may be associated with the fact that IENs do not see attributes of themselves in leaders of their organizations or in nursing. As found in this study, and in general, minorities including IENs are under-represented in leadership positions in nursing (Bessent & Fleming, 2003; Bukola, 2010; Schmieding, 2000; Villarruel & Peragallo, 2004). This is supported by the findings from this study that showed that IENs lacked representation in leadership positions. In addition, the difference in the role model function of mentoring between UENs and IENs can be attributed to the substantial number of UENs’ mentors who are in leadership positions, and UENs shared many demographical characteristics with their mentors. Several studies have reported how perceived and actual demographic similarity between the mentee and mentor can positively influence the quality of mentoring received (Ensher & Murphy, 1997). It seems that IENs lack role models in positions of leadership that are demographically similar who can empower and challenge them to look for opportunities beyond the clinical practice area (Gibson, 2004; Reuler & Nardone, 1994). It is unclear why IENs do not reach out to UENs in positions of leadership to serve as mentors. Perhaps the lack of

demographic similarity between IENs and nurse leaders, along with cultural differences, present barriers that discourage IENs from seeking mentorship from those in a position of leadership.

IENs and UENs also reported similar levels of self-efficacy. One factor that may explain the similarity in self-efficacy between the groups is the fact that all participants in the study were experienced nurses. It is also reasonable to suggest that to be able to practice successfully as a nurse in a dynamic environment, such as an academic medical center, one requires a certain level of self-efficacy. Heslin and Klehe (2006) asserted that, "Research has found that self-efficacy is important for sustaining the considerable effort required to master skills involved in, for instance, public speaking, losing weight, and becoming an effective manager"(p.705). The same principle applies to nurses. Nurses must have a certain level of self-efficacy to be able to safely practice nursing, and even more so, to practice in a highly dynamic environment, such as a tertiary academic medical center.

Another reason for the equivalence in both groups of nurses' self-efficacy levels was the fact that both IENs and UENs had mentors who may have positively influenced and enhanced their careers, either within the practice area or at a higher level of the career ladder. Mentored individuals have higher self-efficacy from vicarious learning and verbal persuasion. An increased efficacy is one outcome of the mentoring experience (Saffold, 2005). Mentoring that includes general orientation programs has also been reported to enhance self-efficacy (Shuman, Heer, & Fiez, 2008). It is possible that the preceptor programs and other hospital infrastructures available to support newly hired nurses helped to equalize the self-efficacy levels of both groups in this study. An important caveat to be considered in interpreting this study's findings about self-efficacy levels is that the main sample site of the study was an academic medical center which had a comprehensive transition program for IENs called TIENS (Transitioning International

Educated Nurses for Success). TIENS has gained recognition as a model program to integrate IENs to the U.S. practice environment (Adeniran et al., 2008; Zizzo & Xu, 2009)). The number of IEN participants who may have undergone the TIENS program is unknown as this was not measured in this study; consequently, its impact on the level of self-efficacy of the participants of this study was not evaluated. However, it is possible that some IEN participants in the study had undergone the TIENS program that further helped to enhance their self-efficacy.

The comparable levels of self-efficacy findings between that of IENs and UENs in this study could also be attributed to the fact that both groups of nurses shared an equal level of belief or confidence in their capabilities to successfully perform a given task. However, the study did not learn which sources of self-efficacy enhanced either group's self-efficacy level to bring their levels to parity. Bandura (1977a, 1977b), in explaining social cognitive theory (SCT), discussed four different sources of self-efficacy. He also defined human behavior as a triadic, dynamic, and reciprocal interaction of three factors (personal, behavior, and environment) and that individual self-efficacy beliefs are usually determined and modified by the four main sources of self-efficacy (Bandura, 1982). The four sources of self-efficacy are: 1) mastery experience, 2) vicarious experience, 3) verbal or social persuasion, and 4) physiological and emotional states. Mastery experience involves how past success influences self-efficacy of future activities (Schyns & von Collani, 2002). Vicarious sources of self-efficacy explain how role modeling impacts the individual's self-efficacy. Self-efficacy is enhanced by seeing the likes of oneself successful in a challenging situation (Schyns & von Collani, 2002). Verbal or social persuasion speaks to the effect of verbal empowerment in increasing self-efficacy from a more experienced person (mentor) to a less experienced individual (mentee) (Bandura, 1982). Conversely, rejection or disapproval of a mentees' behavior by a mentor or more powerful individual can decrease

their self-efficacy through disempowerment (Bandura). The empowerment received from the mentors of both groups of nurses may have helped them succeed at the level where they were mentored. Obviously, UENs, more than IENs, had more opportunities to be successful at a much higher level, because they were more engaged with mentors in leadership roles.

The physiological and emotional sources of self-efficacy speak to how individuals judge their own ability, strength, and vulnerability to dysfunction during stressful or taxing situations (Bandura, 1982). Additionally, Bandura (1982) discussed how individual self-efficacy is uniquely determined by individual exposures to the above mentioned four sources of self-efficacy and the triadic factors of personal, behavior, and environment. Bandura (1989b) clarified that reciprocal interaction of the three factors and sources of self-efficacy do not imply that all sources influencing individuals are of equal strength. SCT recognized that some sources of influence are stronger than others in different individuals, and the sources do not occur simultaneously. Perhaps IENs' main source of self-efficacy arises from mastery experience ebbing from past success; such as the tedious credentialing, licensing, and immigration processes they must overcome to practice in the U.S. (Bieski, 2007); whereas UENs may gain more of their self-efficacy from role modeling or vicarious sources.

Another consideration in determining factors influencing a group's self-efficacy is the role of personal factors, such as how self-reflective thought process affects one's behavior. Individuals' experiences help them to develop perception about their own abilities and characteristics that subsequently guide their behavior by determining what a person tries to achieve and how much effort the person will put into his or her performance (Bandura, 1977a). Both groups of nurses may have shared similarities in the verbal or social persuasion and the physiological and emotional sources of self-efficacy from their personal and practice experiences

as nurses. An explanation to support that assertion is that both IENs and UENs were able to identify a mentor, thus providing an opportunity to gain some form of verbal or social persuasion source of self-efficacy. Kram (1983) found that mentors can develop mentees' competence, self-esteem, and confidence (self-efficacy) through psycho-social support mentoring. Psycho-social support functions of mentoring is comparable between IENs and UENs in this study which could be responsible for or might have influenced the equivalent levels of self-efficacy in both groups of nurses. Additionally, as nurses, both groups probably have equal exposure to stressful and taxing situations or might have been exposed to different challenges or vulnerabilities by just working in a fast-paced, dynamic, academic medical center where patients' lives are often at stake. The experience and environmental exposure of the nurses' practice environment could have supported most participants in the study to develop physiological and emotional sources of self-efficacy on different levels at different times with different experiences. It should be noted that one of the most reported influential sources of self-efficacy is mastery experience, which is how well one has done in previous performance. (Pajares, 2002; VanVianen, 1999). The nurse's role inherently requires some form of self-direction to perform. This job requirement may also have had a moderating effect on the similarity in both groups' self-efficacy levels. Nurses often work under pressure with a need to make quick decisions that can be a matter of life or death. They must have a certain level of self-efficacy, competence, and skill to be able to successfully function and make decisions (Krugman, 2008; Skees, 2010). Thus, it is not a surprising that both IENs and UENs had a similar level of self-efficacy.

Specific Aim # 2: Determine the differences in levels of participation in professional development activities and career advancement opportunities between IENs and UENs.

Hypothesis 2: IENs will demonstrate fewer professional development activities and less career advancement opportunities compared to UENs.

The hypothesis regarding the comparison of both groups' participation in professional development (PD) and career advancement (CA) opportunities were partially supported by the study findings. PD was assessed with the following four variables: 1) mean number of continuing education credits (CE) earned by the participants in the last year before participating in the study; 2) percentage of IENs and UENs who acquired additional formal educational degrees post-licensure; 3) percentage of group participants who were currently pursuing a formal academic degree; and 4) the percentage of professional certifications in each group.

In accordance with Pennsylvania Registered Nurse Rules and Regulations §21.133, described in the Pennsylvania State Board of Nursing (Janury 4, 2010), acceptable CE's must be relevant to patient care or professional nursing or specialty area and have the potential to enhance the knowledge and application of the physical, social, biological, and behavioral sciences. For this study, only CE activities that met the criteria established by the PA State Board of Nursing were included in the count of CE activities for both groups of nurses. CEs credits obtained from advanced life support courses such as Advanced Cardiac Life Support, Pediatric Advanced Life Support, or Advanced Trauma Life Support were excluded in the count because the researchers deemed those courses as fundamental to the participants' practice areas. As such, participants were required to successfully complete those courses to be able to practice in their work areas that include critical care nursing, pediatric intensive care units, trauma nurse etc. Other courses that were excluded in the count for CE credits include any non-professional course with contents relating to participants' self-improvement, change in attitude, or for financial gains.

IENs and UENs shared similarities in their scores in two of the four variables that were used to measure PD: the mean number of CE contact hours received within the last year and the percentage of nurses in each group who had earned professional certifications in their practice areas. Perhaps the parity, in some part, is due to both groups coming primarily from a tertiary academic medical center where there is extraordinary support for nurses to gain CE credits during work hours, as well as financial and professional support for all nurses to gain certifications in their practice specialties. Studies have demonstrated that nurses who do not receive professional and financial support from employers are less likely to engage in PD compared to those who do (Penz et al., 2007).

Academic medical centers and magnet organizations provide many opportunities and supports to allow their nurses to participate in professional activities during work hours, including financial incentives to gain and maintain specialty certification (Shirey, 2005). These findings validate Gibb, Anderson, and Forsyth's (2004) assertion, that supportive mentoring that occurs in the work-place with regard to participation in CE activities determines the level of competency acquired by RNs.

On the other hand, disparities existed in the remaining two variables used to measure PD: namely percentage of nurses who have earned a formal academic degree post-licensure and the percentage of those currently pursuing a formal academic degree at the time they participated in the study. IENs were found to be half as likely to have acquired another degree post-licensure, and also half as likely to be pursuing an advanced degree. The differences in professional development activities related to acquiring or pursuing a formal academic degree between UENs and IENs may be explained in light of some theories and concepts related to

human behavior and function, namely self-categorization and 'othering', which are embedded in self-identity theory, as well as the concept of role conflict that results from role overload.

According to Hogg and Terry (2000), individuals use inter-group and outer-group comparisons to self-identify and categorize and differentiate themselves into one group or another. Self-identity theorists assert that individuals see their identity as an embodiment of certain in-group prototypes, where self is not seen as unique, but rather a replica of in-group characteristics (Hogg & Terry, 2000; Hornsey, 2008; Rise, Sheeran, & Hukkelberg, 2010). This identity of self moves from the individual to in-group characteristics, thus forming the basis for understanding group phenomena, achievements, and social processes that include the concept of 'othering'.

Othering constitutes an exclusionary social process where the targeted individual or population is seen as different from the expected norm or in-group majority (Canales, 2000; 2010; Johnson et al., 2004). Othering has been found to be characteristic of individuals and/or groups experiencing alienation, marginalization or, in extreme cases, racism Canales, 2000; 2010; Johnson et al., 2004). As an example, Dicicco-Bloom (2004) found that despite positive personal attributes and professional abilities of Indian nurses, these nurses were unable to advance in their careers. Also, Alexis, Vydelingum, and Robbins (2007) and O'Brien (2007) reported that ethnic minority IENs working in the British National Health System (NHS) lived through a process of devaluation that resulted in low self-esteem as a result of their experiences and a lack of trust, which subsequently served as a barrier that dampened their interest to develop themselves. Perhaps the lack of representation of IENs in leadership roles may be a factor that has led to IENs' self-categorization, promoting the process of othering. Despite the fact that IENs enter the profession with higher educational preparation, they do not pursue advanced

degrees at the same levels as their UEN counterparts. They may not see their potential or envision the possibilities of acquiring additional or advanced degrees because of the perceived lack of rewards that come in the form of professional advancement.

As the demographic findings demonstrate, role conflict and role overload may also explain some of the disparities in the difference in acquisition or pursuit of an advanced degree between IENs and UENs. Role overload describes a situation that arises when total demand of time and energy exceeds an individual's capability to meet responsibilities of competing life and career demands (Slan-Jerusalim & Chen, 2009). Social roles of IENs that arise from cultural values may serve as a hindrance in their abilities to meet the demands of applying and pursuing formal advanced degree earning programs. Eventually, role overload leads to role conflict. Role conflict is the simultaneous occurrence of two (or more) sets of pressures at such odds that compliance with one would make it more difficult or impossible to comply with the demands of the other (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). Researchers suggest that women who assume traditional female roles such as wife, mother, and care-giver simultaneously with their career are caught in a situation described as normlessness, where they experience greater role conflict, tension and strain that ebbs from role overload (Malhotra & Sachdeva, 2005). In addition, women from cultures that maintain the traditional cultural beliefs of women's and men's roles, regardless of contextual circumstances, may experience role overload and eventually role conflict. Also, other characteristics that may lead or compound role overload or conflict include working in a job with set hours or not having control over one's own schedule.

In this study, as with many other studies (Xu & Kwak, 2005; Yi & Jezewski, 2000), IENs exhibited more of the characteristic factors that contribute to role overload and role conflict. The factors discussed in the literature included having: inflexible work hours or having less control

over work schedules, more dependents at home; higher task challenge through a steeper learning curve posed by cultural differences between their home and host countries; the need to learn and adjust to a different nursing practice culture; different and new communication style; the need to learn appropriate use of idioms and language and of professional values (Daniel, Chamberlain, & Gordon, 2001; Ea, Nov. 30, 2007; Greenhaus & Beutell, 1985; Xu, 2005; Xu, 2006; Yi & Jezewski, 2000). Differences in cultural and interpersonal relationships that IENs must overcome may be posing added barriers to engage in formal academic degree programs. In this study, it appeared that the lack of potential incentives in professional advancement, coupled with cultural barriers and role overload were creating an environment that was discouraging IENs to engage in additional advanced degrees.

Career advancement was measured with seven proxy variables: hourly and annual income, pay type, practice areas, practice roles, weekly worked hours, and rate of promotion through participants' organization's formal career ladder. The results demonstrated that both groups were comparable in hourly and annualized income, pay type, practice areas, and weekly work hours; however, significant differences existed between the groups for practice roles and frequency of promotion through the formal career ladder program. As evidenced from the results, mean annual income was similar between the groups; however, the standard deviation for the mean was higher among UENs ($15,000) compared to IENs ($8,000). In addition, annual income ranged from $54,000 to $125,000 for UENs, and between $69,000 to $92,000 in IENs. Although the difference in mean salary between the groups was not statistically significant, three key aspects of this finding warrant further attention. First, the average salary for UENs was approximately $6,000 more than IENs or around 8% more than what IENs earn in a year. Considering the fact that yearly increment in salary for nurses is around 2-3% in most healthcare

systems, this difference is substantial. Perhaps the difference in annual salary did not reach statistical significance due to a relatively small number of respondents reporting their annual salary (UEN 37%, n=54) and (IEN, 21%, n=12) thereby increasing the probability of Type II error. Secondly, the standard deviation and range for salary was much wider in UENs. Comparatively, IENs' salaries were concentrated within a smaller range. This particular finding demonstrated that there were groups of UENs whose annual income were lower and higher than IENs. Finally, IENs in this sample had a higher starting annual salary ($69,000) compared to UENs ($54,000). Perhaps, the higher entry-level education and experience of the IENs is related to their receiving a higher starting salary. Moreover, the ceiling for annual salary was much higher among UENs ($125,000) compared to IENs ($92,000). One possible explanation for this may be the higher proportion of advanced practice nurses, nurse managers, and administrator among UENs who receive compensation at a higher rate compared to staff nurses. In addition, nurses who pursue higher education through formal degree programs receive promotions frequently, securing leadership roles that includes, but is not limited to, administrators, advance practice nurses, nurse faculty, nurse researchers, and nurse educators. These professionals are often salaried and receive higher compensation compared to clinical or staff nurses who work at the bedside (Shermont et al.; 2010).

Most participants in this study were staff nurses, which is consistent with the data reported in previous studies and representative of the U.S. nursing workforce (HRSA, 2010). As discussed earlier, IENs engage less in formal degree earning programs compared to UENs, possibly due to role overload, role conflict, and the lack of IENs' role models in leadership and administrative positions. IENs are not represented in leadership and administrative positions. It is logical to suggest that a combination of the above mentioned factors, coupled with cultural

barriers, were responsible for IENs' receiving a lower annual compensation than their UEN counterparts. It is quite evident that there is a need to increase representation of IENs in nursing leadership and administration.

Furthermore, with reference to pay type, UENs were slightly more likely to be salaried than IENs (24% versus 17%), although this difference was not statistically significant. This finding is not surprising because nurses in leadership and administrative positions, an area dominated by UENs and under-represented by IENs, are usually salaried.

The explanation for similar findings in group practice areas, work hours, and hourly income may be related to the standardized structure of nursing salaries and vacancies or staff needs in most hospitals. Hospitals recruit nurses with appropriate skills in areas of need to maintain safe and quality care in all clinical units and during all shifts. In general, nurses are hired based on the skills needed to fill the vacancies within the organization. In addition, nurses are hired to a standard work schedule to meet the vacancy needs. Large organizations, such as academic medical centers, have a standard pay structure for clinical nurses. Hourly pay is not negotiable, so nurses are hired to a specific salary structure based on prescribed criteria, such as years of practice and expertise. The challenge is often related to who will work on less desired days and shifts such as weekends and holidays, as well as nightshift. To overcome this challenge, several strategies that include financial incentives that add on to basic salary are offered to cover the less desirable work days and shifts. Some organizations use a strategy that requires each nurse to work specific numbers of days and shifts of the less desirable hours by equally dividing those less desirable hours among the staff within a specific unit or work area. Another proxy measure of career advancement that was not significantly different between groups was the

numbers of hours worked by the participants. This study found that both groups of nurses worked equivalent hours per week. The reason for these findings may be related to evidence in the literature that discourages hospitals from allowing nurses to work overtime hours for safety reasons (Needleman et al., 2002; Rogers et al., 2004). Further, given that the majority of participants in this study came from an academic medical center with a standardized salary and work hour structure, it was not surprising to see the similarities in hourly income, practice areas, and number of hours worked between UENs and IENs.

The two proxy measures of career advancement found to be different between IENs and UENs in this study were frequency of promotion through participants' organization's formal career ladder and practice roles. As this study data showed, higher proportions of UENs were in leadership roles. Leadership personnel in nursing tend to be salaried, meaning they have more control of their work schedules and are not paid overtime for working extra hours (Shermont et al.; 2009). The difference in the rate of promotion demonstrates that IENs significantly differ from UENs when it comes to being promoted at all. Traditionally, hospitals use career advancement or a clinical ladder structure for promoting nurses. Promotion is achieved through a formal process with pre-established criteria, including the development of a professional portfolio to showcase achievements and experience of the individual nurses seeking advancement, as well as a clinical exemplar of current nursing practice submitted to a promotional committee for review and approval (Fusilero, Lini, Prohaska, Szweda, Carney, & Mion, 2008; Wurmser, 2006). It is expected that professional nurses will seek promotion by applying and developing their portfolio to demonstrate accomplishments of the criteria established for the promotional level that individual nurses seek to accomplish. Nurses who choose not to participate in promotional activities remain at their current level until they choose

to participate or seek promotion. There is no penalty for not participating, and all nurses are eligible for regular salary increases and adjustments that arise from the employee performance appraisal system (Goodrich & Ward, 2004; Winslow & Blankenship, 2007; Wurmser, 2006). However, a promotion through the formal career ladder offers additional incentives in salary increase and seniority. Nurses who have received promotions are often expected to supervise and lead other staff nurses at their respective work settings. It is in this category of career advancement where this study found disparities between IENs and UENs. These disparities can be attributed to lack of role models or some form of role overload and social-cultural disconnect between IENs and their practice institutions. In addition, these can be attributed to IENs' lower participation in formal degree earning programs or some form of marginalization. Similar findings from other studies have been reported about IENs' experiences with discrimination, marginalization, and socio-cultural barriers that served as impeding factors to their receiving promotion and career advancement (Allan, et al.; 2009; Nichols & Campbell, 2010; Rahimaghaee, Nayeri, & Mohammadi, 2010). Further, Troy, Wyness, and McAuliffe (2007) reported the frustration of Irish nursing directors who attempted to advance IENs into leadership roles. The directors described IENs' reluctance to assume leadership responsibility due to cultural and language barriers. Furthermore, several scholars have articulated the incongruence between IENs' expectations and actual experiences in their host countries. As frequently reported by IENs, a major disconnect exists between their expectations and reality in their host countries in areas of financial gain, housing, career advancement opportunities, and interpersonal relationships (Dicicco-Bloom, 2004; Matiti & Taylor, 2005; McGonagle, Halloran, & O'Reilly, 2004).

In a meta-synthesis of the literature, Xu (2007) found marginalization, discrimination, and exploitation as a major theme in the lived experiences of immigrant Asian nurses working in Western countries. IENs may be experiencing role strain from extended family obligations and dynamics, in addition to experiences of marginalization and a need for IENs to work harder to prove their competence to peers and superiors (Alexis, et al.; 2006; Hawthorne, 2001; Jones, 2009). The study by Xu (2007) also revealed that Asian nurses felt the need to work harder than other nurses to prove their competence and gain respect, which when attained did not guarantee equal status or wages. To learn more about the factors that might have influenced the difference in career advancement of both groups of nurses participants in this study were asked to rank the importance of five situations that included: financial remuneration, career advancement opportunity, and work-life-balance, family, and leadership opportunities to them. Family and work-life balance were the two areas that IENs selected more frequently to be very important in their life compared to UENs. In contrast, UENs selected financial remuneration and career advancement far more frequently compared to IENs. These findings further indicated that role strain may have been a contributing factor in impeding IENs from pursuing professional development and career advancements.

The second and final proxy measure of career advancement that showed a difference between IENS and UENs was the nurses' practice roles. UENs were appropriately represented in frontline positions and leadership roles that include managerial, director, nurse practitioner, and clinical nurse specialist (HRSA, 2010; Shermont et al., 2009). Conversely, IENs were mainly represented in staff nurse or frontline staff positions. They lacked visibility in positions that required them to lead, direct, or manage. This finding again explains the reason why the IENs may not have seen their mentors as role models. Role models have been associated with helping

to shape an individual's professional identity, advancement, and commitment. Role models play an important part in the professional metamorphosis of an individual, influencing the person's behavior and attitudes at all levels. For example, it has been demonstrated that aspiring managers observed and adapted their role models' professional traits and styles to their own ways of operating, thereby helping them to develop their own style of managing (Donaldson & Carter, 2005; Gibson, 2004; Reuler & Nardone, 1994). In other words, role models present a figure worthy of professional emulation (Bandura, 1977a, 1977b, 1977c**;** Reuler & Nardone, 1994). However, for a frontline nurse aspiring to become a manager, the mentor at the bedside can be at best described as a preceptor. While frontline nurses are able to learn valuable clinical skills from the experience of a mentor, unfortunately, they may consider their mentors' achievements similar to their own for them to emulate.

Another interesting finding of this study is that despite an average work experience of over 10 years by all study participants, one in every three nurses that participated in the study had never received a promotion during his or her nursing career. This finding reiterates the lack of recognition of nurses' contribution to healthcare, as well as the historical challenge that questions nursing as a profession (Apesoa-Varano, 2007; Watson, 1981). HRSA (2010), reported slight increase in the 2008 findings in the numbers of RNs who identified themselves to be staff nurses or its equivalent compared to previous studies, it is imperative that all nurses are empowered to participate in the process that facilitates self-development and professional advancement to meet the challenges presented by the 21st century healthcare environment (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine, 2010). Watson (1981) stated "If an individual is at a lower level of personal development than the profession, her immaturity can retard the development of the

profession. She may be so consumed with the earlier tasks of trust, autonomy, and initiative that she is unable to assist the profession in resolving its own conflicts of identity" (p. 1490). Nurse leaders must also provide resources and infrastructure needed to support career advancement of all nurses (Solveig & Bjork, 2007; Walker, 2005). Career advancement of all nurses can enhance nursing practice by leveraging the increased experience of diverse nurses and their educational preparation to the benefit of the patients, organization, and individuals (Drenkard & Swartwout, 2005; Gustin et al., 1998). It is possible that the combination of lack of a role model, along with role strain, marginalization, and cultural barriers have contributed towards IENs not being able to pursue professional development and career advancement activities, which ultimately have hurt their chances of being promoted at work.

Specific Aim 3: *Explore the relationship of mentorship and self-efficacy with career advancement in both internationally and U.S. educated nurses.*

Hypothesis 3: The association of mentorship and self-efficacy will be different between UENs and IENs.

The third hypothesis was not supported by the findings of this study, as the relationship of mentorship and self-efficacy to career advancement was not statistically different between the groups. This was evident for annualized income and hourly pay. However, for the analysis involving the third measure of career advancement, which was the number of times promoted through the career ladder, the sample size was relatively small. The small sample size may have contributed to the lack of statistical significance.

Several studies have demonstrated the relationship between self-efficacy and successful performance in life to include personal goals, career success, job performance and satisfaction, higher salary or promotions (Abele & Spurk, 2008). Day and Allen (2004) discussed positive correlations between municipal employees' career self-efficacy to salary and performance effectiveness. Other studies have demonstrated how mentorship has positively influenced promotion, career and organizational success, career advancement, and increased job involvement (Koberg et al; 1998). However, only a few have investigated how mentoring actually mediates career advancement (Day & Allen, 2004) . Research that directly links mentorship with self-efficacy is scant, and the few studies that exist are in the field of education and organization development (Barclay, 1982;Noe, 1988a; Hackett & Betz, 1981; Pittenger & Heimann, 2000).

For this study, no mediating effects were found for the relationship of mentorship and self-efficacy on career advancement for either group. However, more IEN's with low levels of mentorship and self-efficacy did not go through any career advancement, compared to IENs and UENs who did receive mentorship and had higher levels of self-efficacy. Interestingly, UENs with low mentorship and self-efficacy seemed to advance as frequently as UENs and IENs with high mentorship and self-efficacy. It is unclear how UENs who had low mentorship and self-efficacy were able to still achieve promotion. Perhaps they were either engaged in professional development activities or have pursued an advanced degree that resulted in more frequent promotion through the career ladder.

Summary of Quantitative Discussion

Healthcare organizations are challenged to identify factors that can advance the skills and competencies of nursing staff, ensure equitable compensation, promote workplace opportunities and representation, and ultimately improve patient safety and care. The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) Initiative on the Future of Nursing report (2010) challenged nursing to achieve higher levels of education and training, gain requisite competencies to deliver higher quality care, conduct research, develop policies, and play a leadership role in an increasingly complex and inter-disciplinary environment. To attain these goals, however, all nurses must engage in professional development and career advancement. Some organizations employ career advancement programs to facilitate these goals, but they are often optional. Despite the extensive body of knowledge in the literature on the importance and implementation of career advancement programs, little empiric evidence exists about their effectiveness and evaluation. In addition, career advancement programs are neither standardized across institutions, nor are nurses required to participate in them. Factors that serve as facilitators or barriers to nurses' participation in these programs are yet to be explored. Some researchers have provided qualitative information about issues that impact participation and engagement of nurses in professional development and career advancement. More specifically, the evidence suggests that discrepancies exist in participation in professional development and career advancement programs between indigenously educated and internationally educated nurses. With the number of IENs gradually increasing in the U.S. nursing workforce, meeting the goals delineated in the RWJ Foundation and IOM report would require effective integration of IENs into the U.S. healthcare system, equivalent access to professional development opportunities, and creation of an environment where all nurses can advance their careers.

The first logical step to fulfill the above goals is to understand the current level of engagement of nurses in professional development and career advancement, as well as the infrastructures that are available to support the process. Research on quantitative measures of professional development and career advancement and factors that influence nurses' engagement in these activities are limited and largely based on qualitative studies describing experiences of nurses, particularly IENs, who often participate less than their indigenous counterparts (Alexis et al.; 2007; Harper, 2000; Henry, 2007; Larsen, 2007; Penz et al., 2007; Smith, 2007). This study bridged that gap by identifying the current state of professional engagement and career advancement among nurses, both UENs and IENs, in addition to providing updated information on the demographics of the local nursing work force. Further, the study provided insight on underlying factors like role modeling and work-life priorities that may explain why some nurses are more likely to engage in professional development and career advancement opportunities compared to others. The study also identified specific areas of professional development and career advancement like advanced degrees, practice roles and frequency of promotions that are different between IENs and UENs. For example, the results from this study revealed that despite having work experience for over 10 years, one in four nurses have never received a promotion. Other studies in the literature have alluded to these findings, but have not measured them quantitatively. The findings from this study, in conjunction with the evidence already published, bridges an important gap in the literature by identifying areas of professional development and career advancement that might be the focus of future program development to retain nurses. For nursing to play a leadership role in a multi-disciplinary healthcare environment, the above issues require prompt attention.

Discussion of the Two Open-Ended Questions

Quantitative and qualitative content analysis (Cavanagh, 1997; Downe-Wamboldt, 1992; Elo & Kyngäs, 2008; Graneheim & Lundman, 2004; Krippendorff, 2004) strategy was used to determine and quantify the sub-themes and themes that emerged in the participants' responses to the study's two open-ended questions. The questions were: (1) "Please discuss the positive factors that have influenced your professional development and career advancement," and (2) "Please discuss the factors that serve as barriers towards your professional development and career advancement."

Three identical themes were identified for both groups' responses to the first question that asked the participants to discuss the positive factors that have influenced their professional development and career advancement. These were: 1) Healthy Work Environment, 2) Commitment to the Profession, and 3) External Support and Engagement. In addition, both groups' responses to the barrier factors were classified into three themes: 1) Poor Work Environment, 2) Competing Priorities and 3) Complacency/Contentment. However, the subthemes aggregated into the positives and barrier factors themes were somewhat different between the two groups. A few of the responses were ambiguous and the doctoral candidate, her chair and the external reviewer were unable to come to agreement about their coding. A summary count of the responses that could not be coded is presented in Table 11 under the classification "Cannot code." Samples of these are included in Appendix M, Tables 1-4

Healthy work environment. The elements that positively influenced participants' career development in their various organizations were aggregated to the healthy work environment theme. Both UENs and IENs acknowledged certain organizational attributes or subthemes to have positively influenced their participation in professional development and career

advancement opportunities. This finding supports the conclusion of the Flynn and Aiken (2002) study that examined issues that are associated with IEN retention, turnover, and productivity in the U.S. healthcare system. The study concluded that healthy work environment is equally important to IENs as to UENs.

The subthemes that were aggregated to the healthy work environment theme also mirrored what researchers have reported in the literature as important attributes of a healthy work environment for nurses (Aiken & Patrician, 2000; Aiken, Smith, & Lake, 1994; Spence Laschinger et al; 2003; Stewart et al; 2010; Ulrich et al., 2006; Wagner et al., 2010). These attributes are also congruent with the recently published 12 Nurse-Friendly elements of ideal work environment that are fundamental to nursing practice (Meraviglia et al., 2009).

Nevertheless, there were differences between the groups in the subthemes that were aggregated to derive the healthy work environment theme. A healthy work environment constitutes the presence of certain structures within the organization or workplace that enable employees to accomplish their work in meaningful ways (Kanter, 1993). Both groups of participants reported the presence of the following subthemes as positive organizational attributes: career advancement opportunities, mentorship, role modeling, supportive colleagues, supportive leadership, and tuition support. However, while UENs' responses revealed that the presence of a high ranking individual in the organization who they could role model was an important organizational attribute that facilitated participation in professional development and career advancement, IENs only reported preceptors and charge nurses with whom they were working with in their respective clinical units as their mentors or role models. This is consistent with the quantitative results that showed that a disproportionately larger number of mentors of UENs were in positions of leadership at their respective organizations, whereby they were

looked upon as role models by their mentees. This helps to explain why UENs emphasized a role-modeling function of mentoring that IENs did not. This finding in the participant responses is congruent with the findings of the quantitative analyses of this study, where it was found that UENs had mentors in higher ranking positions and were more likely to look at their mentors as role models in comparison to their IEN counterparts.

The below testimonials from UEN and IEN participants' responses to the questions can further illustrate the differences in experience of mentorship and role modeling between the groups.

> **According to one UEN:** "The confidence that my superiors have in me and the support that they have provided me. I have been a nurse for 25 years and I think as we move into different phases of our career, mentors can be even more impactful than when we are new nurses. My mentor invited me to lecture to new nurses entering the field as part of the hospital based critical care core curriculum in the field of my expertise. I have presented previous unit-based lectures, but my mentor gave me the opportunity to present to a wider scope of nurses. When the core curriculum became standardized, she submitted my name as a speaker in my field of expertise at TRENDS in Trauma and Cardiovascular Nursing. When I was contacted, I was asked to present not just a topic, but 3. It was definitely a challenge. When I was invited to speak the following year, I reviewed critiques from my previous lecture with my mentor. She interpreted these for me to encourage and improve my speaker skills. She speaks all over the country for CCRN course review. She also has helped me to renew my CCRN certification when it changed over to synergy. I credit her with encouraging me to do more with my career, including writing an article for a nursing journal and possibly writing a nursing book on standards of care in my field of expertise."

> **Another UEN noted** "Every unit I have worked in has had one individual who stands out as a mentor to me. These individuals have mastered their profession, encouraged others to further their education/certification and have been positive role models…"

> **An IEN stated**: "My preceptor helped me to advance to level 2. Then I moved to medicine where I advanced to level 3 after 5 yrs of experience."

> **Another IEN stated**: "Positive approach, preceptors of same culture and race, good manager."

These testimonials provided evidence that UENs had access to and considered themselves to be mentored by professionals who have advanced their own careers, who were able to positively influence their professional growth. The fact that UENs were able to easily identify successful mentors as role models may have a positive bearing on their career advancement. Researchers in organizational development and other fields including nursing have asserted that positive influence of mentorship, and specifically role modeling, is an important in mentees' career advancement of mentees (Kay et al,; 2009; Koberg et al., 1998). It is possible that the role modeling variable will have somewhat impacted UENs' career advancement in addition to other factors. IENs, on the other hand, who draw their mentors from preceptors, may not be able to maximize the benefit of their mentoring experience, perhaps limited by their mentors' positions in the organization. Although these preceptors serve as excellent clinical mentors, they cannot serve as role models as they lack the leadership skills and experience, social reference, credibility, or authority to serve as role models to empower IENs to aim for professional advancement beyond the clinical practice. As found in previous research, IENs would like to role model after those who come from similar socio-demographic backgrounds (Villarruel & Peragallo, 2004). This is a far reality in a nursing work force where leadership demographics remain homogenous (Schmieding, 2000; Sullivan & Suez Mittman, 2010). The differences in the socio-demographic characteristics between UEN and IEN role models in positions of organizational and professional leadership may have been a contributing barrier to why IENs did not participate in professional development and career advancement at an equivalent level as their UEN counterparts. Further, it is highly likely that the lack of IEN engagement in professional development acted as a catalyst to worsen an already abysmal

situation where IEN representation in nursing leadership continues to suffer endlessly (Chen, et al., 2010; Dicicco-Bloom, 2004; Dreachslin & Foster, 2004; Wesley & Dobal, 2009).

Three subthemes were found to be different between the groups. While UENs identified access to education and nursing excellence as factors that have facilitated their engagement in professional development and career advancement opportunities, IENs did not report these factors. In addition, IENs reported inclusion as an important organizational attribute that facilitated their participation in professional development and career advancement opportunities. One explanation to this may be that IENs see organizational commitment to excellence as a given, as organizations should not be in the business of healthcare if they are not committed to the services they provide. Culturally, in most countries, there is no extra reward or recognition for going beyond, it is seen as part of the standard work requirement. Bieski (2007) stated "All individuals as well as cultures, place different values on various aspects of clinical practice" (p. 34). Thus, it is no surprise that development of global standards for nursing education and practice has gained support from the World Health Organization, professional healthcare associations like Sigma Theta Tau International, and individuals in the healthcare field with a forward thinking mindset (Huston & Percival, 2009; Ludwick & Silva, August 14, 2000; World Health Organization, 2009). Consequently, IENs may not have seen organizational commitment to excellence as a factor worth mentioning to have facilitated professional growth. They did, however, recognize inclusiveness to be important for professional growth and development. Perhaps, UENs do not see the need for inclusion, because they do not see themselves as outsiders like their IENs counterparts. IENs, on the other hand, feel much more comfortable and appreciated in an inclusive environment and recognize it as an important element of a healthy work environment. Alexis, Vydelingum, and Robbins (2007) in their study that focused on

understanding experiences of IENs, concluded that a culture of inclusivity is fundamental to mitigating the challenges of the devaluation process, concept of self-blame, discrimination/lack of equal opportunity, concept of invisibility, and experience of fear that IENs must overcome in host countries.

Commitment to the profession. Commitment to the Profession was the second theme of the three themes representing the positive factor responses from both participant groups. Commitment to the Profession theme encompassed responses that demonstrated participants' self-direction motivation and/or dedication to advancing in the profession. It also included responses illustrating the individual nurse's skill and effort to advancing in the profession. Professional commitment has been defined as an individual's loyalty to his or her profession, exhibited by competence, skills, and autonomy that often leads to personal fulfillment, professional growth and competence (Blauner, 1964; Corley & Mauksch, 1993; Lu, Chang, & Wu, 2009). It is an unwritten contract where nurses aspire to be the best professionals they can by demonstrating conscientious efforts on behalf of the profession, showing desire to maintain membership in the profession, honoring the beliefs, goals, and values of the profession, and engaging in ongoing appraisal of their careers (Lu et al., 2009; Teng et al., 2009). UENs and IENs share two of the three subthemes that were aggregated to derive the commitment to the profession theme. These were the experience and self-leadership subthemes. The third subtheme, resilience, was only found in the IENs responses.

Experience is an important career advancement attribute in nursing as reflected in these testimonials below:

> **<u>As one UEN reported</u>** "Experiences in the profession have fueled my confidence and knowledge"

> **An IEN reported:** "I could very well say that indeed the best teacher is by far EXPERIENCE... being in the profession for a long time, nursing all kinds of people of all ages and races and in different places, had helped me in shaping who I am in my career right now".

According to Benner (1984), experience is an essential ingredient for advancement in nursing. Benner articulated a linear trajectory of advancement in nursing based on how nursing expertise develops through skills acquisition with increasing experience and reflection. The process encompasses different stages, extending from the novice to the expert nurse (Lyneham, Parkinson, & Denholm, 2008; Shapiro, 1998). Several career ladder or advancement structure programs in nursing use Benner's model as a framework to guide stages of career advancement (Schmidt et al.; 2003; Shapiro, 1998). Scholars have successfully argued the importance of experience as a knowledge builder for the development of nurses. Specifically, to them, experience constitutes a paradigm for knowledge development through cumulative skills that influence actions (Abraham, 1986; MacLeod, 1996; Reed, 1996; Sutton, et al., 1996). In a study of nurses with a minimum of ten year experience that sought to identify the meaning of experience to nurse's work, experience was found to play an important role in the development of expertise in nursing practice (Arbon, 2004). Excerpts from participants' responses in Arbon's (2004) illustrated the role of experience as a positive factor in the professional development of nurses, similar to the findings of this study, where both UENs and IENs reported experience to be a positive influence of professional development and career advancement. The sample responses shown above from this study further demonstrate the role of experience as a knowledge-builder and facilitator of career advancement for nurses.

The second subtheme common to both groups for the commitment to the profession theme was self-leadership. Self-leadership entails the skills that individual nurses use to

influence themselves in establishing self-direction and self-motivation towards achieving a set goal (Manz, 1986). Scholars have alluded to the combination of experience (McGaghie & Webster, 2009), engagement (Burrage, Shattell, & Habermann, 2005; Fasoli, 2010), and self-leadership (Davidhizar & Giny, 2004) as some of the key factors that facilitate career advancement in nursing and other professions. Self leadership is exemplified by the following testimonials:

> **One UEN informed**: "my own motivation to be the best I can be, surrounding myself w/ clinical experts and seeking continued knowledge about what I know & don't know, and continuing education."
>
> **Another UEN reported**: "being proactive in professional development opportunities, networking and seeking out colleagues who are positive role models."
>
> **Another UEN reported:** "motivation, intelligence, ability to seek/attain advanced degrees, professional support and personal drive."
>
> **One IEN stated:** "my personal and professional demeanor, my excellent interpersonal and problem solving skills, my can-do approach to things, and my willingness to learn and engage in new and challenging assignments."
>
> **Another IEN reported:** "my willingness to learn and to succeed in a foreign country and my goal of being able to equate my skill level to highly skilled nurses."

Both groups of participants recognized the imperativeness of self-leadership as an important factor that influenced participation in professional development and career advancement. Research evidence suggests self-leadership to be related to taking initiative for self-direction and ultimately enhancing performance (Carver, 1975; Neck & Houghton, 2006). However, as seen from the number of testimonials in Table 11, IENs emphasized the importance of self-leadership skills much more frequently than UENs. One reason that IENs stressed self-leadership as fundamental to career development may have been related to their lack of role

models in the profession. As evidenced from the quantitative results of this study, IENs lack role models that can instruct, counsel, guide, and facilitate their career development. Consequently, IENs have come to understand that they must "pave their own way" if they want to succeed in the profession and host countries. The literature is replete with research and anecdotal evidence identifying challenging situations that IENs must overcome in host countries. More than their indigenous counterparts, IENs experience poor working conditions, lack of recognition of their skills, and rejection from their patients, nursing colleagues, and other members of the healthcare team (Adeniran et al., 2008; Allan & Larson, 2003; Ball & Pike, 2005; Blythe & Baumann, 2009; Chege & Garon, 2010). The above excerpt samples from UEN and IEN participants demonstrate how these two groups of nurses view the critical role of self-leadership as related to their professional advancement.

Finally, within the commitment to the profession theme, IENs underscored hard work and resilience to be factors that influenced their career advancement, a factor absent or not recognized by the UENs. The below testimonials' from IENs illustrates resilience:

> **One IEN informed**: "There have always been others who attempted to hold me back, but I learned how to side-step the barriers and move on, often by filling an interesting niche that others were uninterested in developing. 'I think everyone has enough opportunities that present that could improve their work life, if they take them- but, they have to be willing to take the risk. In my mind, the worst you'll hear is, 'no'. Re-work the question and try again, and often, if you give more than you request, the answer will be 'yes'."

> **Another IEN stated:** "…my personal resilience to endure difficulties, both big and small, while transitioning to a new life with my family in a foreign country"

These above quotes from IENs in this study is in support of the literature where scholars have reported that IENs face overt and covert discrimination in their host countries and must be

willing to persevere to remain in their host country's nursing workforce (Alexis et al., 2007; Nichols & Campbell, 2010; O'Brien, 2007; Smith, 2007; Xu, 2005; Yi & Jezewski, 2000).

It is clear from the findings of the commitment to the profession theme that all nurses, regardless of region of education, understand the unique role of professional commitment to their individual career advancement. Nonetheless, it was evident, as in previous studies, that IENs are required to demonstrate a higher level of self-leadership and willingness to overcome tremendous challenges to remain successful nurses.

External support and engagement. The third and last theme of the three positive themes that have facilitated the nurses' participation in professional developmental and career advancement was external support and engagement. External support and engagement encompasses any form of support outside the organization identified by participants to be a factor that has positively influenced professional development and or career advancement. The two subthemes that were aggregated to this theme were supportive family and outside engagements. Supportive family speaks to response from the participants that highlighted how the support they received from their family allowed them to engage in professional development and career advancement activities. This is exemplified by following testimonials

> **As per one UEN:** "Wonderful family support of my endeavors"
>
> **Another UEN said:** "My family has also played a huge role, by making my career important to them as well, therefore making it possible for me to advance."

UENs emphasized family support as an important factor that had positively influenced their participation in professional development and career advancement much more frequently than IENs. This finding from the participants' responses is in congruence with the quantitative

finding of this study where UENs were found to have lesser family burdens and more family support in comparison to their IEN counterparts. Research evidence suggests that family support is a resource that enriches the work life of professionals (Grzywacz & Marks, 2000). Having a supportive family often translates to the form of additional time to engage in activities of interest to self and provides flexibility, as well as psychological enhancement of an individual's self-acceptance. When individuals feel supported by work or family, the tension between balancing work and family responsibilities is greatly reduced, which ultimately enables these individuals to be able to engage in professional growth opportunities (Friedman & Greenhaus, 2000). Greenhaus and Powell's (2006) family enrichment theory reported how supportive family positively influences and enriches professionals work. The sample quotes above from the UEN responses illustrate the importance of a supportive family to an individual's professional growth.

Researchers and scholars alike have alluded to how supportive family increases commitment and performance at work (Featherstone, 2006; Penn & Gough, 2002; Wayne, Randel, & Stevens, 2006). Perhaps, the recurrence of family support as a subtheme in the UENs' responses, more frequently than IENs, is one explanation to the quantitative findings of this study that showed that UENs participate more in degree-earning programs compared to IENs. Family support served as an additional buffer that further influenced their engagement in professional development and/or career advancement opportunities (Featherstone, 2006; Penn & Gough, 2002).

The second subtheme of the external support and engagement theme is participants' recognition and report of how their engagement in outside activities of interest positively influenced participation in professional development.

In the words of a UEN: "... I have a rich life, outside of work, in the arts, which feeds my soul."

Hobbies and outside interests encompassed responses that recognized how participants' participation in some form of external activities helped them to re-energize, renewing their strength to be able to participate in professional development and career advancement opportunities.

A balanced lifestyle, with engagement in volunteer and personal activities that re-energize an individual has been documented to influence career successes (Pachulicz et al; 2008). This subtheme was absent among the IENs' responses. It was apparent from the UENs' responses that their participation in hobbies and volunteer activities facilitated their participation in professional development and career advancement. Evidence suggests that professionals who engage in leisure activities or have family support are more apt to climb the career advancement ladder than those who have less family support and do not participate in leisure activities (Grzywacz & Marks, 2000). Further, research findings have reported that involvement in leisure is an effective source of relief or buffer to the stress and time required of people in demanding professions (Ng et al.; 2005; Pachulicz et al.; 2008). It is therefore logical to suggest that, in addition to other factors, the presence of a supportive family and active engagement in external activities has positioned UENs to be more physically and emotionally prepared than IENs to pursue professional development and career advancement opportunities to elevate their careers to newer heights.

In summary, UENs and IENs share more similarities than differences in the subthemes that emerged from the open-ended question responses. Actually, there was no difference in the

three positive themes that emerged for both groups. The findings from this study showed that a healthy work environment is valued by all nurses, irrespective of being a UEN or IEN, and provides a conducive atmosphere for individuals to pursue excellence in their nursing. Additionally, nurses from both the groups acknowledged that experience and self-leadership are key elements of professional commitment and were instrumental towards advancement in the profession. Finally, family support and engagement in outside activities provides physical and mental rejuvenation for nurses to engage in career advancement and continue to meet the emerging needs of our healthcare system.

As with the positive responses, the barriers identified by both groups of nurses were classified into three identical themes, namely: 1) poor work environment, 2) competing priorities, and 3) complacency/contentment; although the subthemes that were aggregated to themes were different between the two groups. A few of the responses were ambiguous and the doctoral candidate, her chair and the external reviewer were unable to come to agreement about their coding. A summary count of the responses that could not be coded is presented in Table 12 classified as "Cannot Code." Samples of these are included in Appendix M, Tables 1-4

Poor work environment. Both groups of participants reported that certain organizational attributes deterred their engagement in professional development and career advancement opportunities. Responses from both UENs and IENs that suggested engagement in professional development and career advancement opportunities was hindered by factors within their organization or work environment were classified to the following five subthemes: 1) bias/discrimination/exclusion, 2) lack of career advancement opportunity, 3) unsupportive leadership, 4) unsupportive colleagues, and 5) work overload. In addition to these five

subthemes, a sixth subtheme, cultural/language difference, was found among IENs' responses only.

The subthemes from this study that were aggregated to the poor work environment have been extensively studied and reported in the literature as factors that exert negative influence on nurses' work environment. They have been shown to affect organizational productivity, patient outcomes, personal and professional development and/or career advancement (Baernholdt & Mark, 2009; Kanai-Paket al, 2008; Pearson, Laschinger et al., 2007; Pearson, Srivastava et al., 2007; Ulrich, et al; 2005).

For example, research evidence indicates that organizational characteristics that include: bias/discrimination and exclusion constitute a form of bullying that negatively impacts nurses' engagement in their work environment (Allan, Cowie, & Smith, 2009; Dellasega, 2009; Wros, Doutrich, & Ruiz, 2009). In another study Beal, Riley and Lancaster (2008) reported that supportive leadership and colleagues in the nurses' work environment are essential to nurses' engagement in scholarly activities that can enhance practice and professional growth. The responses from the participants of this study mirror the findings by Beal et al.

The sample quote shown below is an example from participant responses to illustrate how bias/discrimination/exclusion affects the respondents' participation in professional growth opportunities.

One UEN Wrote: "Gender - I am male and that often closes doors in this profession."

This UEN testimonial exemplifies some of the long-standing challenges to the nursing profession, where scholars have called on nurses to be more receptive and accepting of their male colleagues (Anthony, 2004; 1997; Meadus, 2000). Nurses are asked to stop bullying each

other and "eating their young" (Dellasega, 2009; Dondale, 2010; Rowe & Sherlock, 2005). Anthony (2004) argued that the historical foundation of the nursing profession has provided only limited information on male contributions and is partly responsible for the perception of nursing as a female-dominated profession where men are not welcomed. Perhaps, the UEN who wrote the above testimonial is a male nurse who experienced bias in obtaining promotion, perceived as related to his gender.

Another example quote of bias/discrimination/exclusion among UENs is presented below.

> **One UEN Wrote:** "Political exclusiveness. Silo activities that do not search for human resources within the setting or considering the collegial resources that could inform projects or initiatives within a particular specialty"

This UEN testimonial which concerns, with regards to political exclusiveness in the professional environment, speaks to another challenge of the nursing profession that has been discussed in the literature (Matheson, & Bobay, 2007; Roberts, 1983). Nursing is seen as a profession that exhibits the characteristic of an oppressed population. Roberts (1983) reported that nurses historically have been submissive to more powerful groups, such as hospital administrators and physicians; this has led to some insecurity in the profession. Indeed, Meadus (2000) stated: "The nurse is seen as someone who is subordinate, nurturing, domestic, humble, and self-sacrificing, as well as not too educated" (p. 6). Insecurity of nursing professionals, arising from experiences of submissiveness, emotional and verbal abuse from their patients, and other members of the healthcare team, including physicians, may have contributed to the feelings of political exclusions of this particular UEN. This UEN's experience may also be

representative of a wider phenomenon of horizontal violence and/or bullying in nursing (Rowe & Sherlock, 2005).

Bias/exclusion/discrimination subtheme among IENs was different in nature compared to the UENs, as exemplified by the quotes below.

> **One IEN Wrote**: "Since I'm not American, I have always been judged by the cover, by the doctors, the patients, families, etc... They had to get to know me, to get the full credit of what I know"
>
> **Another IEN Wrote:** "Nurses are always looking down at you, like they know more than you, just because you came from somewhere else."

These IEN testimonials are in conformity with findings previously reported in the literature (Allan et al.; 2009; Hagey et al.; 2001). Two qualitative studies that examined the experience of IENs working in the British National Health Service (NHS) found discrimination and lack of equal opportunities for education and career advancement as their main themes (Alexis et al.; 2006, 2007). Alexis et al. (2007) also reported that in addition to experience of discrimination and lack of equal opportunity in the workplace, they found evidence that some nurses in the United Kingdom had abused IENs.

The findings from this study suggested that professional nursing is divided by gender, language and culture. The analysis of the study's qualitative responses shows that male nurses perceive discriminatory behavior due to their minority status in the profession. Likewise, the experience of IENs regarding perceived discrimination by patient families, nurse colleagues, and physicians due to their language, accent, or cultural values is not new (Allan & Larson, 2003). These findings of bias and exclusion of male nurses and IENs speak to a need for the nursing profession to assess the values of the profession and to develop strategies to be more inclusive of

others. It is ironic that a profession so proudly-based on caring for others is struggling to care for its own.

Both groups were similar in the responses that were condensed to the unsupportive colleagues' subtheme, as exemplified by the below:

> **One UEN wrote**: "RNs, Managers and NPs can be judgmental at times towards other staff ….unsupportive staff"
>
> **Another IEN wrote:** "Critical and negative environment….put down by colleagues. No support system…"

The nursing literature is replete with the importance of supportive colleagues and leadership in creating a positive work environment to empower and promote nurses to provide quality care (Meraviglia et al.; 2009; Laschinger, Wilk, Cho, & Greco, 2009). Researchers assert that a positive work environment leads to improved patient care, enhanced patient safety and better satisfaction among clinical nurses (Beal et al., 2008). Likewise, studies have reported poor work environments, due to unsupportive colleagues and leadership, usually lead to feelings of excessive stress, inadequacy, anxiety, oppression and disempowerment among clinical nurses (Cortese, Colombo, & Ghislieri, 2010; Muller, et al; 2009; Pearson, Laschinger, et al., 2007). An unsupportive work environment can therefore lead to job dissatisfaction, and compromise patient outcomes and safety (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010). As stated by Robinson (1994), high quality patient care depends on the continued education of those that deliver it. In the absence of supportive colleagues and leadership, engagement in continued education and career advancement becomes a daunting task; that is something difficult to accomplish, ultimately limiting nurses' ability to engage in professional development and provide high quality care.

The final subtheme both groups of nurses alluded to was "work overload" in their various institutions, which impeded their ability to engage in professional development and career advancement.

One UEN Stated: "Too much paperwork and paper document of tasks---need more nursing assistants to do task oriented jobs."

An IEN Stated: "Sometimes frustration with multiple task at same time."

Work overload has been identified in the healthcare literature as one of the most important predictors of burnout in nursing and healthcare (Nirel, Goldwag, Feigenberg, Abadi, & Halpern, 2008). Work overload leads to physical fatigue and mental exhaustion, and ultimately a lack of involvement in work (Gaudine, 2000). The sense of overload and burnout is a characteristic of poor work environment, where nurses have little control of the amount of work entrusted on them (Meraviglia et al., 2009). Work overload makes nurses vulnerable to burnout, thereby reducing the time available and enthusiasm needed to pursue professional development and career advancement.

Finally, within the poor work environment theme, cultural/language difference emerged as a subtheme among IEN responses only.

One IEN wrote: "Even now, some doctors think the nurses with accents know much less than a nurse without an accent. It's not easy to take away that concept or myth"

Another IEN wrote: "The difference in culture is a major factor in my insecurity"

Several authors have reported culture, language and communication as challenges that IENs must overcome in their new countries (Alexis et al.; 2007; Dicicco-Bloom, 2004; Larsen, 2007; Xu, 2007a, 2007b). IENs also identified their own shortcomings concerning how accent and communication act as barriers to their professional development and career advancement. They informed that having an accent, in addition to cultural differences, stood in their way of advancing in the profession, and sometimes segregated them from the rest of the staff, leading to insecurity. Xu (2007b) in a metasynthesis of 14 studies, identified "accent and communication" as grounds for discrimination. Language was identified as a major barrier for Asian nurses, because it is used as a "social marker" for stigmatization.

As reported by IENs in this study, anecdotal and research evidence have documented the unique cultural/communication challenges that confront IENs in their transition to host countries' practice environments, new communities and/or engagement in ongoing professional development (Adeniran et al., 2008; Nichols & Campbell, 2010; Tilley, 2007; Xu, 2007ab). Adeniran and Glasgow (2010) have urged nurse educators and faculty to be inclusive and culturally sensitive by using inclusive pedagogy to minimize exclusion and marginalization of culturally diverse nurse learners. They also suggest that nurse educators and faculty raise awareness of their own conscious and unconscious assumptions about the learning capacities of culturally diverse nurses and students based on gender, race, ethnicity, disability, language, sexual orientation, and/or accent.

IENs are well regarded for their work ethic and bring an exceptional level of expertise to the bedside. They bring a variety of knowledge, skills, and experience to their new practice areas. The benefits of their knowledge, skills, and experience can be enhanced by successfully

integrating them into the healthcare system of their new country. However, the absence of proper transition programs may impede their advancement into leadership positions in their organizations. Healthcare organizations that do not have transition programs for IENs, risk under-utilization of these nurses' skills with potential consequences for both the organizations and the nursing profession. Cultural integration is important, not just for IENs, but for a healthy nursing workforce in an increasing global work environment, where nurses are expected to deliver culturally competent care, regardless of either their own or their patients' background.

In summary, the poor work environment theme is one of the major issues that requires urgent attention. It affects all nurses, irrespective of whether they are UENs or IENs. Nurse leaders must find innovative ways to make the work environment healthier by developing enticing career advancement opportunities, as well as providing a supportive leadership to the clinical nurses. In addition, all nurses must come together to overcome bias and discrimination towards their colleagues and learn to work collaboratively to support each other's careers and ultimately to improve patient outcomes. Healthcare organizations, and those that employ clinical nurses, must recognize the importance of professional development, not just for the nurses, but for the greater good of building a robust team that can stand up to the challenges faced by our increasingly complex healthcare system.

Competing priorities. Competing Priorities is the second theme identified as a barrier affecting a nurse's participation in professional development and career advancement. Both UENs and IENs shared the three subthemes that were aggregated under the umbrella of competing priorities. These subthemes were financial issues, family obligations, and lack of time. The responses from both groups suggested that they often needed to prioritize between

family, finances, and profession. Among nurses, financial and family demands often compete with professional goals, thereby limiting their ability to engage in professional development and career advancement opportunities. For example, a nurse may lack time to engage in professional development due to a demanding work schedule, family obligations, or using that time to earn money. As evidenced from the quotes below, both groups reported the challenge to balance financial and family obligations and the required time to participate in professional development and career advancement.

As one UEN stated: "Single mother with three school age children, no child support. Working two jobs, very stressed"

Another UEN informed: "With family obligations, continuing education is difficult"

One IEN stated: "I am the bread winner and need to have a second job to help me w/ my mortgage and extra income to help my family back home. They are looking forward for my help in any way possible."

It is clear from the above responses that nurses lack time for professional development and career advancement as they all carry hectic schedules that include work and family responsibilities. These findings may be a reflection of the composition of nursing professionals, where more than 93% of nurses are women. Researchers have reported that the traditional trajectory for professionals counteracts women's ability to advance at an equal pace to men in their career, based on potential conflicts with child bearing and rearing (Brown, Swinyard, & Ogle, 2003). Brown and colleagues (2003) state "The demands of career and personal life for women were each great enough to extract compromise from the other" (p.1005). The work hours of a typical nurse, along with little flexibility during shifts, may compound the issues of competing priorities. As reported by Chang, Hancock, Johnson, Daly and Jackson (2005), and

Greenhaus and Beutell (1985), the number of hours worked per week, as well as time demands of shift work, can greatly influence the intensity of the competition between family and work. The challenge of competing priorities can be an added stress for nurses, to the extent that they become complacent or content with their current position. Chang and colleagues (2005) reported common work environment factors that are associated with role stress in the work place which include having little control in one's job or schedule, such as clinical nursing practice.

The qualitative findings related to the competing priorities theme from this study reflect the quantitative results of this study that reported that the majority of nurses have dependents at home. The majority of the UENs and IENs also emphasized the importance of family as the most important factor that interfered with their ability to engage in professional growth. Some women may even experience feelings of guilt or selfishness if they put their career interests before family obligations (Greenhaus & Beutell, 1985; Grzywacz et al., 2007).

Healthcare organizations that intend to attract nurses with outstanding work ethic and skills need to understand the areas where these nurses face extreme conflict between career and personal core values and to develop alternative models of career success that respect these values.

Complacency/Contentment. The third and last theme of the three barrier themes that have hindered the nurses' participation in professional developmental and career advancement in both groups of nurse participants was complacency/contentment. Two subthemes, satisfaction and lack of motivation and interest, were aggregated to the Complacency/Contentment theme. Essentially, participants' responses in both groups that demonstrated avoidance of additional work or showed no reason to engage, were coded to the lack of motivation/interest subtheme,

and eventually represented the complacency section of the theme. Sample responses coded as lack of motivation/ interests by participants of each group are shown below.

> **One UEN Wrote:** "I might want to move up and out of nursing into industry, it required a BS and it was disappointing"
>
> **Another UEN Wrote:** "Clinical advancement ladder is too cumbersome and annoying to pursue. Very little reward for much extra work"
>
> **One IEN Wrote**: "…I'm just doing what is required to keep me updated and also the requirements for me to keep my professional license"

Girrad (2003) defined complacency as a feeling of self-smugness that can turn into procrastination or indecisiveness. Complacency can become detrimental by dampening courage and innovation. Along the same lines, a response from both groups of participants that denotes fulfillment and pleasure with their current practice positions or roles was coded to the satisfaction subtheme and eventually contentment theme. The below testimonials demonstrates o UENs and IENs feelings of satisfaction.

> **One UEN Wrote:** "I had always thought what I wanted to be was a nurse manager when I "grew up", but once I had this opportunity, I was not as interested in the position. I love being a clinical nurse and leader within the unit I work".
>
> **Another UEN Wrote: "**I think I would miss direct patient contact, because developing a rapport with patients and following up with them post procedure establishes a patient/nurse relationship that is like none other".
>
> **One IEN Wrote:** "I have reached the peak of my career. I don't want to be a manager or a nurse practitioner".

Contentment is a state of satisfaction, happiness or pleasure, after reaching a set goal (Carson, 1981). As shown in the above testimonials from the study participants, in addition to individual complacency and/or contentment, it was evident that the nursing professional advancement structure itself contributed to nurse's engagement in professional development and career

advancement, specifically those nurses who have the desire to remain at the bedside or frontline of practice. Some participants made it clear that any effort to advance will take them away from the clinical practice they so much cherish. Walker (2005) captured this contradiction in nursing through her quote, stating, "It has always been one of the greatest paradoxes in our practice-based discipline that, in order to be recognized, rewarded and well-remunerated for one's work as a nurse, nurses have had to move ever further from the very bedside at which they learnt their craft" (p. 185). Given the prevailing belief that going for an advanced education will potentially take nurses farther away from the bedside and an apparent lack of incentive or motivation to practice as a bedside nurse with an advanced degree, nurses see little reason to aspire, innovate, or acquire more education and move up their career ladder.

If the nursing profession were to evaluate and make changes to the current career ladder structure, it would be imperative to consider some of the responses of participants in this study that speak to the role of scheduling, as well as the limitation of a career ceiling for clinical or bedside nurses.

> **One UEN stated**: "Desire to remain at the bedside and not to further my education i.e. MSN or NP, and now at the top of clinical staff nurse ladder without any further advancement or pay scale advancement".
>
> **Another UEN informed**: "I am very torn between advancing to the role of CNS due to the hours required. I love my 3- 12 hour shifts, nothing can beat it"

Consideration and further exploration of these variables, among many others in the literature, is critical to designing an effective career advancement structure for nurses. The quotes below from participants of this study provide some insight to the significance of these variables on the professional advancement of nurses.

Although individual nurses should take responsibility to develop professionally and advance themselves within their profession, nurse leaders have the responsibility of creating an environment that fosters engagement in professional development and career advancement (Levett-Jones, 2005; Skees, 2010). Several nursing scholars have called the attention of nurse leaders to evaluate the education, career advancement structure, and socialization of nurses (Walker, 2005). It is evident from the above written testimonials that nurses' career advancement structures are limited in their ability to provide necessary incentives needed to facilitate career advancement. In fact, the current pyramidal structure of nursing may be one of the leading causes of complacency. Bullough and Bullough, (1971) asserted that, "Nurses, too, are often in dead-end jobs, walled-in and unable to get out" (p.1941). Although over four decades have passed since this statement was written, the observation by Bullough and Bullough still holds true in a many situations today (Walker, 2005).

In summary, it is quite clear that advancement within clinical practice in the nursing profession is viewed as a possible disruption, as there are no clear benefits for pursuing an advanced degree for those interested in remaining at the bedside. Healthcare organizations and nurse leaders currently do not require advanced degrees for clinical nurses to advance through the career advancement ladder, and consequently, do not really push for these levels of professional development. For this reason, clinical nurses remain complacent/content with their current position and see no reason to go beyond to acquire advanced degrees. It is therefore critical that nurse leaders demonstrate to nurses that professional development is important to ensure safe, quality healthcare. Nurse leaders must help them out of this structural induced complacency by creating an environment that supports nurses' participation in professional development and career advancement opportunities at all levels.

It can be said that complacency is both an individual and professional issue as evidenced by the testimonials of participants in this study. Individual nurses must also employ strategies that will mitigate complacency by finding their own niche, and nurse leaders must begin to look for ways to adjust the professional nursing advancement structure to insure that there are incentives that can promote nurses' participation in professional development and career advancement. The findings of this study also call attention to these same issues and beget the question. "Are we contributing to nurse complacency, and what are the incentives to nurse advancement?"

Summary of the Discussion to the Two Open Ended Questions

The findings from the two open-ended questions identified some of the positives factors and barriers that nurses face in their professional development and career advancements. The positive factors identified by both the UENs and IENs that aided professional development were healthy work environment, commitment to the profession, and external support and engagement. Both groups of nurses credited mentorship, role modeling, supportive leadership and colleagues, career advancement opportunities, and tuition support as part of their healthy work environment that was important towards their professional development and career advancement. Still, each group identified some factors that were exclusive to their group only. UENs exclusively identified access to education as an important aspect of healthy work environment. IENs on the other hand alluded to inclusion as important part of their healthy work environment. Similarly, experience and self-leadership were important aspects of commitment to the profession among both UENs and IENs. In addition, IENs identified resilience to be critical part of their commitment to the profession. The final positive factor was external support and engagement,

where both UENs and IENs identified supportive family as important to their professional development and career advancement. UENs also identified being engaged in activities outside of work, something that was missing among the IEN responses. As for the barrier factors to professional development and career advancement, both groups identified three factors that were important to professional development and career advancement. These were poor work environment, competing priorities and complacency/contentment.

In addition to the shared UEN and IEN subthemes under poor work environment theme, IENs also identified cultural/language as a critical barrier to professional development and career advancement. Both groups also identified family and financial obligations, along with lack of time as part of competing priorities that stood in the way of their pursuit of professional development and career advancement. Similarly, UENs and IENs reported the lack of motivation/interest and satisfaction as elements of complacency/contentment that hindered professional development and career advancement. As evidenced from the quantitative findings of this study and the analysis of the two open-ended questions, nurses in general need better opportunities for professional development and career advancement.

Registered nurses account for the single largest percentage of the workforce in hospitals and any other healthcare systems of the world. Healthcare organizations and nurse leaders are challenged to create innovative solutions that define, recognize, and reward expertise at the bedside. Nurses also have the responsibility to participate in professional development and career advancement activities to maintain their skills for professional excellence and fulfillment. Also, healthcare organizations should work together with their nursing staff to develop solutions that allow for better integration of the internationally educated nursing work force in the profession.

The findings of this study provides organizations that recruit internationally educated nurses with a better appreciation of the barriers that face this segment of nurses in the U.S. workforce, so they are able to incorporate cultural responsive initiatives to better integrate these nurses in the workforce.

Limitations

The findings from this study must be interpreted in light of its limitations. First, the cross sectional design limits the inference that can be drawn from the findings. Further, this study was based on a relatively small sample size and must be replicated with larger samples to further validate the results. Other study limitations include the use of non standard measures for the dependent variable: career advancement. Nursing does not have a standardized local, state, or national career progression structure. Additionally, the data were all self-reported, thus method bias cannot be totally discounted. Self reported data is dependent on respondents' abilities to accurately recall past information, making it possible that the information suffers from recall bias. Additionally, the study did not account for the differences in nurse work environments and experiences such as power imbalance, diversity, work climate, absence or presence of career ladders, or organizational type and their potential moderating effects on how survey questions were interpreted and answered by participants. This study used a snowballing sampling strategy to penetrate populations that are difficult for researchers to access like internationally educated nurses working in the U.S. This process was influenced by self-selection; however it was an effective way to ensure that subjects were recruited efficiently with respect to the time and costs associated with this project. Finally, the participants from this study were nurses most of whom worked at an urban academic medical center, and the results may be best generalized to nurses working in an urban medical centers. Still, the findings from this research study provided

valuable information on nurses' professional development and career advancement and raised some important issues on nurses' engagement with professional growth that warrants further attention.

Significance to Advanced Nursing Practice and Future Nursing Research

The nursing profession is organized like a pyramid where the largest group of nurses, clinical nurses, remains at the bottom of the pyramid in almost dead end positions for their entire professional lives (Bullough & Bullough, 1971). Although the situation is changing slowly, the profession continues to lack a standard professional advancement mechanism (Walker, 2005). Clinical ladder or career advancement programs were introduced in the 1970s as way to enhance professional development, provide a reward system for quality clinical performance, promote safe nursing practice, improve job satisfaction, and provide a mechanism for clinical nurses to advance in the profession (Nelson, et al; 2008; Goodrich & Ward, 2004). However, after almost four decades of the introduction of the clinical ladder or career advancement programs, these programs continue to be underutilized, and disappointingly, not all nurses participate in the career advancement activities in organizations that do offer such opportunities (Bjork, et al; 2007; Winslow & Blankenship, 2007).

Findings from this study provide a basis for understanding how the level of mentorship and self-efficacy of nurses influenced their participation in professional development and career advancement. In addition, the study provided insight about the factors that served as facilitators and barriers to nurses' participation in professional development and career advancement. It is evident from the findings that perceived level of self-efficacy was relatively high among all nurses; however, the level and quality of mentorship functions received by IENs was insufficient

for them to advance to positions of leadership and administration as did their UEN counterparts. As the demographics of the U.S. continue to change, it is important that nurse leaders begin to mentor all groups of nurses to develop leadership that will be representative of the profession. This will strengthen the position of professional nursing as it increasingly gets recognized as a valuable player in a multidisciplinary healthcare environment and global community.

Nurse leaders should also note that there is a major issue with career advancement for all nurses, but specifically IENs. As evidenced from this study's findings, career advancement is poor among all nurses, specifically IENs. Historically, women have struggled with professional recognition, and the nursing profession has been subjected to patriarchal oppression by physicians and hospital administrators (Matheson & Bobay, 2007; Rowe & Sherlock, 2005). These are some of the factors that have impacted the image of the nursing profession. Actually, some have questioned the identity of nursing as a profession, as people within and outside the profession continues to doubt whether nursing meets the standards of a profession (Tull, January 1999). One of the factors or obstacles that continue to sabotage nursing's claim to be a profession is the education level of members. It is disturbing to know that as of 2008, less than 50% of UENs in the U.S. were prepared at a level less than baccalaureate degree (HSRA, 2010). As reported in this study finding, it is also a problem for a profession if one-third of the members never received a promotion after practicing for average of 10 years. Allowing opportunities and support for higher education and professional development will enable nurses to participate in ongoing education and career advancement opportunities that lead to more frequent promotion in jobs as well as enhancing the image of the profession.

Historically, nursing practice has struggled with professional identity (Crawford, Brown, & Majomi, 2008; Fawcett, 2003). Establishing and maintaining nursing as a professional discipline and creating a positive image of the profession will require a commitment from all nurses. Social identity theorists have found that the actions, attitudes, and behaviors of members of one group towards another are governed by the strength and relevance of its members (Adams, Hean, Sturgis, & Clark, 2006; Hogg, 2001; Tajfel & Turner, 1979). Professional identity concerns group interactions with relevance on how groups compare and differentiate themselves from other groups. This study identified factors associated with differences in IENs' and UENs' participation in professional development and career advancement that could help in the development of programs to support all nurses to progress in their profession. Such a step will ultimately contribute towards enhancing the professional identity and image of nursing.

The findings from this study bridge some of the important gaps in the literature by providing the foundation for understanding both the professional and personal barriers that continue to impact career advancement in nurses. It also reiterates the importance of healthy work environment for nurses by validating findings of previous research that identified characteristics of nurse friendly environments (Meraviglia, et al., 2009). Further, responses to the study's open-ended questions highlighted the roles of nursing leadership in creating an environment for nurses to participate in professional developmental and career advancement opportunities. This finding underscores the importance of leadership in uncertain times (Porter-O'Grady, 2007; Shirey, 2009; Sofarelli & Brown, 1998).

There is a need for leaders in nursing leadership with diverse backgrounds. Nursing leadership cannot remain homogenous in the 21st century environment characterized by

globalization and change in both the patient's and healthcare provider's demographics. IENs are an integral part of the U.S. workforce. It is imperative for nursing leaders to develop and support programs that will mitigate barriers such as lack of support from colleagues and leadership, lack of access to education, lack of time and flexibility to pursue advanced degrees that have been identified as barriers to advancement of nurses to leadership positions.

The recent joint report by the Robert Wood Johnson Foundation and Institute of Medicine along with recent changes in healthcare policies has empowered nurse leaders with a unique opportunity to enhance the power and autonomy of nurses to improve the safety, quality, and excellence of healthcare by engaging nurses to participate in professional development and career advancement opportunities. This study raised several issues that warrant further investigation. These include issues surrounding professional development and career advancement for all nurses, regardless of their status as UENs or IENs. Furthermore, this study demonstrated that the structure of the nursing profession might hinder professional and career growth, something that needs investigation in further detail. These findings are noteworthy and provide useful information for further research. Developing a standard career advancement measurement instrument for nurses across organizations would be an important contribution to the literature. This study did not measure the actual impact of racial pairing of mentors and mentees, future studies should assess this impact. Moreover, the intensity of mentoring should be measured to accurately reflect the benefit of mentoring. Future research should explore the ways that organizations' provide cultural competence education training and transitional programs e.g. the Transitioning Internationally Educated Nurses for Success (TIENS) impact the professional development and career advancement of all nurses, and ultimately enhance the quality and safety of our healthcare system.

With the drive for safe, quality healthcare and an environment that is constantly fraught with new challenges, healthcare organizations that want better outcomes for their patients and better engagement of their nurses must mitigate the factors that contribute towards a poor work environment and create a supportive and healthy work environment.

One simple, yet effective, way of accomplishing this goal is by providing flexible work hour options and professional development opportunities. Organizations should empower nurses with the option of dedicated time for scholarly activities that can enhance professional development and career advancement, which can ultimately improve positive patient outcomes

References

Abele, A. E., & Spurk, D. (2009). The longitudinal impact of self-efficacy and career goals on objective and subjective career success. *Journal of Vocational Behavior, 74*(1), 53-62.

Abraham, R. D. (1986). Ordinary and extraordinary experience. In V. W. Turner & E. M. Bruner (Eds.), *The Anthropology of Experience*. Urbana IL: The University of Illinois Press.

Adams, K., Hean, S., Sturgis, P., & Clark, J. M. (2006). Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care, 5*(2), 55-68.

Adeniran, R. K., & Glasgow, M. (2010). Creating and promoting a positive learning environment for culturally diverse nurses and students. *Creative Nursing, 16*(2), 53-58

Adeniran, R. K., Rich, V. L., Gonzalez, E., Peterson, C., Jost, S., & Gabriel, M. (2008). Transitioning internationally educated nurses for success: A model program. *OJIN: Online Journal of Issues in Nursing, 13*(2). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN.aspx

Aiken, L. (2008). Economics of nursing. *Policy Politics Nursing Practice, 9*(2), 73-79.

Aiken, L. (2007). U.S. nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research, 42*(3p2), 1299-1320.

Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*(3), 146-153.

Aiken, L. H., Smith, H. L., & Lake, E. T. (1994). Lower Medicare mortality among a set of hospitals known for good nursing care. *Medical Care, 32*(8), 771-787.

Alboim, N. (2002). Fulfilling the promise: Integrating immigrant skills into the Canadian economy. Retrieved from http://www.triec.ca/files/60/original/2002_Maytree_FulfillingThePromise.pdf

Allan, H. T., Cowie, H., & Smith, P. A. M. (2009). Overseas nurses' experiences of discrimination: A case of racist bullying? *Journal of Nursing Management, 17*(7), 898-906.

Allan, H., & Larson, J. A. (2003). "We need respect": Experiences of internationally recruited nurses in the UK. *Royal College of Nursing*. Retrieved online on July 13, 2009 from http://www.rcn.org.uk/__data/assets/pdf_file/0008/78587/002061.pdf

Allen, T. D. (2003). Mentoring others: A dispositional and motivational approach. *Journal of Vocational Behavior, 62*(1), 134-154.

Allen, T. D., Day, R., & Lentz, E. (2005). The role of interpersonal comfort in mentoring relationships. *Journal of Career Development, 31*(3), 155-169.

Allen, T. D., Eby, L. T., Poteet, M. L., Lentz, E., & Lima, L. (2004). Career benefits associated with mentoring for proteges: A meta-analysis. *Journal of Applied Psychology, 89*, 127-136.

Allen, T. D., Poteet, M. L., Russell, J. E. A., & Dobbins, G. H. (1997). A field study of factors related to supervisors' willingness to mentor others. *Journal of Vocational Behavior, 50*(1), 1-22.

Allen, T. D., & Poteet, M. L. (1999). Developing effective mentoring relationships: Strategies from the mentor's viewpoint. *Career Development Quarterly, 48*, 59 - 73

Alexis, O., Vydelingum, V., & Robbins, I. (2006). Overseas nurses' experiences of equal opportunities in the NHS in England. *Journal of Health Organization and Management, 20*(2), 130-139.

Alexis, O., Vydelingum, V., & Robbins, I. (2007). Engaging with a new reality: Experiences of overseas minority ethnic nurses in the NHS. *Journal of Clinical Nursing, 16*, 2221-2228.

American Association of Colleges and Universities. (2010). Making excellence inclusive. Retrieved from http://www.aacu.org/inclusive_excellence/index.cfm

American Nurses Association (ANA), & National Nursing Staff Development Orgnanization (NNSDO). (2010). *Nursing profesional development: Scope and standards of practice.* Silver Spring, MD.

Annelies, E. M., & Van, V. (1999). Managerial self-efficacy, outcome expectancies, and work-role salience as determinants of ambition for a managerial position. *Journal of Applied Social Psychology, 29*(3), 639-665.

Anthony, A. S. (2004). Gender bias and discrimination in nursing education: Can we change it? *Nurse Educator, 29*(3), 121-125.

Apesoa-Varano, E. C. (2007). Educated caring: The emergence of professional identity among nurses. *Qualitative Sociology, 30*(3), 249-274.

Apospori, E., Nikandrou, I., & Panayotopoulou, L. (2006). Mentoring and women's career advancement in Greece. *Human Resource Development International, 9*, 509-527.

Arbon, P. (2004). Understanding experience in nursing. *Journal of Clinical Nursing, 13*(2), 150-157.

Aryee, S., & Tan, K. (1992). Antecedents and outcomes of career commitment. *Journal of Vocational Behavior, 40*(3), 288-305.

Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2007). Better late than never: Workforce supply implications of later entry into nursing. *Health Affairs, 26*(1), 178-185.

Baernholdt, M., & Mark, B. A. (2009). The nurse work environment, job satisfaction and turnover rates in rural and urban nursing units. *Journal of Nursing Management, 17*(8), 994-1001.

Ball, J., & Pike, G. (2005). Managing to work differently: Results from the *Royal College of nursing employment* survey 2005. In RCN (Eds.) Retrieved from http://www.rcn.org.uk/__data/assets/pdf_file/0004/78682/003006.pdf

Bandura, A. (1977a). *Self-efficacy: The exercise of control*. New York, NY: W. H Freeman.

Bandura, A. (1977b). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191-215.

Bandura, A. (1977c). *Social Learning Theory* (Vol. 35). Englewoods Cliffs, NJ Prentice Hall.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *The American Psychologist, 37*, 122-147.

Bandura, A. (1984). Recycling misconceptions of perceived self-efficacy. *Cognitive therapy and research, 8*, 231-235.

Bandura, A. (1986). *Social foundations of thought and actions: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1989a). Human agency in social cognitive theory. *American Psychologist, 44*, 1175-1184.

Bandura, A. (1989b). Social cognitive theory. In R. Vasta (Ed.), *Annals of child development: Six theories of child development* (Vol. 6, pp. 1-60). Greenwich, CT: JAI Press.

Banik, B. J. (1993). Applying triangulation in nursing research. *Applied Nursing Research, 6*(1), 47-52.

Barber, D. (2006). Redefining perceptions of nursing success. *Kai Tiaki Nursing New Zealand, 12*(1), 16-18.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *British Medical Journal, 322*(7294), 1115-1117.

Barker, P., Monks, K., & Buckley, F. (1999). The role of mentoring in the career progression of chartered accountants. *The British Accounting Review, 31*(3), 297-312.

Barroso, J., Buchanan, D., Tomlinson, P., & van Servellen, G. (1997). Social support and long-term survivors of AIDS. *Western Journal of Nursing Research, 19*(5), 554-582.

Bartz, R. L. (2007). A true role model... Thomas M. Heiser, MD. *Orthopedics, 30*(1), 7-7.

Baumeister, R. F., & Vohs, K. D. (2007). Self-regulation, ego depletion, and motivation. *Social and Personality Psychology Compass, (1), 1-14.*

Beal, J. A., Riley, J. M., & Lancaster, D. R. (2008). Essential elements of an optimal clinical practice environment. *Journal of Nursing Administration, 38*(11), 488-493.

Beatty, R. M. (2001). Continuing professional education, organizational support, and professional competence: dilemmas of rural nurses. *Journal of Continuing Education in Nursing, 32*(5), 203-209.

Beaulieu, R., Shamian, J., Donner, G., & Pringle, D. (1997). Empowerment and commitment of nurses in long-term care. *Nursing Economic$, 15*(1), 32-41.

Becker, H. S. (1960). Notes on the concept of commitment. *The American Journal of Sociology, 66*(1), 32-40.

Bell, C. R. (1996). *Managers as mentors: Building Permanet partmerships for learning*. San Francisco: Berrett-Koehler Publishers, Inc.

Benner, P. (1984). *From novice to expert*. CA: Addison-Wesley.

Benson, A. (2010). The (new) economics of staffing registered nurses. Retrieved from http://web.mit.edu/alanmb/www/files/nursingmemo.pdf

Berube, M., Laplante, E., Belmonte, A., Lepage, I., Valiquette, M., & Touchette, S. (2010). Nurse residency program: A solution to safely introduce new grads in critical care while improving accessibility to services. *Dynamics, 21*(2), 32-32.

Berscheid, E. (1994). Interpersonal Relationships. *Annual Review of Psychology, 45*, 79-129.

Bessent, H., & Fleming, J. W. (2003). The Leadership Enhancement and Development (LEAD) Project for minority nurses (in the new millennium model). *Nursing Outlook, 51*(6), 255-260.

Beth Perry, R. N. (2009). Role modeling excellence in clinical nursing practice. *Nurse Education in Practice, 9*(1), 36-44.

Bieski, T. (2007). Foreign-educated nurses: An overview of migration and credentialing issues. *Nursing Economics, 25*(1), 20-23, 34.

Bjørk, I. T., Hansen, B. S., Samdal, G. B., Solveig, T., & Hamilton, G. A. (2007). Evaluation of clinical ladder participation in Norway. *Journal of Nursing Scholarship, 39*(1), 88-94.

Blauner, R. (1964). *Alienation and Freedom*. Chicago University of Chicago Press.

Blythe, J., & Baumann, A. (2009). Internationally educated nurses: Profiling workforce diversity. *International Nursing Review, 56*(2), 191-197.

Brookes, D. (2007). Understanding the value of qualitative research in nursing. *Nursing Times, 103*(8), 32-33.

Brown, M., & Benson, J. (2005). Managing to overload? Work overload and performance appraisal processes. *Group & Organization Management, 30*(1), 219-239.

Brown, A. J., Swinyard, W., & Ogle, J. (2003). Women in academic medicine: A report of focus groups and questionnaires, with conjoint analysis. *Journal of Women's Health 12*(10), 999-1008.

Brown, S. P., Jones, E. E., & Leigh, T. W. (2005). The attenuating effect of role overload on relationships linking self-efficacy and goal level to work performance. *Journal of Applied Psychology, 90*(5), 972–979.

Brush, B., Sochalski, J., & Berger, A. (2004). Imported care: Recruiting foreign nurses to U.S health care facilities. *Health Affairs, 23*(3), 78-87.

Brush, B. L., & Berger, M. (2002). Sending for nurses: Foreign nurse migration to American hospitals, 1965-2002. *Nursing and Health Policy Review, 1*(2), 103-115

Buchan, J., & Thomson, M. (1999). *Recruiting, retaining and motivating nursing staff: The use of clinical ladders*. Brighton U.K: The Institute of Employment.

Buchanan, L., & Likness, S. (2008). Evidence-based practice to assist women in hospital settings to quit smoking and reduce cardiovascular disease risk. *Journal of Cardiovascular Nursing, 23*(5), 397-406.

Buerhaus, P. I., Auerbach, D. I., & Staiger, D. O. (2009). The recent surge in nurse employment: Causes and implications. *Health Affairs, 28*(4), w657-w668.

Buerhaus, P. I., DesRoches, C., Donelan, K., & Hess, R. (2009). Still making progress to improve the hospital workplace environment? Results from the 2008 National Survey of Registered Nurses. *Nursing Economic$, 27*(5), 289-301.

Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2003). Is The current shortage of hospital nurses ending? *Health Affairs, 22*(6), 191-198.

Buerhaus , P. I., Staiger, D. O., & Auebach, D. I. (2004). New signs of a strengthening U.S. nurse labor market. *Health Affairs-Web Exclusive, Web Exclusive*, w4-526-W524-533

Bukola, K. (2010). International nurse migration to Canada: Are we missing the bigger picture? *Nursing Leadership, 23*(2), 16-20.

Bullough, B., & Bullough, V. (1971). A career ladder in nursing: Problems and prospects. *The American Journal of Nursing, 71*(10), 1938-1943.

Burke, R. J. (1984). Mentors in organizations. *Group Organization Management, 9*(3), 353-372.

Burke, R. J., & McKeen, C. A. (1990). Mentoring in organizations: Implications for women. *Journal of Business Ethics, 9*(4), 317-332.

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today, 11*(6), 461-466.

Burrage, J., Shattell, M., & Habermann, B. (2005). The scholarship of engagement in nursing. *Nursing Outlook, 53*(5), 220-223.

Burt, R. S. (2005). *Brokerage and closure: An introduction to social capital*. Oxford, UK: Oxford University Press

U.S. Bureau of Labor Statistics (2010). *Philadelphia-Camden-Wilmington, PA-NJ-DE-MD Economy at a Glance*. Retreived from http://www.bls.gov/eag/eag.pa_philadelphia_msa.htm

Busch, T. (1995). Gender differences in self-efficacy and attitudes toward computers. *Journal of Educational Computing Research, 12*(2), 147-158.

Button, L. A. (2008). Effect of social support and coping strategies on the relationship between health care-related occupational stress and health. *Journal of Research in Nursing, 13*(6), 498-524.

Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science, 22*(4), 16-31.

Canales, M. K. (2010). Othering: Difference understood??: A 10-year analysis and critique of the nursing literature. *Advances in Nursing Science, 33*(1), 15-34.

Carayon, P., & Gurses, A. P. (2008). Nursing workload and patient safety—A human factors engineering perspective. In R. G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* Rockville, MD Agency for Healthcare Reserach and Quality.

Cardoso, J. B., & Thompson, S. (2010). Common themes of resilience among Latino immigrant families: A systematic review of the literature. *Families in Society, 91*(3), 257-265.

Carson, T. L. (1981). Happiness contentment and the good life. *Pacific Philosophical Quarterly, 62*, 378-392.

Carver, C. S. (1975). Physical aggression as a function of objective self-awareness and attitudes toward punishment.. *Journal of Experimental Social Psychology, 11*(6), 510-519.

Castro, A., Scandura, T. A., & Williams, E. A. (in press). Validity of Scandura and Ragins' (1993) Multidimensional Mentoring Measure: An Evaluation and Refinement. *Journal of Career Assessment*.

Catanzaro, M. (1988). Using qualitative analytic techniques. In P. Woods & M. Catanzaro (Eds.), I*n Nursing Research; Theory and practice* (pp. 437-456). New York, NY: Mosby.

Cavanagh, S. (1997). Content analysis: Concepts, methods and applications. *Nurse Researcher 4*(3), 5-16.

Chang, E. M., Hancock, K. M., Johnson, A., Daly, J., & Jackson, D. (2005). Role stress in nurses: Review of related factors and strategies for moving forward. *Nursing & Health Sciences, 7*(1), 57-65.

Chege, N., & Garon, M. (2010). Adaptation challenges facing internationally educated nurses. *Dimensions of Critical Care Nursing, 29*(3), 131-135

Chen, G., Gully, S. M., & Eden, D. (2001). Validation of a new general self-efficacy scale. *Organizational Research Methods, 4*(1), 62-83.

Chen, G., Gully, S. M., & Eden, D. (2004). General self-efficacy and self-esteem: Toward theoretical and empirical distinction between correlated self-evaluations. *Journal of Organizational Behavior, 25*(3), 375-395.

Chen, P. G., Nunez-Smith, M., Bernheim, S. M., Berg, D., Gozu, A., & Curry, L. A. (2010). Professional experiences of international medical graduates practicing primary care in the United States. *Journal of general internal medicine, 25*(9), 947-953.

Cho, J.-O., & Cooley, T. F. (1994). Employment and hours over the business cycle. *Journal of Economic Dynamics and Control, 18*(2), 411-432.

Creighton, H. (1964). Nurse clinician needs special line of advancement. *Modern Hospitals 103*, 106-107.

Crim, B. J., & Hood, A. W. (1995). Learning partners: Preceptor, mentor, facilitator, learner. *Seminars in Perioperative Nursing, 4*(1), 67-72.

Crothers, L. M., Hughes, T. L., & Morine, K. A. (2008). *Theory and cases in school-based consultation: A resource for school psychologists, school counselors, special educators, and other mental health professionals.* . New York NY: Routledge.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage.

Cohen, S. A. (2009). A review of demographic and infrastructural factors and potential solutions to the physician and nursing shortage predicted to impact the growing U.S. elderly population. *Journal of Public Health Management and Practice, 15*(4), 352-362.

Cohen, J. (1992). A power primer. *Psychological Bulletin 112,* 155–159.

Colarelli, S. M., & Bishop, R. C. (1990). Career commitment. Functions, correlates and management. *Group and Organization Studies,15,* 158-176.

Committee on the Robert Wood Johnson Foundation Initiative on the future of nursing at the Institute of Medicine. (2010). The future of nursing: Leading change advancing health Retreived from http://www.rwjf.org/files/research/Future%20of%20Nursing_Leading%20Change%20Advancing%20Health.pdf

Cook, C., Heath, F., & Thompson, R. L. (2000). A meta-analysis of response rates in web- or internet-based surveys. *Educational and Psychological Measurement, 60*(6), 821-836.

Corley, M. C., & Mauksch, H. O. (1993). The nurse's multiple commitments. *Journal of Professional Nursing, 9*(2), 116-122.

Cortese, C. G., Colombo, L., & Ghislieri, C. (2010). Determinants of nurses' job satisfaction: the role of work-family conflict, job demand, emotional charge and social support. *Journal of Nursing Management, 18*(1), 35-43.

Crawford, P., Brown, B., & Majomi, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies, 45*(7), 1055-1063.

Dalley, K., & Smith, P. M. (2000). Room at The Top? Claim your spot at the executive level. *Nursing Management, 31*(3), 32-36.

Daniel, P., Chamberlain, A., & Gordon, F. (2001). Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing, 10*(4), 254-265.

Darling, L. A. (1984). The mentoring dimension: What do nurses want in a mentor? . *Journal of Nursing Administration, 14*(10), 42-44.

Davidhizar, R. (1988). Mentoring in doctoral education. *Journal of Advanced Nursing, 13,* 775-781.

Davidhizar, R., & Giny, Y. (2004). Self-promotion: A strategy for career advancement. *Health Care Manager, 23*(1), 11-14.

Day, R., & Allen, T. D. (2004). The relationship between career motivation and self-efficacy with protégé career success. *Journal of Vocational Behavior, 64*(1), 72-91.

DeCicco, J., Laschinger, H., & Kerr, M. (2006). Perceptions of empowerment and respect: Effect on nurses' organizational commitment in nursing homes. *Journal of Gerontological Nursing 32*(5).49-56

DeGroot, H. A., Burke, L. J., & George, V. M. (1998). Implementing the differential pay structure model. *Journal of Nursing Administration 28*, 28–38.

Dellasega, C. A. (2009). Bullying among nurses. *AJN The American Journal of Nursing, 109*(1), 52-58.

Dicicco-Bloom, B. (2004). The racial and gendered experiences of immigrant nurses from Kerala, India. *Journal of Transcultural Nursing, 15*(1), 26-33.

Dondale, K. (2010). Nurses eat their young . *NENA Outlook, 33*(1), 5.

Donaldson, J. H., & Carter, D. (2005). The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students. *Nurse Education in Practice, 5*(6), 353-359.

Dorsey, L. E., & Baker, C. M. (2004). Mentoring Undergraduate Nursing Students: Assessing the State of the Science. *Nurse Educator, 29*(6), 260-265

Douglas, C. A., & Schoorman, F. D. (1988, August). *The impact of career and psycho-social mentoring by supervisors and peers.* Paper presented at the 48th Annual Meeting of the Academy of Management Anaheim, CA.

Downe-Wamboldt, B. (1992). Content analysis: Method, applications, and issues. *Health Care For Women International, 13*(3), 313-321.

Dracup, K., & Bryan-Brown, C. W. (2004). From novice to expert to mentor: Shaping the future. *American Journal of Critical Care, 13*(6), 448-450.

Dreachslin, J., & Foster, E. F. (2004). Study of factors affecting the career advancement of women and racially/ethnically diverse individuals in healthcare management. *Journal of Health Administration Education, 21*(4), 441-448.

Dreher, G. F., & Cox Jr, T. H. (1996). Race, gender, and opportunity: A study of compensation attainment and the establishment of mentoring relationships. *Journal of Applied Psychology, 81*(3), 297-308

Dreher, G. F., & Ash, R. A. (1990). A comparative study of mentoring among men and women in managerial, professional, and technical positions. *Journal of Applied Psychology* (75), 539-546.

Drenkard, K., & Swartwout, E. (2005). Effectiveness of a clinical ladder program. *Journal of Nursing Administration, 35*(11), 502-506.

Drey, N., Gould, D., & Allan, T. (2009). The relationship between continuing professional education and commitment to nursing. *Nurse Education Today, 29*(7), 740-745.

Duncan, D. F. (1989). Content analysis in health educaton research: An introduction to purposes and methods. *Heatlth Education, 20*(7), 27-31.

Ea, E. (Nov. 30, 2007). Facilitating acculturation of foreign-educated nurses. *Online Journal of Issues in Nursing, 13*(1). Retrieved on October 13, 2010 from http://www.nursingworld.org/mainmenucategories/anamarketplace/anaperiodicals/ojin/tableofcontents/vol132008/no1jan08/articlepreviousto pic/foreigneducatednurses.aspx

Earvolino-Ramirez, M. (2007). Resilience: A concept analysis. *Nursing Forum, 42*(2), 73-82.

Eby, L. T., Lockwood, A. L., & Butts, M. (2006). Perceived support for mentoring: A multiple perspectives approach. *Journal of Vocational Behavior, 68*(2), 267-291.

Eden, D. (2001). Means efficacy: External sources of general and specific efficacy. In M. Ere & U. Klein Beck (Eds.), *Work motivation in the context of a globalizing economy* (pp. 73-85). Mahwah NJ: Lawrence Erlbaum.

Edwards, P. A., & Davis, C. R. (2006). Internationally educated nurses'perceptions of their clinical competence. *The Journal of Continuing Education in Nursing, 37*(6), 265-269.

Elgie, R. (2007). Politics, economics, and nursing shortages: A critical look at United States Government policies. *Nursing Economics, 25*(5), 285-292.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115.

Ensher, E. A., Grant-Vallone, E. J., & Donaldson, S. I. (2001). Effects of perceived discrimination on job satisfaction, organizational commitment, organizational citizenship behavior, and grievances. *Human Resource Development Quarterly, 12*(1), 53-72.

Ensher, E. A., & Murphy, S. E. (1997). Effects of race, gender, perceived similarity, and contact on mentor Relationships. *Journal of Vocational Behavior, 50*(3), 460-481.

Ensher, E. A., Thomas, C., & Murphy, S. E. (2001). Comparison of traditional, step-ahead, and peer mentoring on protégé support, satisfaction, and perceptions of career success: A social exchange perspective. *Journal of Business and Psychology, 15*(3), 419-438.

Fagenson, E. A. (1989). The mentor advantage: Perceived career/job experiences of protégés versus Non-protégés. *Journal of Organizational Behavior, 10*(4), 309-320.

Fasoli, D. R. (2010). The culture of nursing engagement: A historical perspective. *Nursing Administration Quarterly, 34*(1), 18-29.

Fawcett, J. (2003). On bed baths and conceptual models of nursing. *Journal of Advanced Nursing, 44*(3), 229-230.

Featherstone, B. (2006). Rethinking family support in the current policy context. *British Journal of Social Work, 36*(1), 5-19.

Fitzpatrick, J. J., & Abraham, I. (1987). Toward the socialization of scholars and scientists. *Nurse Educator, 12*(3), 23-25.

Flynn, L., & Aiken, L. (2002). Does international nurse recruitment influence practice values in U.S. hospitals? *Journal of Nursing Scholarship, 34*(1), 67-73.

Fowler, J. L., Gudmundsson, A. J., & O'Gorman, J. G. (2007). The relationship between mentee-mentor gender combination and the provision of distinct mentoring functions. *Women in Management Review, 22*(8), 666-681.

Friedman, S. D., & Greenhaus, J. H. (2000). *Work and family – Allies or enemies? What happens when business professionals confront life choices.* New York NY: Oxford University Press.

Friss, L. (1983). Organisational commitment and job involvement in directors of nursing services. *Nursing Administration Quarterly, 7*(2), 1-10.

Furaker, C. (2003) Vardenhetsschefers mal och arbete Ward manager's goals and work. *Verdi Norden* 3, 27–32.

Fusilero, J., Lini, L., Prohaska, P., Szweda, C., Carney, K., & Mion, L. C. (2008). The career advancement for registered nurse excellence program. *Journal of Nursing Administration, 38*(12), 526-531.

Gardner, D. L. (1992). Career commitment in nursing. *Journal of Professional Nursing, 8*(3), 155-160.

Gardner, D. G., & Pierce, J. L. (1998). Self-esteem and self-efficacy within the organizational context: An empirical examination. *Group Organization Management, 23*(1), 48-70.

Gaudine, A. P. (2000). What do nurses mean by workload and work overload? *Canadian Journal of Nursing Leadership, 13*(2), 22-27.

Gibb, S. (1999). The usefulness of theory: A case study in evaluating formal mentoring schemes. *Human Relations, 52*(8), 1055-1075.

Gibb, H., Anderson, J., & Forsyth, K. (2004). Developing support for remote nursing education through workplace culture that values learning. *Australian Journal of Rural Health, 12*(5), 201-205.

Gibson, D. E. (2004). Role models in career development: New directions for theory and research. *Journal of Vocational Behavior, 65*(1), 134-156.

Gibson, T., & Heartfield, M. (2005). Mentoring for nurses in general practice: An Australian study. *Journal of Inte-professional Care, 19*(1), 50-62.

Girard, N. J. (2003). Competency is no reason for complacency. *AORN Journal, 77*(5), 908.

Godshalk, V. M., & Sosik, J. J. (2003). Aiming for career success: The role of learning goal orientation in mentoring relationships. *Journal of Vocational Behavior, 63*(3), 417-437.

Goodrich, C. A., & Ward, C. W. (2004). Evaluation and Revision of a Clinical Advancement program. *MedSurg Nursing, 13*(6), 391-398.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112.

Green, S. B. (1991). How many subjects does it take to do a regression analysis? *Multivariate Behavioral Research*, 26, 499-510.

Greene, M. T., & Puetzer, M. (2002). The value of mentoring: A strategic approach to retention and recruitment. *Journal of Nursing Care Quality, 17*(1), 63-70.

Greenhaus, J. H., & Beutell, N. J. (1985). Sources of conflict between work and family roles. *The Academy of Management Review, 10*(1), 76-88.

Greenhaus, J. H., & Powell, G. N. (2006). When work and family are allies: A theory of work family enrichment. *Academy of Management Review, , 31(1), 72–92.*(1), 72-92.

Grzywacz, J. G., Arcury, T. A., Márin, A., Carrillo, L., Burke, B., Coates, M. L., Quandt, S. A. (2007). Work-family conflict: Experiences and health implications among immigrant Latinos. *Journal of Applied Psychology, 92(4), 1119-1130.*

Grzywacz, J. G., & Marks, N. F. (2000). Reconceptualizing the work–family interface: An ecological perspective on the correlates of positive and negative spillover between work and family. *Journal of Occupational Health Psychology, 5*(1), 111-126.

Gustin, T. J., Semler, J. E., Holcomb, M. W., Gmeiner, J. L., Brumberg, A. E., Martin, P. A., Lupo, T.C. (1998). A clinical advancement program: Creating an environment for professional growth. *Journal of Nursing Administration, 28*(10), 33-39.

Hackett, G., & Betz, N. E. (1981). A self-efficacy approach to the career development of women. *Journal of Vocational Behavior, 18*(3), 326-339.

Hagey, R., Choudhry, U., Guruge, S., Turrittin, J., Collins, E., & Lee, R. (2001). Immigrant nurses' experience of racism. *Journal of Nursing Scholarship, 33*(4), 389-394.

Happell, B. (2004). Facilitating the professional development role of clinicians: Evaluating the impact of the clinician-trainer program. *Nurse Education in Practice, 4*(2), 83-90.

Harper, J. P. (2000). Nurses' attitudes and practices regarding voluntary continuing education. *Journal for Nurses in Staff Development, 16*(4), 164-167.

Havens, D. S., & Laschinger, H. S. (1997). Creating the environment to support shared governance: Kanter's theory of power in organizations. *Journal of Shared Governance, 3*(1), 15-23

Hawthorne, L. (2001). The globalisation of the nursing workforce: Barriers confronting overseas qualified nurses in Australia. *Nursing Inquiry, 8*, 213-229.

Hayes, E. F. (1998). Mentoring and nurse practitioner student self-efficacy. *Western Journal of Nursing Research, 20*(5), 521-535.

Heale, R., & Griffin, M. T. Q. (2009). Self-efficacy with application to adolescent smoking cessation: A concept analysis. *Journal of Advanced Nursing, 65*(4), 912-918.

Health Resources and Services Administration (2004). *What is behind HRSA projected Supply, demand, and shortage of registered nurses*. Retrieved from ftp://ftp.hrsa.gov/bhpr/workforce/behindshortage.pdf

Health Resources and Services Administration (HRSA). (2010). *The registered nurse population: Findings from the 2008 National Sample Survey of Registered Nurses*. Retrieved from http://bhpr.hrsa.gov/healthworkforce/rnsurvey/2008/nssrn2008.pdf

Heesch, K. C., & Mâsse, L. C. (2004). Lack of time for physical activity: Perception or reality for African American and Hispanic Women? *Women & Health, 39*(3), 45-62.

Henry, L (2007). Institutionalized disadvantage: Older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS. *Journal of Clinical Nursing, 16*(12), 2196-2203.

Heslin, P. A., & Klehe, U. C. (2006). Self-efficacy In S.G. Rogelberg (Ed.) *Encyclopedia of industrial/organizational Psychology* (Vol. 2, pp. 705-708). Thousand Oaks CA: Sage.

Hogg, M. A. (2001). A social identity theory of leadership. *Personality and Social Psychology Review, 5*(3), 184-200.

Hogg, M. A., & Terry, D. J. (2000). Social identity and self-categorization processes in organizational contexts. *The Academy of Management Review, 25*(1), 121-140.

Holton, G. (2004). Robert K. Merton: Biographical memoirs.*Proceedings of the American Philosophical Society, 148*(4), 506–517.

Hornsey, M. J. (2008). Social identity theory and self-categorization theory: A historical review. *Social and Personality Psychology Compass, 2*(1), 204-222.

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288.

Hsu, N., Chen, B., Lee, L., Chen, C., & Lai, C. (2005). The comparison of nursing competence pre- and post implementing clinical ladder system. *Journal of Clinical Nursing, 14*(2), 264-265.

Hunt, D. M., & Michael, C. (1983). Mentorship: A career training and development tool. *Academy of Management Review, 8*(3), 475-485.

Huston, C. J., & Percival, E. (2009). Quick reads: The international Academic Nursing Alliance (IANA): A resource for global nursing knowledge exchange. *Nursing Education Perspectives, 30*(3), 188-190.

Hyrkäs, K., & Shoemaker, M. (2007). Changes in the preceptor role: re-visiting preceptors' perceptions of benefits, rewards, support and commitment to the role. *Journal of Advanced Nursing, 60*(5), 513-524.

Ismail, M., & Arokiasamy, L (2007). Exploring mentoring as a tool for career advancement of academics in private higher education institutions in Malaysia. *The Journal of International Social Research, 1*(1), 135-148.

Jasovsky, D., Grant, V., & Lang, M. (2010). How do you define nursing excellence? *Nursing Management, 41* 19-24.

Jinks, A. M., & Chalder, G. (2007). Consensus and diversity: an action research study designed to analyse the roles of a group of mental health consultant nurses. *Journal of Clinical Nursing, 16*(7), 1323-1332.

Joel, L. A. (1990). Changes in the hospital as a place of practice. In J. McClosky and H.K. Grace (Eds.) *Current issues in nursing, p.238.* St Louis, MO: The C.V. Mosby Company.

Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication, 16*(2), 255-271.

Johnson, S. K., Geroy, G. D., & Griego, O. V. (1999). The mentoring model theory: dimensions in mentoring protocols. *Career Development International, 4*, 384-391.

Jones, D. P. (2009). Preparing African American nurses for graduate school: Practical tips. Journal of the Association of Black Nursing Faculty (ABNF), *20*(3), 76-80.

Kahn, R. L., Wolfe, D. M., Quinn, R., Snoek, J. D., & Rosenthal, R. A. (1964). *Organizational stress*. New York NY: Wiley.

Kalbfleisch, P. J., & Bach, B. W. (1998). The language of mentoring in a health care environment. *Health Communication, 10*(4), 373-392.

Kalbfleisch, P. J., & Davies, A. B. (1993). An interpersonal model for participation in mentoring relationships *Western Journal of Communication, 57,* 399-415.

Kammeyer-Mueller, J. D., & Judge, T. A. (2008). A quantitative review of mentoring research: Test of a model. *Journal of Vocational Behavior, 72*(3), 269-283.

Kanai-Pak, M., Aiken, L. H., Sloane, D. M., & Poghosyan, L. (2008). Poor work environments and nurse inexperience are associated with burnout, job dissatisfaction and quality deficits in Japanese hospitals. *Journal of Clinical Nursing, 17*(24), 3324-3329.

Kanter, R. M. (1993). *Men and women of the corporation, (2nd ed)*. NewYork NY: Basic Books.

Kaplowitz, M. D., Hadlock, T. D., & Levine, R. (2004). A comparison of web and mail survey response rates. *Public Opinion Quarterly, 68*(1), 94-101.

Kay, F. M., Hagan, J., & Parker, P. (2009). Principals in practice: The importance of mentorship in the early stages of career development. *Law & Policy, 31*(1), 69-110.

Kelloway, E. K., Sivanthan, N., Francis, L., & Barling, J. (2005). Poor leadership. In J. Barling, E. K. Kelloway, & M. Frone (Eds.), *Handbook of Workplace Stress*. Thousand Oaks CA SAGE.

Kim, M. S. (2009). Role of self-leadership in the relationship between organizational culture and informatics competency. *Journal of Korean Academy of Nursing, 39*(5), 731-740.

Knafl, K. A., & Breitmayer, B. J. (Eds.). (1989). *Triangulation in qualitative research: Issues of conceptual clarity and purpose, In qualitative nursing research J.M. Morse (Ed.).* Aspen, Rockville, Maryland.

Knafl, K. A., & Breitmayer, B. J. (Eds.). (1991). *Triangulation in qualitative research: Issues of conceptual clarity and purpose, In J.M. Morse (Ed.).* Newbury Park, CA: Sage.

Koberg, C. S., Boss, R. W., Chappell, D., & Ringer, R. C. (1994). Correlates and consequences of protégé mentoring in a large hospital. *Group Organization Management, 19*(2), 219-239.

Koberg, C. S., Boss, R. W., & Goodman, E. (1998). Factors and outcomes associated with mentoring among health-care professionals. *Journal of Vocational Behavior, 53*(1), 58-72.

Kolbe, R. H., & Burnett, M. S. (1991). Content-Analysis Research: An Examination of Applications with Directives for Improving Research Reliability and Objectivity. *The Journal of Consumer Research, 18*(2), 243-250.Kondracki, N. L., Wellman, N. S., & Amundson, D. R. (2002). Content Analysis: Review of methods and their applications in nutrition education. *Journal of Nutrition Education and Behavior, 34*(4), 224-230.

Kovach, C. R. (1991). Content analysis of reminiscences of elderly women. *Research in Nursing & Health, 14*(4), 287-295.

Kram, K. E. (1983). Phases of the mentor relationship. *Academic of Management Journal*, 26(4)608-625.

Kram, K. E. (1985). *Mentoring at work: Developmental relationships in organizational life*. Glenview IL: Scott, Foresman.

Krippendorff, K. (2004). *Content analysis: An introduction to its methodology.* Thousand Oaks CA: SAGE.

Krugman, M. (2008). Continuing nursing education accreditation: What you need to know. *Colorado Nurse, 108*, 9.

Krugman, M., Smith, K. M., & Goode, C. (2000). A clinical advancement program: Evaluating 10 years of progressive change. *Journal of Nursing Administration, 30*(5), 215-225.

Kullman, J. (1998). Mentoring and the development of reflective practice: concepts and context. *System, 26*(4), 471-484.

Kwan, H. K., Liu, J. & Yim, F. H. (2011). Effects of mentoring functions on receivers' organizational citizenship behavior in a Chinese context: A two-study investigation. *Journal of Business Research, 64*(4), 363-370.

Larsen, J. A. (2007). Embodiment of discrimination and overseas nurseses career progression. *Journal of Clinical Nursing, 16*(12), 2187-2195

Lash, A. A., & Munroe, D. J. (2005). Magnet designation: A communiqué to the profession and the public about nursing excellence. *Medical Surgical Nursing, April Suplemntal* 7-13.

Lee, C. H. (2006). Nursing 2006 salary survey. *Nursing, 36*(10), 46-57.

Levett-Jones, T. L. (2005). Continuing education for nurses: a necessity or a nicety? *Journal of Continuing Education in Nursing, 36*(5), 229-233.

Lichstein, P. R., & Young, G. (1996). “My most meaningful patient". Reflective learning on a general medicine service. *Journal of General Internal Medicine, 11*(7), 406-409.

Lin, P., & Wang, R. (1997). Perceived self-efficacy for weight control and related factors among obese junior high school students [Chinese]. *Nursing Research, 5*(5), 401-412

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*: Beverly Hills, Calif.: Sage Publications.

Little, D. M. (1991) Shattering the glass ceiling (Survey of Women in the Senior Executive Service). *Bureaucrat, Fall*(*20),* 24-48.

Lockwood-Rayermann, S. (2003). Preceptor leadership style and the nursing practicum. *Journal of Professional Nursing, 19*(1), 32-37.

Lombe, M., & Sherraden, M. (2008). Inclusion in the policy process: An agenda for participation of the marginalized. *Journal of Policy Practice, 7*(2/3), 199-213.

Lu, K.-Y., Chang, L.-C., & Wu, H.-L. (2009). Relationships between professional commitment, job satisfaction, and work stress in public health nurses in Taiwan. *Journal of Professional Nursing, 23*(2), 110-116.

Ludwick, R., & Silva, M. C. (August 14, 2000). Ethics: Nursing around the world: Cultural values and ethical conflicts. *Online Journal of Issues in Nursing, 5*(3). Retrieved from www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Columns/Ethics/CulturalValuesandEthicalConflicts.aspx

Lyneham, J., Parkinson, C., & Denholm, C. (2008). Explicating Benner's concept of expert practice: Intuition in emergency nursing. *Journal of Advanced Nursing, 64*(4), 380-387.

Lyons, B. D., & Oppler, E. S. (2004). The effects of structural attributes and demographic characteristics on protege satisfaction in mentoring programs. *Journal of Career Development, 30*(3), 215-229.

MacLeod, M. L. P. (1996). *Practicing nursing, becoming experienced* New York NY: Churchill, Livingstone.

Malhotra, S., & Sachdeva, S. (2005). Social roles and role conflict: An interprofessional study among women. *Journal of the Indian Academy of Applied Psychology, 31*(1-2), 37-42.

Manz, C. C. (1986). Self-leadership: Toward an expanded theory of self-influence processes in organizations. *The Academy of Management Review, 11*(3), 585-600.

Martin, M. Y., Person, S. D., Kratt, P., Prayor-Patterson, H., Kim, Y., Salas, M., Pisu, M. (2008). Relationship of health behavior theories with self-efficacy among insufficiently active hypertensive African-American women. *Patient Education & Counseling, 72*(1), 137-145.

Matheson, L. K., & Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of professional nursing, 23*(4), 226-234.

Matiti, M. R., & Taylor, D. (2005). The cultural lived experience of internationally recruited nurses: A phenomenological study. *Diversity in Health and Social Care, 2*(1), 7-15.

Mayrhofer, W., Meyer, M., Schiffinger, M., & Schmidt, A. (2008). The influence of family responsibilities, career fields and gender on career success: An empirical study. *Journal of Managerial Psychology, 23*(3), 292-323

Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal, 311*(6997), 109-112.

McClure, M. L., Poulin, M. A., Sovie, M. D., & Wandelt, M. A. (2002). Magnet hospitals: Attraction and retention of professional nurses . In M. L. McClure, & A. S. Hinshaw (Eds.), Magnet hospitals revisited: Attraction and retention of professional nurses (pp. 2-22). Washington, DC: American Nurses.

McDonald, G., Vickers, M. H., Mohan, S., Wilkes, L., & Jackson, D. (2010). Workplace conversations: Building and maintaining collaborative capital. *Contemporary Nurse, 36*(1-2), 96-105.

Mc Gonagle, C., Halloran, S. O., & O'Reilly, O. (2004). The expectations and experiences of Filipino nurses working in an intellectual disability service in the Republic of Ireland. *Journal of Learning Disabilities, 8*(4), 371-381.

McGuire, G. M. (1999). Do race and sex affect employees' access to and help from mentors? Insights from the study of a large corporation In A. J. Murrell, F. J. Crosby, & R. Ely Eds. *Mentoring dilemmas: Developmental relationships within multicultural organizations. Mahwah, NJ, Erlbaum.*

McGaghie, W. C., & Webster, A. (2009). Scholarship, publication, and career advancement in health professions education: AMEE Guide No. 43. [Article]. *Medical Teacher, 31*(7), 574-590.

Meadus, R. J. (2000). Men in nursing: Barriers to recruitment. *Nursing Forum, 35*(3), 5-12.

Meleis, A. I., Hall, J. M., & Stevens, P. E. (1994). Scholarly caring in doctoral nursing: Promoting diversity and collaborative mentorship. *Journal of Nursing Scholarship, 26*(3), 177-180.

Meraviglia, M., Grobe, S. J., Tabone, S., Wainwright, M., Shelton, S., Miner, H., Jordan, C. (2009). Creating a positive work environment: Implementation of the nurse-friendly hospital criteria. *Journal of Nursing Administration, 39*(2), 64-70

Miller, P. A., Goddard, P., & Laschinger, H. K. S. (2001). Evaluating physical therapists' perception of empowerment using Kanter'stheory of structural power in organizations. *Physical Therapy, 81(12),* 1880–1888.

Mills, J. F., & Mullins, A. C. (2008). The California Nurse Mentor Project: Every nurse deserves a mentor. *Nursing Economic$, 26*(5), 310-315.

Milton, C. L. (2004). The ethics of personal integrity in leadership and mentorship: A nursing theoretical perspective. *Nursing Science Quarterly, 17*(2), 116-120.

Mullen, E. (1994). Framing the mentoring relationship in an information exchange. *Human Resource Management Review, 4*, 257-281.

Muller, J., Maclean, R., & Biggs, H. (2009). The impact of a supportive leadership program in a policing organisation from the participants' perspective. *Work, 32*(1), 69-79.

Neck, C. P., & Houghton, J. D. (2006). Two decades of self-leadership theory and research:Past developments, present trends, and future possibilities. *Journal of Managerial Psychology: Self-leadership 21*(4), 270-295.

Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine, 346*(22), 1715-1722.

Nelson, J. M., & Cook, P. F. (2008). Evaluation of a career ladder program in an ambulatory care environment. *Nursing Economic$, 26*(6), 353-360.

Nelson, J., Sassaman, B., & Phillips, A. (2008). Career ladder program for registered nurses in ambulatory care. *Nursing Economic$, 26*(6), 393-398.

Ng, T. W. H., Eby, L. T., Sorensen, K. L., & Feldman, D. C. (2005). Predictors of objective and subjective career sucess: A meta-analysis. *Personnel Psychology, 58*(2), 367-408.

Nichols, J., & Campbell, J. (2010). The experiences of internationally recruited nurses in the UK (1995-2007): An integrative review. *Journal of Clinical Nursing, 19*(19/20), 2814-2823.

Nirel, N., Goldwag, R., Feigenberg, Z., Abadi, D., & Halpern, P. (2008). Stress, work overload, burnout, and satisfaction among paramedics in Israel. *Prehospital & Disaster Medicine, 23*(6), 537-546.

Noe, R. A. (1988a). Women and mentoring: A review and research agenda. *The Academy of Management Review, 13*(1), 65-78.

Noë, R. A. (1988b). An investigation of the determinants of successful assigned mentoring relationship. *Personnel Psychology, 41*(3), 457-479.

Nolan, M. (2010). Resilience among very old men and women. *Journal of Research in Nursing, 15*(5), 419-431.

O'Brien, T. (2007). Overseas nurses in the National Health Service: A process of deskilling. *Journal of Clinical Nursing, 16*(12), 2229-2236.

Office of Management Budget (2008). *Update of statistical area definitions and guidance on their uses*. Retrieved from http://www.whitehouse.gov/omb/assets/omb/bulletins/fy2009/09-01.pdf

O'Gorman, R., Wilson, D. S., & Miller, R. R. (2008). An evolved cognitive bias for social norms. *Evolution and Human Behavior, 29*(2), 71-78.

Olian, J. D., Carroll, S. J., Giannantonio, C. M., & Feren, D. B. (1988). What do proteges look for in a mentor? Results of three experimental studies. *Journal of Vocational Behavior, 33*(1), 15-37.

Oliver, C., & Aggleton, P. (2002). Mentoring for professional development in health promotion: A review of issues raised by recent research. *Health Education & Behavior, 102*(1), 30-38.

Owens, B. H., Herrick, C. A., & Kelley, J. A. (1998). A prearranged mentorship program: Can it work long distance? *Journal of Professional Nursing, 14*(2), 78-84.

PA State Board OF Nursing (SBON). (Janury 4, 2010). *FAQs on mandatory continuing education (CE) for registered nurses*. Retrieved from http://www.recovery.pa.gov/portal/server.pt/community/state_board_of_nursing/12515

Pachulicz, S., Schmitt, N., & Kuljanin, G. (2008). A model of career success: A longitudinal study of emergency physicians. *Journal of Vocational Behavior, 73*(2), 242-253.

Pajares, F. (2002). *Overview of social cognitive theory and of self-efficacy*. Retrieved from http://www.emory.edu/EDUCATION/mfp/eff.html

Pajares, F., & Valiante, G. (1999). Grade level and gender differences in the writing self-beliefs of middle school students. *Contemporary Educational Psychology, 24*(4), 390-405.

Palgi, M., & Moore, G. (2004). Social Capital: Mentors and Contacts. *Current Sociology, 52*(3), 459-480.

Parse, R. R. (1998). *The human becoming school of thought : A perspective for nurses and other health professional*. Thousand Oaks, CA: Sage.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Service Research, 34*(5 Pt2), 1189–1208.

Pearson, A., Laschinger, H., Porritt, K., Jordan, Z., Tucker, D., & Long, L. (2007). Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. *International Journal of Evidence-Based Healthcare, 5*(2), 208-253.

Pearson, A., Srivastava, R., Craig, D., Tucker, D., Grinspun, D., Bajnok, I., Griffin, P., Long, l.,

Porritt, K., Han, T., A Gi, A., (2007). Systematic review on embracing cultural diversity for developing and sustaining a healthy work environment in healthcare. *International Journal of Evidence-Based Healthcare, 5*(1), 54-91.

Pekmezi, D., Jennings, E., & Marcus, B. H. (2009). Evaluating and enhancing self-efficacy for physical activity. *ACSM's Health & Fitness Journal, 13*(2), 16-21.

Pellico, L., Djukic, M., Kovner, C., & Brewer, C. (Nov. 2, 2009). Moving on, up, or out: Changing work needs of new RNs at different stages of their beginning nursing practice. *OJIN: The Online Journal of Issues in Nursing 15*(1). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/

Penn, H., & Gough, D. (2002). The price of a loaf of bread: Some conceptions of family support. *16*, 17-32.

Penz, K., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D., & Smith, B. (2007). Barriers to participation in continuing education activities among rural and remote nurses. *Journal of Continuing Education in Nursing, 38*(2), 58-68.

Pilette, P. C. (2006). Collaborative capital: conversation for a change. *Nursing Management, 37*(11), 24-29.

Pittenger, K. K. S., & Heimann, B. A. (2000). Building effective mentoring relationships. *Review of Business, 21*(1/2), 38.

Polit, D. F., & Hungler, B. P. (1999). *Nursing research: Principles and Method (6th ed.)*. Philadelphia PA: Lippincott, Williams, Wilkins.

Polsky, D., Ross, S. J., Brush, B. L., & Sochalski, J. (2007). Trends in characteristics and country of origin among foreign-trained nurses in the United States, 1990 and 2000. *American Journal of Public Health, 97*(5), 895-889.

Poon, R. (2006). A model for Servant Leadership, self-efficacy and mentorship. Retrieved from http://www.cgel.org/LinkClick.aspx?fileticket=d%2BLBuQx%2BpPA%3D&tabid=1281&mid=1864

Porter-O'Grady, T. (2007). *Quantum Leadership: A resource for healthcare innovation (2nd Ed)*. Sudbury, MA: Jones and Bartlett.

Portney, L. G., & Watkins, M. P. (2009). *Foundations of clinical research: Application to practice (3rd Ed.)7* Upper Saddle River, NJ: Prentice Hall Health.

Prestholdt, C. O. (1990). Modern mentoring: Strategies for developing contemporary nursing leadership. *Nursing Administration Quarterly, 15*(1), 20-27.

Pudney, S., & Shields, M. (2000). Gender, race, pay and promotion in the British nursing profession: Estimation of a generalized ordered probit model. *Journal of Applied Econometrics, 15*(4), 367-399.

Ragins, B. R. (1999). Gender and mentoring relationships: A review and research agenda for the next decade. In G. N. Powell (Ed.), *Handbook of gender and work* (pp. 347-370). Thousand Oaks CA: Sage.

Ragins, B. R., & Cotton, J. L. (1999). Mentor functions and outcomes: A comparison of men and women in formal and informal mentoring relationships. *Journal of Applied Psychology, 84*(4), 529-550.

Ragins, B. R., Cotton, J. L., & Miller, J. S. (2000). Marginal mentoring: The effects of type of mentor, quality of relationship, and program design on work and career attitudes *Academy of Management Journal, 43*(6), 1171-1194.

Rahimaghaee, F., Nayeri, D., & Mohammadi, E. (2010). Iranian nurses´ perceptions of their professional growth and development. *OJIN: The Online Journal of Issues in Nursing, 16*(1).

Rawl, S. M., & Peterson, L. M. (1992). Nursing education administrators: Level of career development and mentoring. *Journal of Professional Nursing, 8*(3), 161-169.

Reed, E. S. (1996). *The necessity of experience*. New Haven CT: Yale University Press.

Reineck, C., & Furino, A. (2005). Nursing career fulfillment: Statistics and statements from registered nurses. *Nursing Economic$, 23*(1), 25-30.

Reuler, J. B., & Nardone, D. A. (1994). Role modeling in medical education. *Western Journal of Medicine, 160*(4), 335-337.

Ricker, F. (2008). A supportive nursing model: Innovative nurse residency program eases new graduate transition. *Colorado Nurse, 108*(2), 6-7.

Reilly, N. P., & Orsak, C. L. (1991). A career stage analysis of career and organizational commitment in nursing. *Journal of Vocational Behavior, 39*(3), 311-330.

Riley, J. K., Rolband, D. H., James, D., & Norton, H. J. (2009). Clinical ladder: Nurses' perceptions and satisfiers. *Journal of Nursing Administration, 39*(4), 182-188

Rise, J., Sheeran, P., & Hukkelberg, S. (2010). The role of self-identity in the theory of planned behavior: A meta-analysis. *Journal of Applied Social Psychology, 40*(5), 1085-1105.

Risjord, M. W., Dunbar, S. B., & Moloney, M. F. (2002). A New Foundation for Methodological Triangulation. *Journal of Nursing Scholarship, 34*(3), 269-275.

Roberts, H. E., & Foti, R. J. (1998). Evaluating the interaction between self-leadership and work structure in predicting job satisfaction *Journal of Business & Psychology, 12*(3), 257-267.

Roberts, S. J. (1983). Oppressed group behavior: mplications for nursing. *Advances in Nursing Science, 5*(4), 21-30.

Robinson, S. (1994). Professional development in midwifery: findings from a longitudinal study of midwives' careers. *Nurse Education Today, 14*(3), 161-176.

Robinson, K., Eck, C., Keck, B., & Wells, N. (2003). The Vanderbilt professional nursing practice program: Part 1: Growing and supporting professional nursing practice. *Journal of Nursing Administration, 33*(9), 441-450.

Rogers, A. E., Hwang, W., Scott, L. D., Aiken, L. H., & Dinges, D. F. (2004). The working hours of hospital staff nurses and patient safety: Both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch. *Health Affairs, 23*(4), 202-212.

Rokeach, M. (1973). *The nature of human values*. New York NY: Free Press.

Rourke, L., Anderson, T., Garrison, D. R., & Archer, W. (2000). Methodological Issues in the Content Analysis of Computer Conference Transcripts. *International Journal of Artificial Intelligence in Education*(12), 8-22.

Rowe, M. M., & Sherlock, H. (2005). Stress and verbal abuse in nursing: Do burned out nurses eat their young? *Journal of Nursing Management, 13*(3), 242-248.

Saffold, F. (2005). Increasing self-efficacy through mentoring. *Academic Exchange Quarterly* Retrieved from http://www.thefreelibrary.com/_/print/PrintArticle.aspx?id=142636383

Sands, R. G. (2006). Faculty mentoring faculty in a public university. *The Journal of Higher Education, 62,* 174-193.

Scandura, T. A. (1992). Mentorship and career mobility: An empirical investigation. *Journal of Organizational Behavior, 13*(2), 169-174.

Scandura, T. A., & Ragins, B. R. (1993). The effects of sex and gender role orientation on mentorship in male-dominated occupations. *Journal of Vocational Behavior, 43*(3), 251-265.

Scandura, T. A., & Ragins, R. E. (1994). Mentoring in public accounting firms: An analysis of mentor-protégé relationships, mentorship functions, and protégé turnover intentions. *Accounting, Organizations and Society, 19*(8), 717-734.

Schmidt, L., Nelson, D., & Godfrey, L. (2003). A clinical ladder program based on carper's fundamental patterns of knowing in nursing. *Journal of Nursing Administration, 33*(3), 146-152.

Schmieding, N. J. (2000). Minority nurses in leadership positions: A call for action. *Nursing Outlook, 48*(3), 120-127.

Schockett, M. R., & Haring-Hidore, M. (1985). Factor analytic support for psycho-social and vocational mentoring functions *Psychological Reports*, 57, 627-630.

Schoen, L. G., & Winocur, S. (1988). An investigation of the self-efficacy of male and female academics. *Journal of Vocational Behavior, 32*(3), 307-320.

Schultz, A. W. (1993). Evaluation of a clinical advancement system. *Journal of Nursing Administration, 23*(2), 13-19.

Schwartz, S. H. (1992). Universals in the content and structure of values: Theoretical advances and empirical tests in 20 countries. . In M. P. Zanna (Ed.), *Advances in Experimental Social Psychology.* (pp. 1 - 62). San Diego CA Academic Press.

Schwartz, S. H. (1994). Are there universal aspects in the structure and contents of human values? *Journal of Social Issues, 50*(4), 19-45.

Schyns, B. (2004). The influence of occupational self-efficacy on the relationship of leadership behavior and preparedness for occupational change. *Journal of Career Development, 30*(4), 247-261.

Schyns, B., & von Collani, G. (2002). A new occupational self-efficacy scale and its relation to personality constructs and organizational variables. *European Journal of Work and Organizational Psychology, 11*, 219-241.

Seale, C., & Silverman, D. (1997). Ensuring rigour in qualitative research. *The European Journal of Public Health, 7*(4), 379-384.

Seidel, J., & Kelle, K. U. (Eds.). (1995). *Different functions of coding in the analayis of data.* . Thousands Oaks, CA: Sage publications.

Shapiro, M. (1998). A Career ladder based on Benner's model An analysis of expected outcomes. *Journal of Nursing Administration, 28*(3), 13-19.

Shermont, H., Krepcio, D., & Murphy, J. (2009). Career mapping: Developing nurse leaders, reinvigorating careers. *Journal of Nursing Administration, 39*(10), 432-437.

Shirey, M. R. (2009). Authentic leadership, organizational culture, and healthy work environments. *Critical Care Nursing Quarterly, 32*(3), 189-198.

Shirey, M. R. (2005). Celebrating certification in nursing: Forces of magnetism in action. *Nursing Administration Quarterly, 29*(3), 245-253.

Shuman, M., Heer, D., & Fiez, T. S. (2008). Work in progress - Improving self-efficacy with a Freshman Mentor Program. Retrieved from http://eecs.oregonstate.edu/education/news/OSU_WIP_SelfEfficacy.pdf

Shusterman, C. (2005). Expect changes to nurse visa rule this year. *Nursing Management, 36*(1), 14-52.

Silverman, B. E., Goodine, W. M., Ladouceur, M. G., & Quinn, J. (2001). Learning needs of nurses working in Canada's First Nations communities and hospitals. *Journal of Continuing Education in Nursing, 32*(1), 38-47.

Skees, J. (2010). Continuing education: A bridge to excellence in critical care nursing. *Critical Care Nursing Quarterly, 33*(2), 104-116.

Slan-Jerusalim, R., & Chen, C. P. (2009). Work-family conflict and career development theories: A search for helping strategies. *Journal of Counseling & Development, 87*(4), 492-500.

Smith, L. M., Andrusyszyn, M. A., & Spence Laschinger, H. K. (2010). Effects of workplace incivility and empowerment on newly-graduated nurses' organizational commitment. *Journal of Nursing Management, 18*(8), 1004-1015.

Smith, P. (2007). Editorial: Overseas-trained nurses, diversity and discrimination: Perceptions, practice and policy. *Journal of Clinical Nursing, 16*(12), 2185-2186.

Smith, R. B., Heady, J. B., Hamilton, J. B., & Phillips, C. P. (1996). SWIFT: A software program for the analysis of written comments. *Journal of Education for Business, 71*(6), 354–358.

Solveig, R., & Bjork, T. I. (2007). Nurse leader's views on clinical ladders as a strategy in professional development. *Journal of Nursing Management, 15*, 817-824.

Sofarelli, D. & Brown, D. (1998). The need for nursing leadership in uncertain times. *Journal of Nursing Management, 6*(4), 201-207.

Spence Laschinger, H. K. (2008). Effect of empowerment on professional practice environments, work satisfaction, and patient care quality: Further testing the Nursing Worklife Model. *Journal of Nursing Care Quality, 23*(4), 322-330.

Spence Laschinger, H. K., Almost, J., & Tuer-Hodes, D. (2003). Workplace empowerment and magnet hospital characteristics: Making the link. *Journal of Nursing Administration, 33*(7/8), 410-422.

Spence Laschinger, H. K., Wilk, P., Cho, J., & Greco, P. (2009). Empowerment, engagement and perceived effectiveness in nursing work environments: Does experience matter? *Journal of Nursing Management, 17*(5), 636-646.

Stewart, J. G., McNulty, R., Griffin, M. T. Q., & Fitzpatrick, J. J. (2010). Psychological empowerment and structural empowerment among nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 22*(1), 27-34.

Stewart, B. M., & Krueger, L. E. (1996). An evolutionary concept analysis of mentoring in nursing. *Journal of Professional Nursing, 12*(5), 311-321.

Stonewater, B. B., Eveslage, S. A., & Dingerson, M. R. (1990). Gender differences in career helping relationship relationships. *The Career Development Quarterly, 39,* 72-85.

Sullivan, L. W., & Suez Mittman, I. (2010). The state of diversity in the health professions a century after flexner. *Academic Medicine, 85*(2), 246-253

Sutton, F., Smith, C., Wright, K., Arbon, P., Eldredge, K., Forbes, D., Robbillard, N., Zeitz, K. (1996). Discovering and affirming knowledge in nursing practice. *International Journal of Nursing Practice, 2*(2), 63-70.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–48). Monterey CA: Brooks/Cole.

Takeno, Y. (2010). Facilitating the transition of Asian nurses to work in Australia. *Journal of Nursing Management, 18*(2), 215-224.

Teng, C., Dai, Y., Shyu, Y. L., Wong, M., Chu, T., & Tsai, Y. (2009). Professional commitment, patient safety, and patient-perceived care quality. *Journal of Nursing Scholarship, 41*(3), 301-309.

Thomas, D. A. (1990). The impact of race on managers' experiences of developmental relationships (mentoring and sponsorship): An intra-organizational study. *Journal of Organizational Behavior, 11*(6), 479-492.

Thurmond, V. A. (2001). The point of triangulation. *Journal of Nursing Scholarship, 33*(3), 253-258.

Tilley, C. M. (2007). Support for internationally educated nurses transitioning into practice: An integrative literature review (Unpublished Master thesis), University of Victoria, British Columbia, Canada.

Tillman, L. (2001). Mentoring African American faculty in predominantly white institutions. *Research in Higher Education 42*(3), 295-325

Tourangeau, A. E., Cummings, G., Cranley, L. A., Ferron, E. M., & Harvey, S. (2010). Determinants of hospital nurse intention to remain employed: broadening our understanding. *Journal of Advanced Nursing, 66*(1), 22-32.

Troy, P. H., Wyness, L. A., & McAuliffe, E. (2007). Nurses' experience of recruitment and migration from developing countries: A phenomological approach. *Human Resources for Health, 5*(15), 1-7.

Truglio-Londrigan, M. (2002). An analysis of wisdom: An experience in nursing practice. *Journal of the New York State Nurses Association, 33*(2), 24-30.

Tull, P. (January 1999). Research paradigms and professionalisation of nursing. Retrieved from www.olney.demon.co.uk/new/NDIP09.htm\

Ulrich, B. T., Buerhaus, P. I., Donelan, K., Norman, L., & Dittus, R. (2005). How RNs view the work environment: Results of a national survey of registered nurses. *Journal of Nursing Administration, 35*(9), 389-396.

Ulrich, B. T., Lavandero, R., Hart, K. A., Woods, D., Leggett, J., & Taylor, D. (2006). Critical care nurses' work environments: A baseline status report. *Critical Care Nurse, 26*(5), 46-57.

Urbano, M. T., & Jahns, I. R. (1988). A conceptual framework for nurses' participation in continuing education. *Journal of Continuing Education in Nursing, 19*(4), 182-186.

U.S. Bureau of Labor Statistics. (2008-2009). Delaware Valley Metropolititan-Retrieved from http://www.bls.gov/eag/eag.pa_philadelphia_msa.htm

U.S. Department of Home Land Security (December 5, 2008). *Improving the processing of "Schedule A" Nurse Visas : Recommendation from the CIS Ombudsman to the Director, USCIS.* Retrieved from *http://www.dhs.gov/xlibrary/assets/cisomb_recommendation_36.pdf*

U.S. Department of Labor, Bureau of Labor Statistics (2008-2009 Edition). *Occupational Outlook Handbook* Retreived from http://www.bls.gov/oco/ocos083.htm.

Vance, C. (1977). *A group profile of contemporary influential's in American Nursing* (Unpublished doctoral dissertation). Columbia University, New York NY.

Vance, C. (2002). Mentoring: A professional obligation. *Creative Nursing, 8*, 4-9.

Vance, C. (2003). Mentoring at the edge of chaos. *Nurse Leader, 1*(1), 42-43.

Vance, A., & Davidhizar, R. (1996). The importance of role socialization towards achieving professional status in nursing administration. *Journal of Nursing Science, 1*(5/6), 199-203.

Vance, C. ., & Olson, R. K. (Eds.). (1998). *The Mentor Connection* New York NY: Springer.

Vasil, L. (1992). Self-efficacy expectations and causal attributions for achievement among male and female university faculty. *Journal of Vocational Behavior, 41*(3), 259-269.

Vestal, K. W. (1984). Financial considerations for career ladder programs. *Nursing Administration Quarterly, 9*(1), 1-8.

Villarruel, A. M., & Peragallo, N. (2004). Leadership development of Hispanic nurses. *Nursing Administration Quarterly, 28*(3), 173-180.

Wagner, J. I., Cummings, G., Smith, D. L., Olson, J., Anderson, L., & Warren, S. (2010). The relationship between structural empowerment and psychological empowerment for nurses: A systematic review. *Journal of Nursing Management, 18*(4), 448-462.

Walker, K. (2005). Reaching for the stars: Career advancement and the registered nurse. *International Journal of Nursing Practice, 11*(4), 185-190.

Wallace, J. E., & Haines, V. A. (2004). The benefits of mentoring engineering students. *Journal of Women and Minorities in Science and Engineering, 10*, 377-391.

Watson, J. (1981). Professional Identity Crisis: Is nursing finally growing up? *The American Journal of Nursing, 81*(8), 1488-1490.

Wayne, J. H., Randel, A. E., & Stevens, J. (2006). The role of identity and work-family support in work-family enrichment and its work-related consequences. *Journal of Vocational Behavior, 69*(3), 445-461.

Weekes, D. (1989). Mentor-protégé relationships: A critical element in affirmative action. *Nursing Outlook, 37*(4), 156-157.

Weng, L., Dai, Y., Wang, Y., Huang, H., & Chiang, Y. (2008). Effects of self-efficacy, self-care behaviors on depressive symptom of Taiwanese kidney transplant recipients. *Journal of Clinical Nursing, 17*(13), 1786-1794.

Wesley, Y., & Dobal, M. T. (2009). Nurses of African descent and career advancement. *Journal of Professional Nursing, 25*(2), 122-126.

Whitehead, L. C. (2007). Methodological and ethical issues in Internet-mediated research in the field of health: An integrated review of the literature. *Social Science & Medicine, 65*(4), 782-791.

Whyte, D. A., Lugton, J., & Fawcett, T. N. (2000). Fit for purpose: The relevance of Masters preparation for the professional practice of nursing. A 10-year follow-up study of postgraduate nursing courses in the University of Edinburgh. *Journal of Advanced Nursing, 31*(5), 1072-1080.

Williams, R., & Blackburn, R. T. (1998). Mentoring and junior faculty productivity. *Journal of Nursing Education, 27*(5), 204-209.

Wills, C. E., & Kaiser, L. (2002). Navigating the course of scholarly productivity: The protégé's role in mentoring. *Nursing Outlook, 50*(2), 61-66.

Winslow, S., & Blankenship, J. (2007). Mentoring clinical ladder advancement with a facilitated prep class. *Journal for Nurses in Staff Development, 23*(4), 180-182.

Wittmann-Price, R. A., & Bhattacharya, A. (2008). Reexploring the subconcepts of the Wittmann-Price Theory of Emancipated Decision Making in Women's Healthcare. *Advances in Nursing Science, 31*(3), 225-236.

Wood, D. (2010). Climbing the clinical ladder: Nurses moving into executive leadership positions. *Nurse Zone*. Retrieved from http://www.nursezone.com/printArticle.aspx?articleID=34164

World Health Organization. (2009). *Global standards for the initial education of professional nurses and midwives*. Retrieved from http://www.who.int/hrh/resources/standards/en/index.html

Wros, P., Doutrich, D., & Ruiz, M. E. (2009). Giving voice: Incorporating the wisdom of Hispanic RNs into practice. *Journal of Cultural Diversity, 16*(4), 151-157.

Wurmser, T. (2006). Recognizing the clinical nurse: The Meridian Health Clinical Advancement and Recognition of Excellence program. *Teaching and Learning in Nursing, 1*(1), 22-26.

Xu, Y. (2005). Clinical challenges of Asian nurses in foreign healthcare environment. *Home Health Care Management & Practice, 17*(6) 492-494.

Xu, Y. (2006). Clinical Differences in nursing between the east and west implication for Asian nurses. *Home Health Care and Management, 18*(5). 420-423

Xu, Y. (2007a). Diveristy discussion: Adaptation strategies of Asian nurses working in Western Countries. *Home Health Care and Management, 19*(2), 146-148.

Xu, Y. (2007b). Strangers in strange lands: A metasynthesis of lived experiences of immigrant Asian nurses working in Western countries. *Advances in Nursing Science, 30*(3), 246-265.

Xu, Y., & Kwak, C. (2005). Characteristics of internationally educated nurses in the United States. *Nursing Economics, 23*(5), 233-238.

Xu, Y., & Kwak, C. (2007). Comparative trend analysis of characteristics of internationally educated nurses and U.S. educated nurses in the United States. *International Nursing Review, 54*(1), 78-84.

Xu, Y., Zaikina-Montgomery, H., & Shen, J. J. (2010). Characteristics of internationally educated nurses in the United States: An update from the 2004 National Sample Survey of Registered Nurses. *Nursing Economic$, 28*(1), 19.

Yi, M., & Jezewski, M. A. (2000). Korean nurses' adjustment to hospitals in the United States of America. *Journal of Advanced Nursing, 32*(3), 721-729.

Yoder, L. (1990). Mentoring: A concept analysis. *Nursing Administration Quarterly*, *15*(1), 9-19.

Yoder-Wise, P. S. (2008). One more time: Professional development and patient safety. *Journal of Continuing Education in Nursing, 39*(6), 243-243.

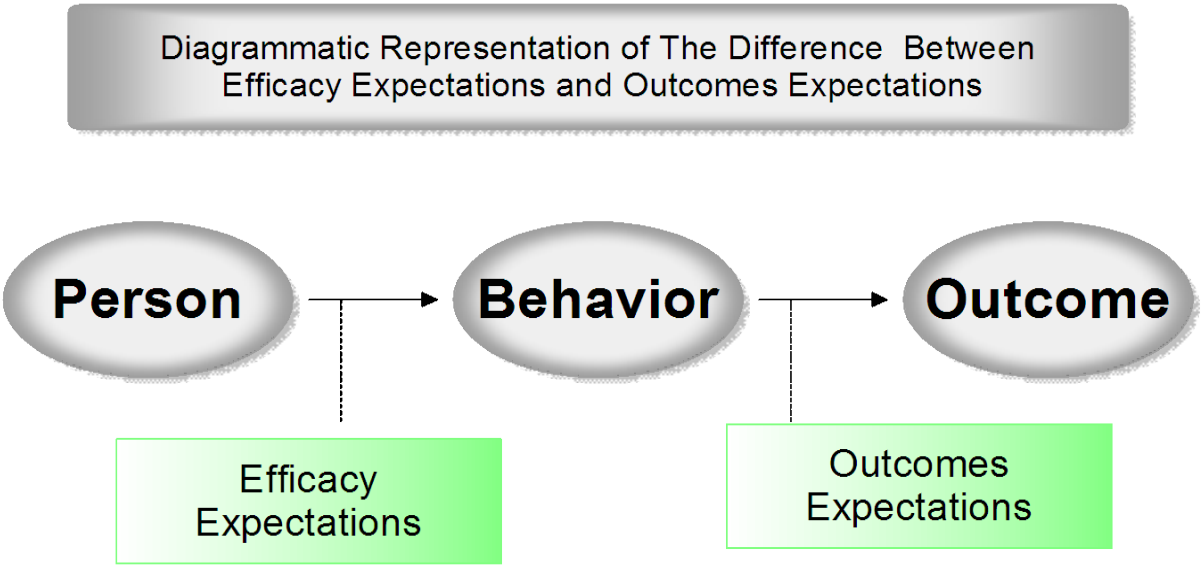
Young, A. M., & Perrewé, P. L. (2000). The exchange relationship between mentors and protégés: The development of a framework. *Human Resource Management Review*, *10*(2), 177-209.

Zimmerman, B. (2002). Becoming a self-regulated learner: An overview. *Theory into Practice, 41*(2), 64-72.

Zizzo, K., & Xu, Y. (2009). Post-hire transitional programs for international nurses: A systematic review. *Journal of Continuing Education in Nursing, 40*(2), 57-64.

Appendix A

Diagrammatic Representation of Efficacy and Outcome Expectation



Appendix B

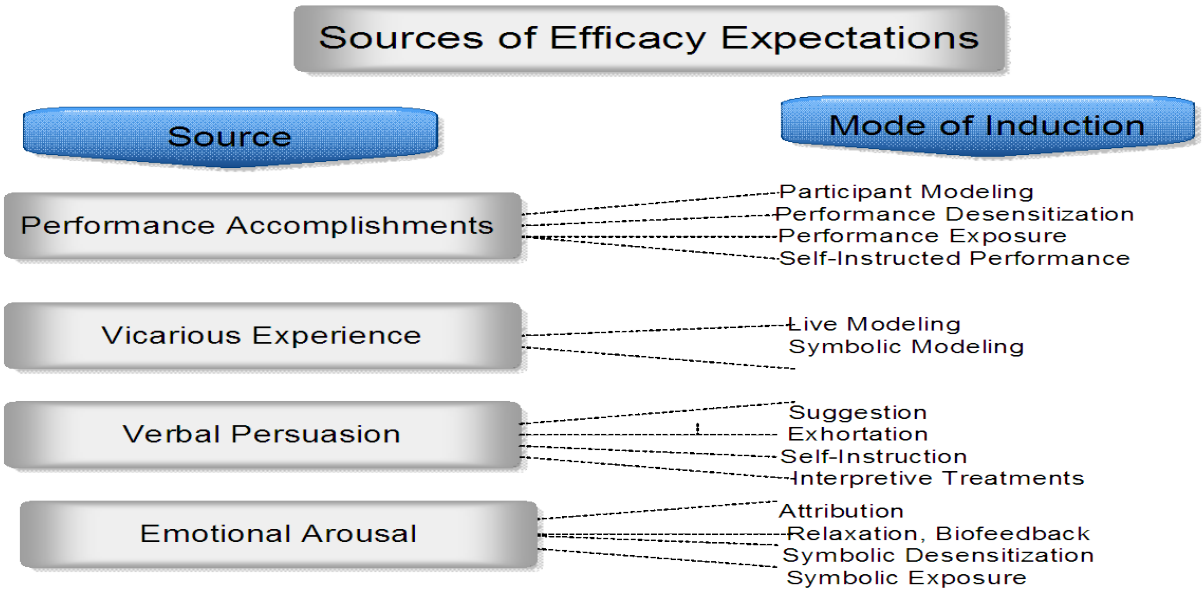
The Conceptual Difference Between Self-esteem and Self-efficacy

Dimensions	**Self- Esteem**	**Self- Efficacy**
Definition	A personal judgment of worthiness; attitude of self approval	A belief about one's ability to execute a future action
General vs. Specific	Varies from global to intermediate (e.g. organization based self-esteem) to task specific	Varies in general (generalized self-efficacy) to highly specific tasks (Specific self-efficacy)
State vs. Trait	Trait does not change quickly say something her about "state"	Generalized self-efficacy is trait oriented; specific self-efficacy is state oriented
Potential targets or Dimensions	Any aspect of the self (e.g., person, parent employee)	Any defined task or action
Affective vs. Cognitive	Both more effective than cognitive does not make sense.	Mostly cognitive
Time	Assessment of one's current self	Current assessment of one's future success at a task
Belief	Belief about one's worthiness (self-approval)	Belief about one's ability to execute a particular task or tasks in general

Source: Gardner & Pierce, 1998

Appendix C

Sources of Efficacy Expectations



Source: Bandura, 1977b.

Appendix D

Instruments for Research Study Data Collection

Study Title: A Comparison of the Effects of Mentorship and Self-efficacy on the Career Advancement of Nurses Educated Internationally and in the United States.

Please respond to each item on this questionnaire. The responses will be analyzed to understand how mentorship and self-efficacy has influenced professional development and career advancement of Internationally Educated Nurses (IENs) compared to United States Educated Nurses (UENs). ** Please note that by proceeding to complete any portion of this survey or answering the questionnaires, you are consenting to participate in the study. No personal identifier will be obtained from you in relation to the study, all responses will be confidential and only aggregate data will be reported!

On completion of the questionnaire, you will be re-directed to a new survey to enter your name, telephone number and e-mail to be eligible for a raffle to win *one of five VISA gift cards in the amount of $100.00 from a raffle that will be drawn at the end of the data collection period.*

Winners of the VISA gift cards will be contacted via the name and email that corresponds with the numbers that were randomly drawn from the second survey by an honest broker who is not a member of the research study. To maintain respondent's anonymity, the second survey is hosted on a separate database that is not be linked to the original research survey and questions and an honest broker will be responsible for taking the information on the second survey and drawing the raffle. The honest broker will also contact the winners.

Please answer the all questions in this survey to the best of you ability. You should only complete this survey once even if you are a member of the several organizations that are hosting this survey; or even if you receive multiple links to complete this survey.

Please answer the following questions we want to insure that that you are eligible to participate in this study.

1. Are you an RN practicing within an hospital located in the Philadelphia County of the Delaware Valley Region of the, U.S for a minimum of three years?

a. Yes
b. No

2. Are you between the ages of 22 and 65 years?

a. Yes
b. No

3. Do you speak, read, write and understand English?

a. Yes
b. No

4. Are you comfortable using the internet and are willing to devote approximately 30minutes to an hour to complete this study survey items?

a. Yes
b. No

5. Is his the first time that you are completing this study survey?

a. Yes
b. No

Section 1 A: Mentorship

Definition of a Mentor?

A mentor is a high-ranking, influential individual, who has advanced experience and knowledge in the profession, makes a commitment to provide upward mobility and support to the mentee's or inexperienced individual's career (Ragins & Cotton , 1999)

1. Are you able to identify an individual in the nursing profession who is in a higher position than yourself in terms of their career advancement level that has had a significant and positive impact on your nursing career advancement and meets the criteria or definition of a mentor.

c. Yes
d. No

If you answered **NO** to the above question, please skip to **Section 2 of the survey;** if you answered **YES** to the above question please answer the section **1B** to provide information about

the mentor you have identified and answer section **1C to provide** information about your mentorship experience.

Section 1 B

Please describe the characteristics of the mentor you have identified above.

2. Mentor's position at the time he/she mentored you _____

    a. Age of Mentor_____ at the time he/she became your mentor
    b. Sex of mentor_____
    c. Gender of mentor _____
    d. Race of mentor _____
    e. Ethnicity of mentor_____
    f. How you did meet your mentor_____

Section 1 C: Scandura and Ragins (1993) 15-item mentorship questionnaire Questions 3-17

Please read the following and select the most appropriate response that describes how your mentor has influenced your career advancement. *** *Please note only study participants who are able to identify a mentor in section* **1A** *should complete this section based on their relationship with the identified mentor*

3. Mentor takes a personal interest in my career

    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

4. Mentor has placed me in important assignments

    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

5. Mentor gives me special coaching on the job

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

6. Mentor advises me about professional opportunities

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

7. I share personal problems with my mentor

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

8. Mentor helps me identify professional goals

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

9. I socialize with my mentor after work

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

10. I try to model my behavior after my mentor

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree

e. Strongly agree

11. I admire my mentor's ability to motivate others

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

12. I exchange confidences with my mentor

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

13. I respect my mentor's knowledge of the Nursing profession

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

14. I consider my mentor to be my friend

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

15. I respect my mentor's ability to teach others

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

16. My mentor has devoted special time and consideration to my career

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

17. I often go to lunch with my mentor

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

Section 2: The 8 Items New General Self-efficacy (NGSE) Scale Questions 18- 25

Please read the following and select the most appropriate as it applies to you.

18. I will be able to achieve most of the goals that I have set for myself.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

19. When facing difficult tasks, I am certain that I will accomplish them.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

20. In general, I think that I can obtain outcomes that are important to me.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

21. I believe I can succeed at most any endeavor to which I set my mind.

a. Strongly disagree

b. Disagree
c. Neutral
d. Agree
e. Strongly agree

22. I will be able to successfully overcome many challenges.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

23. I am confident that I can perform effectively on many different tasks

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

24. Compared to other people, I can do most tasks very well.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

25. . Even when things are tough, I can perform quite well.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

Section 3 Narrative or Essay Questions

26. Please discuss the positive factors that have influenced your professional development and career advancement?

27. Please discuss the factors that serve as barriers toward your professional development or

Career advancement

Section 4 Demographics: Demographic Questions:

4A Personal Information

28. How old are you? _____

29. What is your gender? _____
    a. Male
    b. Female

30. What is your religious background?

    a. Christian
    b. Buddhist
    c. Hindu
    d. Jewish
    e. Muslim
    f. Sikh
    g. Other Religion_____
    h. None_____

31. What best describes your Race/Ethnicity

    a. African American (U.S. Born)
    b. American Indian or Alaska Native
    c. Asian
    d. Black (Non-U.S Born)
    e. Native Hawaiian or Other Pacific Islander
    f. White (Non-Hispanic)
    g. White (Hispanic Origin)
    h. Bi-Racial _____
    i. Other _____

32. In what country were your parents born? _____

33. In what country were you born? _____

34. List all the countries you lived in before the age of 18?

    (1) _____
    (2) _____
    (3) _____
    (4) _____

35. What year did you migrate to the U.S.?

    a. Year_____
    b. Not applicable, I did not migrate, I was born in the US____

36. What is your marital status?

    a) Single, never married
    b) Married
    c) Divorced
    d) Widowed or Widower
    e) Living with Partner (Not Married)

37. If married or living with your spouse or partner currently: (please mark the accurate answer)

    a. Living with you in the U.S.
    b. Living in another country

38. Number of children, parents or relatives that are physically or/and financially dependent on you?

    a. Yes _____Number _____
    b. No

4B: Nursing Education and Professional Development Information

39. In which country did you complete your initial nursing educational program that qualified you to take the U.S. NCLEX-RN Exam?
    a. The U.S. *Which state*: _____
    b. Outside the U.S., *Which country* _____

40. What initial nursing educational program preparation qualified you for the NCLEX-RN Exam?

    a. Diploma program
    b. Associate degree
    c. Bachelor's degree
    d. Master's degree
    e. Doctorate degree
    f. Other_____

41. What year did you complete your initial nursing educational program? _____

42. In what U.S. State or District of Columbia do you currently practice? _____

43. Have you earned a formal degree(s) since graduating from your initial nursing educational program?

    a. Yes
    b. No

44. If yes, What degree _____

45. If you answered yes to question **43**, in what country did you earn the additional degree?

    _____

46. Do you anticipate pursing a formal educational degree program within the next 5 years?

    a. Yes
    b. No

47. Are you currently pursuing an academic degree?

    a. Yes
    b. No

48. If yes, what degree are you pursuing?

    a. Degree _____
    b. N/A I am not pursing any educational degree

49. Please list all professional nursing or specialty certifications that you have earned since you became a nurse in the U.S.? Examples of specialty certifications are: Critical Care Certification, Medical Nursing Certification, Case Management Certification, Oncology Certification; or any other:

    (a) _____

    (b) _____

    (c) _____

    (d) _____

    (e) _____

    (f) _____

50. How many contact hour credits have you earned in the last one year. _____

51. What are your career goals in the next three years? (Please include your educational, professional development goals, as well as positions/career aspirations
_____
_____
_____

52. On a scale of 1-5 with the item ranked one having the least importance and item 5 having the highest importance. Please rank the followings situations as it applies to you?

a. Financial remuneration _____
b. Career advancement opportunity _____
c. Work-life balance _____
d. Family _____
e. Leadership opportunity _____

Section 4 C: Employment and Financial Earnings Information

53. Which setting best depicts your practice area?

a. Administration
b. Acute care-Medical-Surgical
c. Ambulatory/Out Patient Care
d. Specialty Nursing Unit Oncology Nursing, Women's Health, Psychiatric Nursing, Community-Nursing/Home Health, Peri-operative Nursing, Critical care (CCU, ICU, MICU)
e. Skilled Long term care
f. Education
g. Other, please specify _____

54. Name the hospital located in the Philadelphia County that you have been working for a minimum of the last 3 years: _____

55. Which role best depicts your practice?

a. Staff Nurse
b. Middle-Management (Nurse Manager)
c. Staff development or Clinical Nurse Specialist
d. Case Manager
e. Nursing Faculty or College Professor

f. Nurse Practitioner
g. Executive Leadership (Directors, Vice President and Chief Nursing officers)
h. Other

56. On a scale of A to E, where A = extremely dissatisfied and E extremely satisfied, please rate your level of satisfaction with your current nursing job?

a. Extremely satisfied _____
b. Somewhat Satisfied _____
c. Satisfied _____
d. Somewhat Dissatisfied _____
e. Extremely dissatisfied _____

57. How long have you been employed in your current nursing position?
_____

58. Your first nursing job was in which country? _____

59. What year did you secure your first nursing job in the U.S.?
_____

60. How many years have you practiced as a Registered Nurse in the U.S?
_____

61. How many years have you practiced as a Registered Nurse outside the U.S
_____

62. Total number of Years you have Practiced as a Registered Nurse =
_____

63. Does your current hospital or healthcare organization have a formal Career Ladder or Career Advancement Program?

a. Yes_____
b. No _____

64. If no, how many years have you worked in a hospital without a formal Career Ladder or Career Advancement Program? _____

65. In what city is the hospital where you practice located_____

66. When was the last time you were promoted or advanced through the professional career ladder? (*Please note this does not include the annual salary or wage increase that is given*

on a yearly basis annually to all eligible employees in some organizations as an adjustment to inflation.

a. Once in the last year
b. Once in the last 3 years
c. Twice in the last 3 years
d. Once in the last 5 years
e. Twice in the last 5 years
f. Twice in the last 10 years
g. Never advanced or promoted

67. Please indicate the number of regularly scheduled work hours you work each week _____

68. Are you salaried or hourly paid?
    a. Salaried _____
    b. Paid hourly _____

69. Your current hourly pay is:
    a. _____

70. Do you currently work additional overtime hours?
    a. Yes
    b. No

71. If yes, how many overtime hours do you work each week? _____

72. What is your current annual gross pretax income including overtime hours?
    a. _____
    b. Refuse to answer _____

Thank you for completing the survey. Your input is greatly appreciated!

Rita K. Adeniran DrNP(C), MSN, RN, CNAA, BC,
Principal Investigator and DrNP Candidate

Drexel College of Nursing and Health Professions
Drexel University PA
Email: rka32@drexel.edu.

Appendix E

Sample Recruitment Email Letter

Dear Participants:

I invite you all to participate in a study survey entitled: **"A Comparison of the Effects of Mentorship and Self-efficacy on the Career Advancement of Nurses Educated internationally and in the United States."** that aims to understand the relationship of mentorship and self-efficacy on professional development and career advancement of nurses. The confidential 72 -item questionnaire will take approximately 30 minutes to an hour to complete, the study has been approved by Drexel University IRB.

Please review the attached flyer for more information about the study.

On completion of the survey, you will be redirected to a new survey where you will enter your name, telephone number and e-mail to be eligible to win one of five $100.00 VISA gift cards.

To maintain confidentiality and anonymity, the second survey is hosted on a separate database and cannot be linked to the original survey.

I sincerely value your input for this project!

SURVEY LINK: https://www.surveymonkey.com/s/ritadissertation

Rita K. Adeniran DrNP(C), MSN, RN, CNAA, BC,
Drexel College of Nursing and Health Professions
Drexel University PA
Email: rka32@drexel.edu

Appendix F

Sample Recruitment Flyer

Research Study!!!

Calling on all Registered Nurses (RNs)
Practicing in a hospital located in Philadelphia County
Please take a minute and go over this information.
You may be interested in participating in this online research study.

The **purpose** of this study is to determine and compare how mentorship and self-efficacy influences internationally educated nurses and U.S. Educated Nurses participation in professional development and career advancement

*The **long-term goal*** of this study is to develop programs that would foster professional development and career advancement of all nurses

Important information about the research study:

The research team is looking for RNs to participate in the study. The study is approved by the IRB at Drexel University. To be able to participate, you must meet the following study inclusion criteria:

- *Actively practicing as an RN in an hospital located within the Philadelphia County of the Delaware Valley Region of The U.S. for a minimum of three years*
- *An RN within the age is between age 22 and 65 years,*
- *Received basic nursing education within the U.S qualifies as a UEN*
- *Received basic nursing education outside the U.S qualifies as an IEN*
- *Comfortable using the Internet*
- *A willingness to devote 30 minutes to an hour to complete the study survey online*
- *Able to speak, read, write and understand English.*

**** Every participant has a chance of winning one of five VISA gift Cards in the amount of $100.00 (one hundred U.S. dollars) on a raffle draw. To read more about the study and to participate, please go online at: www.sample@health1stcares.com*

For more information about this study, you may contact the Principal Investigator:

Rita K. Adeniran, DrNP(c), MSN, RN, NEA, BC Drexel University College of Nursing and Health Professions

Email: rka32@drexel.edu

Appendix G

Sample Raffle-Draw Questionnaire

Thank you for completing the survey. You have now entered the website of the second survey where you may provide a few personal information to be eligible for raffle draw to win *one of five VISA Gift cards in the amount of $100.00. (One hundred dollars).*

The raffle will be drawn at the end of the data collection period. The five (5) Winners of the $100.00 VISA gift cards will be contacted via the name and email and telephone number that corresponds with the numbers that were randomly drawn from the information provided below.

An **honest broker** who is not a member of the research team is responsible for taking the information you entered below to draw the raffle. The honest broker will also be contacting winners.

To maintain participant's anonymity, this website is hosted on a separate database that is not linked to the original research survey you answered earlier. The research team will not have access to the below information and will not be able to link the information you provide below to the original survey.

Please note that you do not have to participate in the raffle draw, if you are not interested, you may exit the survey now without providing any personal information. Only those that provided the below information will be eligible for the raffle. Please, be sure that the information you provided is correct for the honest broker to be able to reach you if you are come up as one of the five winners of the raffle.

Again, thanks for taking time to complete the surveys!!

Sincerely yours,

Rita K. Adeniran DrNP(c), MSN, RN, NEA, BC

What is your name?

_____

What is your email address:

_____?

What telephone number can we use to reach you?

_____

Appendix H

Sample letter requesting organisations to Email and /or Host Survey-Link

Dear _____:

Good day! I hope this email finds you well. My name is Rita K. Adeniran, I am a doctoral Candidate at Drexel University College of Nursing and Health Professions. The purpose of this letter is to seek your support in reaching out to nurses in your organization to participate in a research study. *The aim of the study is to determine the association of mentorship and self-efficacy with professional development and career advancement among internationally educated nurses and nurses educated in the U.S.* The confidential 72 -item questionnaire will take approximately 30 minutes to complete. The study has been approved by Drexel University Institutional Review Board.

Attached to this email are two documents: One provides a brief background of the study; the other is the flyer calling on all nurses working in any hospital located in Philadelphia County to participate in the study by completing the an online survey through this link: **https://www.surveymonkey.com/s/ritadissertation**

I am wondering if it will be possible to host the study's survey-link on your organization intranet and/or have the flyer and link emailed to your organization nurses to participate. I would be honored to meet and explore the possibilities of obtaining your organization support for this study, at a time that is convenient for you. .

You may reach me on my cell 610-513-7587 or email rka32@drexel.edu for question/clarification you may have regarding the study.

Thanking you in advance for your support!

Sincerely yours,

Rita K. Adeniran DrNP(C), MSN, RN, CNAA, BC,
Drexel College of Nursing and Health Professions
Drexel University PA
Email: rka32@drexel.edu

Appendix I

Letter of Support to Send Survey Link to Nurses Who are Members of :

Asian American Pacific Islander Nurses Association (U.S.A.)

From: yu.xu@unlv.edu [mailto:yu.xu@unlv.edu]
Sent: Saturday, March 06, 2010 2:30 PM
To: Adeniran, Rita
Subject: Study Survey
Importance: High

Hi Rita,

This is to inform you that, as President-Elect of the Asian American Pacific Islander Nurses Association, I am happy to assist you with your dissertation study survey by forwarding your upcoming e-mail with hyperlink to your survey to our listserv for our general membership.

Good luck with your study!

****

Yu (Philip) Xu, PhD, RN, CTN, CNE
Professor & PhD Program Coordinator
School of Nursing
University of Nevada Las Vegas
Las Vegas, Nevada 89154-3018, U.S.A.
Tel: (702) 895-3175, Fax: (702) 895-4807
Dr. Xu's bio: http://nursing.unlv.edu/faculty/xu.html

President-Elect (2010-2011)
Asian American Pacific Islander Nurses Association (U.S.A.)

Appendix J

Letter of Support to Host Survey at the Hospital of the University of Pennsylvania

Office of the Associate Chief Nursing Officer
Hospital of the University Of Pennsylvania
Department of Nursing
HUP Nursing Administration
Dulles 106
Philadelphia Pa 19104

March 11, 2010

To Whom It May Concern:

This is to advise the research community and whom it may concern that the Department of Nursing at the Hospital of the University of Pennsylvania (HUP) and the Clinical Practices of the University Of Pennsylvania (CPUP) has granted Rita K. Adeniran, MSN, RN, NEA, BC a doctoral candidate at Drexel College of Nursing and Health Professions permission to host a web link to the survey for her study titled: *"A Comparison of the Effects of Mentorship and Self-efficacy on the Career Advancement of Nurses Educated Internationally and in the United States"* on the HUP Nursing intranet as well as sending the survey link to nurses at HUP and CPUP practices under the condition to show proof of authorization to collect data from the Drexel Institution Review Board (IRB) that is overseeing this study

Please do not hesitate to contact me with questions or clarifications you may have regarding this letter,

Sincerely yours,

Sandra G. Jost, RN, MSN
Associate Chief Nursing Officer
Hospital the University of Pennsylvania
Telephone: 215-615-4102

Appendix K

Letter of Support to Host Survey by *ADVANCE for Nurses*

Gail Guterl, Editor
ADVANCE for Nurses
Areas of PA/NJ/DE & MD/DC/VA
3100 Horizon Drive
King of Prussia, PA 19406

March 16, 2010

To Whom It May Concern:

This is to advise the research community and whom it may concern that *ADVANCE for Nurses* has agreed to host a research survey web link to the study entitled: "A Comparison of the Effects of Mentorship and Self-efficacy on the Career Advancement of Nurses Educated Internationally and in the United States" that will be conducted by Rita K. Adeniran, MSN, RN, NEA, BC a doctoral candidate at Drexel College of Nursing and Health Professions, at the Advance for nurses web site: www.advanceweb.com/nurses, click on Regions, then choose Eastern Pennsylvania, Southern NJ and Delaware. I understand Rita is getting an IRB authorization to conduct this study and we're happy to help her publicize it and include a link to her study on our website

Please do not hesitate to contact me with questions or clarifications you may have regarding this letter.

Sincerely yours,

Gail Guterl, Editor
ADVANCE for Nurses
Areas of PA/NJ/DE & MD/DC/VA
3100 Horizon Drive
King of Prussia, PA 19406
(Tel) 800-355-5627 X1260 (Fax) 610-275-856

Appendix L

June 4, 2010

Raffle Draw Winners Notification Letter

Dear Research Participant:

Congratulations! You have been selected as one the five winners of the $100.00 (one hundred dollars) VISA gift cards by participating in the research study survey entitled: **"A Comparison of the Effects of Mentorship and Self-efficacy on the Career Advancement of Nurses Educated internationally and in the United States"** that aims to understand the relationship of mentorship and self-efficacy on professional development and career advancement of nurses.

As indicated in the study's recruitment flyer, the raffle winner was drawn from the second survey where 267 participants provided their information to be eligible to win

The raffle was drawn by me, Teresito Tiu, I am the **honest broker** selected by the research team to draw the raffle as I am **NOT** a member of the research team.

Please contact me via phone at 215- 662- 4643 or email Teresito.Tiu@uphs.upenn.edu to arrange a time to pick up the $100.00 visa card.

On behalf of the research team, I would thank you for taking time to complete the surveys!!

Sincerely yours,

Teresito Tiu
Hospital of the University OD Pennsylvania
3400 Spruce Street], Philadelphia Pa 19104

Winner # 1 Reference Visa Card #: ********7863

Winner # 2 Reference Visa Card #: ********7871

Winner # 3 Reference Visa Card #: ********7889

Winner # 4 Reference Visa Card #: ********7897

Winner # 5 Reference Visa Card #: ********7905

Appendix M

Tables of Sample Coding of Open Ended Questions

Table 1: Sample meaning unit, subthemes, and themes of **UENs** responses to the open-ended question:"Please discuss the ***positive*** factors that have influenced your professional development and career advancement."

Sample Meaning Unit	Subthemes	Themes
I believe that the academically motivating environment in which I work is the strongest influence on my professional development. It provides constant learning opportunities….	Access to Education	Healthy Work Environment
Working in a health care institution that promotes education and advancement has propelled my interest in professional development.	Career Advancement Opportunity	
Excellent mentors that show honesty, compassion, and willing to coach you	Mentorship	
Working in a culture that encourages scholarship, research, and evidence based practice.	Nursing Excellence	
Being able to associate with successful nurses and model after their career.	Role Modeling	
Bright, positive, candid, and forward thinking colleagues.	Supportive Colleagues	
Professionally, the nursing administration make it easy to continue my education	Supportive Leadership	
I believe that major factor of me advancing at the organization was the wonderful tuition benefit that allowed me to get my MSN.	Tuition Support	
Working with such a difficult population of patients has given me confidence for advancement in the profession including working at future hospitals.	Experience	Commitment to the Profession
I am self motivated. I am able to accomplish whatever goals I set for myself	Self-Leadership	
Having a strong support system like my family and friends.	Supportive Family	External Support and Engagement
Although my time in the hospital environment is limited, I do a significant amount of volunteer work that I incorporate my nursing education and experience into.	Outside Engagement	
The factors that positively influenced my career were that she was very diversified and continued to accomplish advances in her career.	Cannot Code	Un able to classify

Table 2: Sample meaning unit, subthemes, and themes of **IENs** responses to the open-ended question: "Please discuss the ***positive*** factors that have influenced your professional development and career advancement.

Sample Meaning Unit	Subthemes	Themes
Clear career ladder in place and how to achieve each step (explained),	Career Advancement Opportunity	Healthy Work Environment
Through my mentor I was able to advance my career to being a charge nurse and through her support I pursue it further	Mentorship	
My mentor serving as a good role model.	Role Modeling	
Colleagues willing to help out, good team work, dynamic multi-disciplinary team in unit.	Supportive Colleagues	
Positive Professional practice environment - Nursing in the forefront, supportive manager	Supportive Leadership	
Opportunities that the hospital provides, like tuition	Tuition Support	
It is also highly motivating when organization has a vision and a dream where it incorporates diversity into a single entity or group no matter what individual positions or educational attainments may be.	Inclusion	
I find my knowledge and experience being a BSN graduate to be a very positive factor that influenced professional development.	Experience	Commitment to the Profession
Desire within oneself to achieve higher, thirst for knowledge and advancement	Self-Leadership	
Would be my personal resilience to endure difficulties both big and small while transitioning to a new life with my family in a foreign country.	Resilience	
Supportive family	Supportive Family	External Support and Engagement
Advancements in science and longevity	Cannot Code	Unable to classify

Table 3: Sample meaning unit, subthemes, and themes of **UENs** responses to the open-ended question: "Please discuss the factors that have served as a ***barrier*** to your professional development and career advancement.

Sample Meaning Unit	Subthemes	Themes
Working in an institution that is new to me and trying to forge relationships with people who at times seem to have pre conceived notions about my abilities because I was not "home grown" in their hospital	Bias/Exclusion/ Discrimination	Poor Work Environment
The lack of a sound clinical ladder for nursing staff, as well merit recognition	Lack of Career Advancement Opportunities	
Negative environment….No Support system, poor leadership	Unsupportive Leadership	
Not having fellow co-workers support is a big barrier	Unsupportive Colleagues	
Increase in job demands… Sometimes we need to take 4 - 5 patients at a time on our unit which makes the job more challenging in a negative way	Work Over Load	
My own personal struggles of balancing my personal priorities (life issues - family, kids, school, hours worked, friends...)	Family Obligations	Competing Priorities
Lack of money to advance my career to a PhD	Financial Issues	
Factors that have served as barriers toward my professional development and career advancement are: having limited amount of time to take part in nursing beyond the bedside (work) at times, only being a nurse for almost four years some may view that as not having a lot of experience	Lack of Time	
Would like to go for Masters but not sure I want to take the stress that goes along with going back to school.	Lack of Motivation/Interest	Complacency/ Contentment
I think I would miss direct patient contact, because developing a rapport with patients and following up with them post procedure establishes a patient/nurse relationship that is like none other.	Satisfaction	
Deciding on DNP versus PhD.	Cannot Code	Unable to classify

Table 4: Sample meaning unit, subthemes, and themes of ***IENs*** responses to the open-ended question: "Please discuss the factors that have served as ***barrier*** to your professional development and career advancement.

Sample Meaning Unit	Subthemes	Themes
Some people in the ward are bias in treating other nurses especially the international nurses … Because I am different from most Americans, culturally and racially, sometimes people also treat me differently.	Bias/Exclusion/ Discrimination	Poor Work Environment
Lack opportunities for advancement	Lack of Career Advancement Opportunities	
You don't get any management support; you have to work 4 times more and do million times better. You see people get away with murder every day, but you can't afford to even drop a towel, otherwise you get written up. You have to be perfect, not even close to perfection, but really perfect. You see people steel your ideas every day, because when you bring it up no one listen to you, but when they use your same idea, they get recognized an awarded for….	Unsupportive Leadership	
Behavior of co-workers toward Internationally Recruited Nurses (IRN…. coming from a different culture makes it not easy for me to find a colleague where I can talk to comfortably just the same as others	Unsupportive Colleagues	
Barriers would include heavy workload with poor staff management	Work Over Load	
Language barriers & cultural differences are the main barriers I have to encounter	Cultural/language difference	
Personal priorities as family, children etc and less time to dedicate to career outside of work hours	Family Obligations	Competing Priorities
Financial obligations outside of work…the hospital's "free education" really isn't free d/t insane taxes. In fact, the way that the hospital counts the money they give for tuition (adding it to net income for the year) essentially makes it so that I am receiving less salary overall. I have thought numerous times to stop my master's degree because I just can't afford it and I already have too much in student loans.	Financial Issues	
Inability to take time off at times for career conferences that are required for my practice.	Lack of Time	
The requirements needed to become level 3 RN	Lack of Motivation	Complacency/ Contentment

	/Interest	
I am happy at just being a staff nurse doing bedside care … I have reached the peak of my career. I don't want to be a manager or a nurse practitioner	Satisfaction	
Person to talk sit down with regarding my career advancement	Cannot Code	Unable to classify