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Culturally Diverse Newly Graduated Registered Nurses' Lived Experience of Being Mentored: A Phenomenological Study

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CULTURALLY DIVERSE NEWLY GRADUATED REGISTERED NURSES' LIVED EXPERIENCE OF BEING MENTORED: A PHENOMENOLOGICAL STUDY

DISSERTATION

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By

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Abstract

Culturally Diverse Newly Graduated Registered Nurses'

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Mentors have lasting influence on the socialization and commitment of nurses throughout their careers. The purpose of the study was to explore culturally diverse newly graduated nurses' lived experience of being mentored Thirteen RNs from five South Florida Hospitals who were post graduation 6 months to 2 years were interviewed. Participants' validation of transcripts served as member checks. Van Manen's phenomenological methodology guided the analysis. Four essential themes emerged, Stumbling, Connecting, Becoming, and Being. The theory of transition elucidated the challenges of change from student nurse to professional nurse. Positive mentoring had a significant role that mitigated the graduates' intense distress during transition. The study supports the need for mentoring culturally diverse new graduates in transition.

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Brothers Joe, Walter, David, and my sisters Lois and Karen.

My brother Dallas who loved learning, too and left life far too soon.

My Heavenly Father whose blessings never cease to amaze me.

DEDICATION

In memory of my grandmother, Lincie McSwain, who was a nurse and healer in rural Georgia almost a century ago. Her courage, compassion and character deeply influenced me.

In memory of my mother, Mary Lois Ingram whose love of learning inspired me.

To my family, John, Brian and Cathie who loved me and kept me going.

To the culturally diverse, newly graduated registered nurses who took the time to share their stories of *stumbling, connecting, becoming* and finally, *being* a real nurse.

To all culturally diverse, newly graduated nurses who have the courage to live their dreams.

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CHAPTER I

INTRODUCTION

Nursing literature has described the experience of newly graduated nurses as extremely stressful and difficult in their first year in practice. New graduate literature did not identify whether culturally diverse participants were included. Therefore, the voice of these new graduates seemed to have remained silent about how they fared and achieved professional status (Boswell, Lowry, & Wilhoit, 2004; Bowles & Candela, 2005; Casey, Fink, Krugman & Propst, 2004; Delaney, 2003; Duchscher, 2001; Duchscher & Cowin, 2004; Gerrish, 2000; Grindel & Roman, 2002; Halfer & Graff, 2006; North, Johnson, Knotts & Whelan, 2006; Owens, Turjanica, Scanion, Sandhusen, Williamson, Hebert, & Facteau, 2001; Thomka, 2001).

Culturally appropriate health care for an increasingly diverse population has received significant attention from federal health agencies, medial groups and nursing leaders. Knowledge of the graduates' transition process and their acclimation to nursing may support the goals of the nursing profession to increase diversity among its members (American Association of College of Nursing [AACN], 2001, 2003; American Nurses Association [ANA], 1998; National Advisory Council on Nursing Education and Practice [NACNEP], 1999.

Additionally, approximately 60% to 80% of newly graduated Registered Nurses leave after their first year of employment which has a significant cost financially and professionally. The estimated financial cost was $40,000 per new graduate (VHA, 2002). The potential loss of culturally diverse new graduates could produce results counter to

the goal to increase diversity in nursing (Bowles & Candela, 2005; Halfer & Graf, 2006; Winter-Collins and McDaniel, 2000). Therefore, mentoring of culturally diverse new graduate nurses is one way health care institutions are preparing new nurses and retaining them in the workforce.

Aim of the Study

The purpose of this phenomenological study was to explore the lived experiences, perceptions, and meanings of mentoring for new graduate nurses from diverse cultures who had completed a formal mentoring program at their place of employment following graduation. The phenomenological question, "What is the culturally diverse newly graduated nurse's lived experience of mentoring?" guided the study. The investigator hoped this study would provide increased knowledge and insight into the mentoring needs of culturally diverse new graduate nurses. The information could serve to deepen understanding and facilitate early intervention to support and prepare these graduating student nurses for the entry process into professional practice. Additionally, anticipation of the needs of the new graduates could significantly support them in the transition toward professional development (Atwood, 1979, 1986; Duchscher, 2001; Washington, Erickson, & Dimotassi, 2004).

Mentoring as the phenomena of interest, the significance of studying the culturally diverse newly graduated registered nurses' mentoring experiences, and the assumptions of phenomena of mentoring will follow. The qualitative method, philosophical underpinning, including assumptions, and bias related to the study are discussed. Finally, the relevance and implications for nursing education, practice, administration, and policy are explicated.

Phenomena of Interest

In this study mentoring is defined as an interactive relationship with a respected person, the mentor, who is concerned with the protégé's best interest and supports, encourages, and guides the protégé. The mentor has a significant influence in the protégé's decisions because the mentor believes in him or her. Mentoring is a relationship that requires multiple skills. The mentor's skills include teaching, advising, and counseling. Mentoring can greatly influence the future of one's career by promoting professional and psychosocial development. Psychosocial development is defined as the socialization process that builds a sense of confidence, belonging, and job satisfaction (Phillips-Jones, 2001; Winter-Collins & McDaniel, 2000). In this study, protégé is defined as a person who is protected and guided by another person with greater experience while the protégé is learning. The protégé is a mentored person (Merriam-Webster, 2007).

Kram (1988) described the major function of a mentor, which was to facilitate career and psychosocial development of the protégé. Career mentoring activities of the mentor prepared the protégé for career advancement through protecting and coaching them. The mentor provided the protégé opportunities for visibility and challenging projects. Psychosocial mentoring activities included counseling, validation, modeling, and friendship. Other psychosocial mentoring activities consisted of modeling professional behavior, ethical decision making, guidance, support, and partnership. These psychosocial functions were vital to foster self-esteem, a sense of belonging, proficiency, and competence for professional, organizational, and personal growth.

Kram (1988) has identified four phases of the mentor relationship as initiation, cultivation, separation, and redefinition. These phases served as predictable indicators of progression and the protégé's degree of needed support. Mentoring can be an effective way for the mentor to pass on accumulated knowledge, wisdom, and skills (Kram, 1988).

The initiation phase of the mentoring relationship was described as a getting-to know you for both mentor and protégé (Kram, 1988). In the cultivation phase, the relationship developed, goal setting occurred, and major work completed in this phase often resulted in career and psychosocial growth. Separation was characterized as a difficult period in which the protégé achieved a level equal to or greater than the mentor was. How the mentor perceived protégé development determined the mentor and protégé relationship in the next phase of the mentoring relationship, which was re-definition. In this phase, the mentor and protégé went their separate ways with a mutual relationship, became colleagues, or ended the relationship (Kram, 1988; Phillips-Jones, 2001). The mentoring process as previously described could support culturally diverse new graduates in their professional and psychosocial development and encourage their commitment to nursing (Matlock & Matlock, 2001; Phillip-Jones 2001; Rodriguez, 1995; Villarruel, 2002, 2004; Villarruel & Peragallo, 2004).

Perceived Justification for Studying the Phenomenon

Over twenty years ago, a small group of ethnic nurse leaders first spoke out about the connection between the lack of ethnic nurses and the quality of health care delivered to culturally diverse patients (Bellamy, 1983; Bessent, 1983). Approximately 20 years afterwards, the federal government and medical groups amplified their message (*Healthy*

People 2010; Institute of Medicine [IOM], 2003; Sullivan Commission, 2004; Spratley, Sochalski, Fritz, & Spencer 2000; U.S. Census, 2000a, 2000b, 2002).

Culturally diverse populations will be a majority by 2050 (U. S. Census, 2000a, 200b); 36 million Hispanics will increase to 103 million; Asian-American's will triple from 11 million to 33 million; and African Americans will double from 36 million to 61 million. The U.S. Census (2000a) revealed only 23 % of African Americans, 26% of Hispanics and 39 % of Asian Americans will find health care professionals like themselves. Yet, 82% of White Americans will have a same culture health care provider (Health and Human Services [HHS], 2003; Health Resources and Service Administration [HRSA], 2003).

African-Americans, Hispanics, and American Indians have been underrepresented in medicine, nursing, and dentistry. According to the U. S. Census (2000), there were approximately 2.2 million employed nurses, 600,000 physicians, and 153,000 dentists within the U.S. health care system. African-Americans, Hispanic Americans, and American Indians represented more than 25 percent of the U.S. population. They represented less than nine percent of nurses, six percent of physicians, and five percent of dentists (IOM, 2003; Spratley, Sochalski, Fritz & Spencer, 2000; U.S. Health and Human Services (HRSA), 2003).

Inadequate access to culturally diverse health care providers contributes to the burden of disease for the minority patient (Sullivan Commission, 2004). "The lack of minority health professionals is compounding the nation's persistent racial and ethnic health disparities" (Sullivan Commission, 2004, p. i). The commission reported that when a health care organization lacks cultural diversity, cultural competence is

compromised (Sullivan Commission, 2004). Therefore, health disparities of culturally diverse populations and the low numbers of diverse health care professionals comprise a major concern to federal agencies, medical groups, and the nursing profession (*Healthy People*, *2010*; IOM, 2003; NACNEP, 2004; Sullivan Commission, 2004; U.S. Health Resources and Services Administration (HRSA), 2003).

In *Healthy People 2010* an overarching goal expressed is to achieve equity of access to inclusive, culturally competent health care for every woman, child, and man of every age, regardless of culture differences, socioeconomic status, sexual preference and education. The first goal addresses life years and quality of life for all ages. Goal two focuses on eradication of health disparities in ethnic populations, including health differences by gender, socioeconomic status, geographical local, and sexual orientation. A separate document of *Healthy People 2010,* addresses diversity workforce issues. The goal is to further the effort to increase the number of culturally diverse health professionals, provide continuing education and increase training in vital public health services (*Healthy People 2010*).

The Institute of Medicine (2003) study goal was to understand the reasons for health disparities. They discovered that the deeply embedded culture of non-diverse professionals has dominated health care. Most health care providers are well-intentioned, yet biases and prejudices combined with other factors to create the gap in health care. Access to quality care was inadequate and disease burdens higher for multiple diverse populations. Further, the culturally diverse received less care from private physicians, even with insurance. The study resulted in recommendations that included the use of

cross cultural education for health care professionals to increase awareness of attitudinal bias, prejudice, and stereotypes.

The Sullivan Commission (2004) was formed to study the scarcity of cultural diversity in nursing, medicine, and dentistry. The expressed purpose of the Commission was to develop policy recommendations that facilitated general structural changes to increase ethnic professionals in the health professions. Reasons for the failure of health care professionals to reflect the diversity of the population were explored.

During hearings conducted by the Sullivan Commission, culturally diverse health care professional participants stressed the importance of mentoring for ethnic health care students. They asserted that mentoring for recruiting and retention of diverse students fell short of meeting the diverse student needs for social support, modeling, and friendship. Ethnic mentors who mentored non ethnic protégés would contribute to that protégés' self awareness of biases. Awareness of the deep and abiding influence of the non-diverse culture on communication, interactions, assessment, and treatment of diverse patients was deemed necessary to create culturally appropriate and quality care (Sullivan Commission, 2004).

The presence of culturally diverse professionals would support diversity in health care professions, promote change in the ethnocentricity of health care, and increase the level of cultural competence in health care (AACN, 2001; IOM, 2003; Sullivan Commission, 2004; U.S. Health and Human Services [HHS], 2003). Data showed that patients preferred someone like themselves as a health care provider because similarity facilitated comfort, communication, and trust in the health care provider's treatment decisions. Non-ethnic providers tended to practice in areas with patients like themselves.

In contrast, culturally diverse professionals tended to practice in underserved areas and provide opportunity for increased access to health care for the diverse patient. Cultural similarity of the health care provider and patient might promote a level of comfort, better communication, and increased rapport. The patient might more easily understand the health issues, medical intervention and treatment goals. In the process culturally competent health care and outcomes might be promoted(ANA, 1998; IOM, 2003; HHS, 2003; Sullivan Commission, 2004).

The lack of diversity in nursing was emphasized by the results from the National Sample Survey of Registered Nurses (Spratley, Johnson, Sochalski, Fritz & Spencer, 2000). The results revealed that 12% of surveyed nurses self-identified as culturally diverse, compared with a similar patient population of 30%. Native American nurses represented only 0.5% to 0.6% of the nursing workforce (HHS, 2003). These statistics became the basis for nursing to focus on increasing the numbers of diverse nurses and to improve access to culturally diverse health care (*Healthy People 2010*; IOM, 2003; Sullivan Commission, 2004).

Culturally diverse nursing leaders have stated that a non-diverse cultural heritage has continued to influence nursing practice and leadership. The biases became more difficult to detect but are explicated in the low numbers of minority nurse practitioners and leaders. The presence of culturally diverse nurses would increase the self awareness of non-diverse nurses about their biases. Greater awareness of biases may result in improved communication, rapport with ethnic patients. Diversity would increase the presence of ethnic nursing leaders, strengthen, and enrich the profession (Gonzalez, 1999; Gonzalez, Gooden & Porter, 2000; Holloway, 2002; Nugent, Childs, Jones, Cook &

Ravenell, 2002; U.S. Census, 2000b; Villarruel, 2002, 2004; Villarruel & Peragallo, 2004).

Villarruel (2004) believed that nursing was asking the wrong questions about increasing the numbers of minority nurses. We need to ask: (a) Why are culturally diverse persons are not choosing nursing? (b) What educational and professional barriers contribute to the low number of diverse nurses? and (c) How can we delineate the barriers and eliminate them? If the profession is to increase diversity, these questions need to be addressed (Villarruel, 2002). One barrier for culturally diverse nurse is the reported distress they experience for being regarded as different. "It's a reality. . . . your capabilities are many times questioned because you are different" (Villarruel & Peragallo, 2004 p. 29). Mentoring to recruit and retain culturally diverse nurses may result in effective socialization of new graduate nurse and increasing a diverse nursing workforce (AACN, 2001; Duchscher & Cowin, 2004; Evers, 2000; Hom, 2003; Simmons, 2002; Wilson, Sanner & McAllister, 2003).

Literature could not be found regarding the mentoring requirements of culturally diverse new graduate nurses. In this aspect, the nursing profession appears to have lagged behind other professions. A variety of factors could have contributed to this situation. One factor is the mentoring process is confused with precepting, role-modeling, and coaching (Carroll, 1994; Dingman, 2002; Fox, Rothrock, & Skelton, 1992; Hayes, 1999). The second factor is the traditional view that mentoring is exclusive to leadership development for managers (Vance & Olson, 1998; Yoder, 1990). Third, a scant amount of literature was found that reported research exploring mentoring as the means of retention and professional development of new graduate culturally diverse

nurses. A fourth factor is a scant amount of literature identifying the mentoring relationship as a way to improve culturally effective health care practice. Further exploration is needed about how the mentoring relationship contributes to the newly graduated, culturally diverse nurse's professional and psychosocial development.

Definitions

Definitions of race, minority, ethnicity, and discrimination are presented here to clarify and assist in understanding the terms used in this study. The meaning of the following terms was drawn from authoritative sources and represents an intention on the part of the researcher to be as free of bias as possible. The following definitions are used in this study:

- Culture is defined as "The accumulated store of shared values, ideas (attitudes, beliefs, values and norms), understandings, symbols, material products, and practices of a group of people. Culture has both material and non-material aspects" (IOM, 2003, p. 522).
- Cultural diversity refers to a variety of cultural backgrounds of this study's participants and does not refer to a particular culture.
- An ethnic group is recognized as different by society or by itself, which is a result of bias based on the group's culture or nationality (U.S. Census 2000b, 2002).
- Ethnicity refers to a group of people who share a unique culture, language, and religion (Office of Minority Health, 2005).
- "Hispanic" means a person with Latin American ancestry who lives in the U.S. and may have other race or ethnic group identities (Office of Minority Health, 2005; U.S. Central Intelligence Agency, 2005; U.S. Census, 2000a, 2002).

- Mentor is derived from *mentos* "intent, purpose, spirit, passion." The root word can be to traced *man-tar*, "one who thinks," from Sanskrit (Harper, 2001).
- Mentoring is defined as an interactive relationship with a respected, more experienced person who was concerned about the protégé's best interest and who taught, supported, encouraged, and guided the protégé. The mentor has a significant influence on the protégé's career and psychosocial development (Hart, 2002.
- Minority refers to the six racial and ethnic groups, (a) Black or African-American, (b) American Indian and Alaska Native, (c) Hispanic, (d) Native Hawaiian and Other Pacific Islanders, (e) Asian-American, and (f) Multiracial, i.e. persons belonged to two or more federally designated groups (U.S. Census 2000).
- Protégé comes from French originally meant one who is protected (Harper, 2001). The intent of the mentor is to protect protégé while he or she is learning. The terms mentor and protégé are used in this study to describe the mentor who has a significant role in the protégé's entry into nursing practice as a new graduate.
- Race is a means of population identification and racial categories are based on social usage, not on biological or genetic definitions (Office of Minority Health [OMH], 2005; U.S. Census, 2000a, 2000b, 2002).

To qualify for this study, the culturally diverse new graduate nurse self-identified with a government designated racial or ethnic group. They could also identify with an ethnic group not included in the formal categories.

Phenomenon Discussed Within a Specific Context: Lived Experience

As mentoring for diversity increases within the profession, assimilation as a means of socialization will have to be addressed (Bailey & Cervero, 2002; Ragins, 1997; Rodriguez, 1995). An effective mentoring program would create a climate of inclusion for culturally diverse nurses. The increased sense of belonging and acceptance of cultural identity would be the outcome of an effective mentoring relationship because the mentor has a major influence in both the career and psychosocial development of the protégé. The benefits of being mentored extend to improved health care (Villarruel, 2002, 2004; Villarruel & Peragallo, 2004). "Being culturally present means first knowing who we are in terms four own culture, and then knowing our patients, their beliefs, customs traditions and ways of being" (Washington, Erickson, & Dimotassi, 2004, p. 166).

Mentoring as a socialization process evoked issues about assimilation and maintenance of cultural identity (Bailey & Cervero, 2002). Assimilation occurred when mentors tried to shape the protégé to reflect the mentor's own characteristics rather than respecting the individual's personality. In successful diversity mentoring, differences have to be recognized and respected (Bailey & Cervero, 2002). Other culturally diverse nurses recognized that inherent benefits of mentoring also included issues of assimilation (Villarruel, 2004; Villarruel & Peragallo, 2004; Washington, Erickson, & Dimotassi, 2004).

Rodriguez (1995) raised the question, "Is mentoring today a vehicle for assimilation or pluralism?" (p. 1). Rodriguez (1995) suggested that a multicultural model of mentoring would include acceptance of differences that enhance the richness of society. For successful mentoring of ethnic nurses, health care institutions needed to consider the

presence of the following: (a) the level of diversity among its leaders, (b) committed support for diversity at every level of organizational structure, (c) assess presence and degree of Eurocentric bias, and (d) strategies to implement increased respectful awareness of cultural difference. Traditionally, mentors expected the protégé to behave in the same manner as the mentor (Ragins, 1997). Diversity mentoring requires cultural sensitivity and awareness of the other individual. The following example of diversity mentoring addresses this issue.

"Mentoring across cultural boundaries is an especially delicate dance that juxtaposes group norms and societal pressures and expectations with individual personality traits" (Bailey & Cervero, 2002, p.1). As the result of what Bailey learned in her mentoring relationship with a non diverse mentor, she suggested the following essential qualities of a culturally diverse relationship: (a) develop trust, (b) acknowledge racial biases, (c) assist culturally diverse protégés to gain visibility and negotiate, and (c) commit to caring relationships that allowed the struggle for learning to occur without power plays (Bailey & Cervero, 2002).

Effective diversity mentoring required commitment at the personal individual level. According to Ragins (1997) this commitment includes: (a) the mentor's and coworker's perception and racial stereotypes, (b) individual attitudes toward cultural differences, (c) prior experience in working with and mentoring culturally different personnel, and (d) individual awareness that comfort with cultural differences was critical to successful mentoring. The second level of support is interpersonal: (a) rapport between mentor and protégé regardless of cultural difference, (b) mentor confidence about protégé's abilities since ethnic persons are seen as less competent, (c) mentor comfort with protégé,

(d) perceived degree of risk involved in mentoring a diverse protégé, and (e) coworker response to mentor and protégé relationship (Ragins, 1997).

Mentors have lasting influence on the socialization and commitment of nurses throughout their careers (Vance & Olson, 1998). Researchers and those that have written about mentorship have discussed the influence on new graduates as they moved from nursing school to professional practice. Stress and anxiety combined to create a state of uncertainty. The guidance, encouragement, and honest, supportive feedback of mentors could facilitate the professional and psychosocial development of the protégé (Beecroft, Santner, Lacy, Kunzman & Dorey, 2006; Boswell, Lowry & Wilhoit, 2004; Bowles & Candela, 2005; Casey, Fink, Krugman & Propst, 2004; Delaney, 2003; Duchscher, 2001; Ferguson & Day, 2004; Gerrish, 2000; Halfer & Graf, 2006; Hom, 2003; Mallory, Konradi, Campbell & Redding, 2003; Mitchell, 2004; Ronsten, Andersson, & Gustaffson, 2005; Thomka, 2001).

Assumptions and Biases Related to the Study of the Phenomenon

Delineation of assumptions and biases related to the study comprise an important element of credibility and trustworthiness in phenomenological research. Assumptions of phenomenological philosophy, theory, and mentoring strategies were discussed prior to the study with peers, research committee chair, professors, and institutional review boards.

Phenomenology has been described as the science of being and the study of essences (Merleau-Ponty, 1968). Phenomenologists assume that people interpret lived experience in the world because they are by nature self interpreting. An interpretation of lived experience developed only after the lived experience occurs. Reflection on how the

event influences the individual's life offers a descriptive interpretation (van Manen, 1990).

In phenomenological research, participant's self report lived experiences provide data. The self interpretation offers valuable and unique information to assist the researcher's understanding of the phenomenon. The interviewer's role in phenomenological research is interactive with the participant during information collection and requires personal self understanding of interviewer's own biases. Therefore, two assumptions guided interviews in the current study: (a) participants were assumed to be aware of the meaning of their lived experience and would fully disclose their lived experience: and (b) the interviewer had explored her own preunderstandings and biases (Heidegger, 1926/1962; Munhall, 2001; Munhall & Boyd, 1999; Munhall & Oiler, 1986; van Manen, 1990).

The assumptions described below comprise a summary of assumptions about mentoring throughout the current study. A mentor would enhance both career and psychosocial development for protégés in a way the protégés could not do on their own. Indeed, if one had no mentor, professional growth and effectiveness would be limited. A second basic assumption was that hierarchical success in an organization would be assured if one had a mentor (Phillips-Jones, 2001; Vance & Olson, 1998). Mentoring would have the same meaning or definition regardless of the context in which mentoring occurred. The mentoring process was the same across disciplines. The lack of success for women and multicultural individuals was due to the lack of mentoring (Hagerty, 1986; Kram, 1988; Phillips-Jones, 1982, 2001, 2002; Rodriguez, 1995; Vance & Olson, 1998; Villarruel, 2002, 2004). The protégés have a situated freedom to choose based on

their inner knowledge, beliefs, and goals. The mentor as an accountability partner supports the protégé's freedom to choose and accept responsibility for choices made or not made. Human growth is "The never ending journey of giving-receiving in coming to know" (Parse, 2004, p.34).

It is assumed in this study that people have a mutuality of shared connections with each other based on the universality of being. People are always in partnership with the universe. People have a situated freedom to choose freely and create meaning within the paradoxes of living, and changing patterns of experience that ultimately form future experiences. Personal values and meaning form the core of lived experiences. People transcend the present state of being through bringing to light possibilities based on personal interpretation of meaning. The mentor who sees an individual's potential and possibilities, empowers and transforms the protégé (Carroll, 1994; Parse, 1994, 1998, 2004; Wunder, 2002).

The following assumptions were summarized from the literature and assumed to be true by this writer.

- The current ethnocentric dominated health care system continues to be geared to non-diverse societal norms and creates health disparities for ethnic groups.
- The same health care system creates under representation of culturally diverse health care professional.
- Under representation of ethnic groups among health care professionals limits availability of ethnic mentors for ethnic newly graduated nurses.
- Historical marginalization of diversity populations, in addition to marginalization of new graduates contributes to increased stress.

- Historical racial biases limit effective communication, trust, and rapport.
- Differences in communication style and interpersonal relating require culturally diverse persons to work harder to be successful.
- Under representation of culturally diverse nurses at staff and management and administration levels perpetuates a culture lacking ethnic diversity.
- Traditionally nursing policy aims at socialization methods that result in assimilation of minority nurses instead of cultural change that embraces diversity.
- New ethnic graduate nurses often struggle to keep cultural identity while adjusting to the demands of the profession.
- Feelings of self doubt, being separate or different, and powerlessness erodes the ethnic graduate's career and psychosocial development.

Effective and culturally appropriate mentoring of new graduate minority nurses may be vital to provide effective health care for ethnic minority patients and to develop a climate of diversity. Exploration of the culturally diverse new graduate nurses' lived experiences of mentoring regarding their career and psychosocial development may assist the nursing profession to plan appropriate mentoring programs that address the needs of ethnic nurses and students.

Phenomenological Method of Inquiry

The phenomenological interpretive paradigm guided the study. The Hermeneutic phenomenological framework assumes that the lived experience of others is knowable. Individuals self-interpret and their lived experiences can be known through their cultural

background, language, and social contexts (Heidegger, 1926/1962); Munhall, 2001; van Manen, 1990).

Ontology

As a naturalistic and interpretive philosophy, the phenomenological paradigm was appropriate to the quest to understand and make sense of the experience of living in the world. An interpretive ontological belief views reality as relativistic and composed of multiple realities based on language, social, and cultural experiences. A relativistic ontology approach assumes that interpretations vary across time, culture, and context. Groups and individuals define reality that may be shared by others but reality will never be absolute; thus, the definition remains open to change (Creswell, 1998, 2003; Denzin & Lincoln, 1994, 1998; Guba & Lincoln, 1985; Munhall, 2001; Speziale & Carpenter, 2003).

Epistemology

Multiple realities are reflected in the lived experiences of the individual. Epistemologically, the researcher and participant interact during the research process to discover meaning. Shared knowledge is used to further understanding of both individual and collective meanings. The methodology includes entry into the context or setting of the participant and journaling by the inquirer. Purposive sampling is used to obtain appropriate participants to deepen and enrich information. Information is gathered until new information is no longer obtained. When the information is validated by the participant, the researcher assumes meaning can be extracted from the texts. Interpretation of data is guided by the interview texts.

Interpretations of experiences evolve from the need to make sense of the everyday world (Schwandt, 1994). New experiences and information create further changes to interpretations of lived experiences. Groups of individuals may agree upon certain interpretations and use them to develop professional practice. For example, physicians, nurses, and social workers have commonalities and agreements concerning health. Simultaneously, their differences or disagreements have defined the boundaries of each profession. The paradigms held by each group determine their reality. Traditionally, physicians embrace the post positivist view of reality and are not concerned with the meaning of illness to a patient. Their post positivistic paradigm supports the finding of the scientific truth and requires a detached position to provide accurate data. This methodology requires quantitative and statistical procedures to collect and measure information (Denzin & Lincoln, 1994, 1998; Patton, 2002).

For the phenomenologist, absolute proof of one truth and one correct paradigm does not exist. However, quantitative research is based on rules to discover truth. These different beliefs led to philosophical debates about what is true science. In the last few years, nurse researchers began investigations based on hermeneutic phenomenology. By focusing on the lived experiences of patients, the mind-body dualism supported by medicine might be enhanced by exploration of an individual's interpretation of experience (Appleton, 1997; Benner, 1994; Dieklemann, 2002; Dreyfuss, 1993; Pascoe, 1996; Walters, 1995a, 1995b).

Nurses have a different reality of patient health care. In addition to the post positivist view, they are interested in the meaning that patients assign to their lived experiences of illness and health. Phenomenology is suited to nursing which recognizes

the need to understand the meaning of lived experiences of others (Appleton, 1997; Benner, 1994; Borbasi, 1996; Cirgin, 2002; Cohen, Kahn & Steeves, 2000; Diekelmann, 2002; Drauker, 1999; Ironside, 2001; Munhall, 2001; Smith, 1999).

This investigator was interested in the lived experience of recent graduates as they transitioned into delivery of competent health care. Based on the philosophy of phenomenology and the importance of lived experiences, this study looked for the essence or core meaning of the mentored experience for culturally diverse new graduate nurses.

Researcher-Participant Relationship

In a phenomenological study the essence or essential structure of the individual's experience is revealed and described. Phenomenology, as qualitative design, incorporates a personal one-to-one interaction between the participant and the researcher to collect information. The appropriate relationship is interpersonal, interactive, and interpretive. The researcher seeks to develop rapport and create a climate of mutual trust, understanding, and discovery (Kvale, 1996; Patton, 2002; van Manen, 1990).

In phenomenological inquiry the researcher is expected to become the instrument of discovery and interpretation through observation and finely honed skills (Benner, 1994; Kvale, 1996; Munhall, 2001; Patton, 2002; van Manen, 1990). Through interviews and open-ended questions with the protégés, the researcher gathers information about the participant's interpretation of a lived experience. Participant information is collected until no new information appears. In qualitative inquiry the number of participants needed for the study cannot be predetermined (Cohen, Kahn & Steeves, 2000; Patton

2002). Phenomenology is best suited for studies when little is known about the phenomena of interest (Cohen, et al., 2000).

Relevance for Nursing

Education

A possible benefit of this study to education is increased understanding of the importance of mentoring. In preparation for moving from the classroom to professional nursing, some of the mentoring needs could be addressed before hand. In addition, mentoring was supported as an important for recruiting and retaining culturally diverse students by the American Association of Colleges of Nursing (AACN) 2001 and National Advisory Council on Nurse Education and Practice, (NACNEP) 2004.

Wilson, Sanner, & McAllister (2003) supported mentoring for retention of culturally diverse nurses. "Minority nurses significant contributors to health care services and leaders in the development of models of care that address the unique needs of populations" (Wilson, et al., 2003, p.11). Knowledge of how student nurses from culturally diverse backgrounds experience the mentoring process would assist in the development of effective mentoring programs.

In summary, mentoring makes a difference. Nursing educators would benefit from the realization that what they bring to a student is the gift of themselves and nursing expertise. According to Tosteson (1979), the most vital thing we can give our students is ourselves. The rest can be found in textbooks.

Practice

A possible benefit of this study to practice is that mentoring of culturally diverse nurses may be a means of providing appropriate health care to a diverse population. An

early leader in mentoring believed that mentoring improved health care for all patients (Atwood, 1979, 1986). Recently major nursing leaders and organizations also addressed the mentoring issue (AACN, 2001; Casey, Fink, Krugman & Propst 2004; Mitchell, 2004; Vance & Olson, 1998; Wilson et al., 2003).

When one hospital piloted a mentoring program, changes were quickly noted. Not only did one mentor seamlessly integrate new nurses into practice, but also the mentored nurses reported greater job satisfaction. Other benefits indicated improved quality of care. For example, physicians noted and commented on morale of nurses and other physicians requested their patients be admitted to the unit of mentored nurses. Patients and families spoke of greater satisfaction with nursing care (Atwood, 1979, 1986).

Mentoring could ease new graduates into practice (Winter-Collins & McDaniel, 2000).

In summary, mentoring was cited as an important strategy for nursing practice. The possible benefits included delivery of effective health care to culturally diverse patients. Mentoring may assist with socialization of new graduates while they develop nursing skills, a sense of belonging, self-esteem, and self-efficacy. Job satisfaction was connected to mentoring and job satisfaction has implications for retention of nurses and for health care.

Policy

The possible benefit of this study would be incorporation of a mentoring policy to guide the mentor during the mentoring process. Policy makers have three possible decisions regarding mentoring programs: (a) do nothing, (b) sanction a program, and (c) create a mentoring culture climate through guidance of the program (Cameron-Jones, &

O'Hara, 1996). The decisions are mutually exclusive and decision makers will invariably choose one of the three options. Health care institutions and nurse leaders need to consider the evidence of mentoring benefits in health care delivery.

Allen (2002) believed creation of a mentoring culture in nursing would make mentoring a part of everyday practice, management, and leadership. "Strong mentoring relationship is transformational action" (p. 444). Mentoring for change benefits the patient and the nursing profession. Mentoring of nurses may serve to: (a) bridge the gap between education and practice, (b) develop professional skills and talents, (c) increase effective communication and understanding of politics within the health organization including the nursing department, and (d) increase morale.

The development of a mentoring program within organizations is a process that requires the valuing of mentorship as a strategy (Grindel, 2003; Grindel & Roman, 2002). The mentoring process may be incorporated into the philosophy and mission statement of nursing organizations as policy. The philosophical and conceptual framework for the mentoring process has to be stated and communicated at all levels of management and staff. A designated coordinator and support team would oversee the development of a plan. A mentor selection and training program, matching of mentor and protégé, and tracking of the mentoring relationship and outcome comprise the last step (Grindel, 2003).

Nursing administration could consider the following studies. Ragins (1997) identified organization factors that influenced access to mentoring. The degree of inclusion of culturally diverse employees in all departments and positions indicated the degree of structural integration. Management policy could include greater numbers of

diverse employees and if so may increase the mentoring opportunities of diverse employees. Ragins (1997) suggested that organizational culture that mentors for integration not only increased the diversity of employees, but also increased the diversity of ideas and talent to promote corporate productivity.

Organizational priority could be development of policy that proactively supported increased diversity of nurses. "Cultural competence is not about tolerance" (Washington, Erickson, & Dimotassi, 2004, p. 41). Cultural competence is about inclusion of diversity at every level of nursing. Culturally effective nursing practice requires a paradigm shift of personal views and the support of organizational policy (Washington el al., 2004).

Mentoring literature clearly identified benefits and reasons for management to institute mentoring programs as a matter of policy. Recognition of the importance of mentoring for continuity of nursing knowledge and wisdom, and tapping diversity for talent was crucial. A formal vision statement and policy regarding mentoring would require not only commitment to mentoring diversity at all levels, but also an active institutional and individual assessment of cultural biases (Grindel, 2003; Ragins, 1997). Mentoring at all levels of nursing would create a respect for diversity by mutuality of personal commitment, caring, support, and professional growth. Without commitment by nursing management, effective mentoring programs will lack the vital support needed at the policy level. (Grindel, 2003).

Research

A possible benefit of this study to research is the addition of new information for further study. Nurse researchers have scarcely begun to investigate the mentoring requirements of culturally diverse students and nurses. It appeared that the profession

lagged behind other professions (Hart, 2002). Perhaps the lag can be contributed to a variety of factors: (a) lack of an operational mentoring definition, (b) confusion regarding the definition of mentoring with precepting, role modeling and coaching, (c) the traditional view of mentoring as exclusive to leadership development for managers, (d) gaps between connecting mentoring with retention of new graduates and culturally diverse nurses, and (e) the unrecognized connection between culturally effective health care practice and the mentoring process (Hart, 2002).

In our increasing multicultural societies, the ability of culturally diverse nurses, as well as Caucasian nurses, to provide culturally appropriate health care will become critical. Mentoring literature clearly identified benefits and reasons for management to institute policies for effective mentoring programs. A formal vision statement and policy based on an active institutional and individual assessment of cultural biases required commitment to mentoring diversity at all levels. The nursing profession was encouraged to recognize the importance of mentoring for continuity of corporate knowledge and wisdom, and the importance of tapping diversity for talent. Focused mentoring research is needed (Gonzales, 1999; Grindel, 2003; Grindel & Roman, 2002; Hegstad, 1999; IOM, 2003; JCAHO, 2005; Nugent, Childs, Jones, Cook & Ravenell, 2002; Rodriguez, 1995; Vance & Olson, 1998; Villarruel, 2002, 2004; Villarruel & Peragallo, 2004).

Summary

The rising census of culturally diverse populations has created a need for increased cultural diversity in health care professionals. The existence of low numbers of diverse health care professionals has limited culturally diverse patients' access to appropriate health care and consequently has contributed to health care disparities.

Health care agencies, medical groups and nursing leaders have advocated for mentoring as a strategy to recruit and retain future culturally diverse students and professionals. The importance of mentoring to support cultural diversity and for improved health care was actively supported by the federal agencies, medical groups and nursing leaders. Without the presence of culturally diverse population of health care professionals, the health of diverse patients may be seriously undermined (Bellamy, 1983; Bessent, 1983; Gonzales, 2000; Rodriguez, 1995; Villarruel, 2002, 2004; Villarruel & Peragallo, 2004).

This chapter has discussed the aim of the current study which was to explore the culturally diverse new graduate nurses' lived experience of being mentored. The perceived justification for the study was based on the nursing goal of increasing diversity within the profession. The researcher has described the assumptions and biases related to the perceived importance of the study. The phenomenological method and the appropriateness for this study were explicated. Implications for nursing education, practice, policy, and research were also described.

Overview of Chapters

The following chapters are discussed. Chapter Two is the evolution of the study. The historical context of the phenomenon, a concept analysis of mentoring and the researcher's experience with mentoring are explored. Chapter Three is the phenomenological method of the study and contains the background of phenomenology and van Manen's method of researching lived experience. Chapter Four is the application of the phenomenological study method. This chapter includes turning to the nature of lived experience and existential investigation. Human subject protection and the research protocol are delineated. Guarding credibility and trustworthiness are

included. In Chapter Five, the findings of the study are described. The participants' lived experiences and essential themes are defined and discussed. A biographical sketch of each participant is included. In Chapter Six, phenomenological reflections on the findings are discussed, along with a literature review. The essential themes and the how the theory of transitions connects with them are described. The strengths and weakness of the study and the method are included. Finally, the implications and relevance for nursing are discussed.

CHAPTER II

Evolution of the Study

This chapter contains the concept analysis of mentoring. The elements of concept analysis of mentoring include the historical context of mentoring, and the requisite elements. A definition, essential attributes, empirical referents and researcher experience with mentoring will be discussed (Rodgers & Knafl, 2000). The elements of mentoring are delineated to provide an understanding of the concept of mentoring as the phenomena of interest and focus of this study.

Rationale for the Method

This writer explored the concept of mentoring through the method of an evolutionary concept analysis. This technique offered a comprehensive process to identify the core or essence of a concept and clarify the conceptual meaning of mentoring. Nursing concepts can be studied and measured as the meaning evolves through time, thus contributing to, or revising the theoretical knowledge base. Clarification of concepts enhances understanding, and appropriate application to all aspects of nursing (Rodgers & Knafl, 2000).

A synthesis and conceptual analysis of mentoring literature from five disciplines: nursing, medicine, education, psychology, and business, formed the foundation of the information in this chapter. The historical evolution of the concept of mentoring, four evolving attributes, and six core attributes of the phenomena are included. Mentoring and the benefits of mentoring have generated much interest since ancient time. Therefore, an understanding of the concept begins with exploration of its historical

context (Daloz, 1999; Oak Ridge National Laboratories, 2004; Olliver, 1998; Phillips, 1977).

Historical Context

Mentoring has existed since the beginning of recorded time and is as old as humans are themselves. Mentoring is described starting with first recorded stories. Classic literature, biblical references, and historical records of mentoring track the changes over time. The core meaning of the mentoring remained the same through out recorded history and will be described along with evolving attributes in this chapter.

Classic Greek literature described the mentoring relationship between the Goddess Athena and Telemachus, the son of Ulysses. Telemachus was placed in the care and guidance of his teacher Mentor who was unable to provide the wisdom, counseling and protection needed to protect his student's birthright. The Goddess Athena assumed the masculine form of Mentor and became guide, counselor, protector and teacher to Telemachus (Homer, n.d.).

Mentoring between notables, Moses and Joshua, was recorded in the Bible and in classic and philosophical literature (Oak Ridge National Laboratories, 2004). The next recorded period of history noted the guild system mentoring between masters and apprentices. A historical term related to the concept is the master crafts person who had apprentices with whom they shared knowledge, experience, and strategies for success in business (Olliver, 1998). Mentors were prominent in the arts and humanities. Queen Elizabeth I was mentored by Lord Cecil; psychologist Carl Jung was mentored by Freud, and Helen Keller was mentored by Anne Sullivan. Michelangelo, Leonardo de Vinci,

Sigmund Freud, Margaret Mead, and violinist, Itzhak Perlman had mentors (Oak Ridge National Laboratories, 2004).

As time evolved the concept of mentoring was adopted by modern business. Initially, informal arrangements existed, but later evolved to more structured formal programs. The "good old boy" network in traditional management was the outcome of mentoring (Olliver, 1998). Mentors evolved further in the 21st century, as knowledge brokers and cheerleaders who often orchestrated critical turning points in the careers and lives of others (Daloz, 1999; Olliver, 1998; Phillips-Jones, 2001; Vance & Olson, 1998). Three leaders in the professions of psychology, nursing, and business produced early works that expanded the meaning of mentoring. Their contributions are described.

Phillips (1977) discussed a new form of mentoring in professional careers for her doctoral dissertation. Traditionally mentors decided whom they would mentor. Planned mentoring by the protégé was a new and controversial concept. Phillips' doctoral dissertation research used a grounded theory design and a survey of career women (N = 331) of which 2% were women from ethnic cultural backgrounds. The number of participants contradicted the standard protocol for grounded theory research but study was based on a survey. Phillip's found three aspects of mentoring which were: (a) the relationship, (b) the assistance of the organization, and (c) the timing within the work environment (1977). The first aspect, the relationship, included: (a) attitudes of mentor and protégé about themselves and each other, (b) individual needs and personal characteristics, (c) length of time in the relationship, (d) a voluntary or involuntary nature of the relationship, and (e) protégés' interpretation of the mentors' level of interest in them. The second aspect, organizational assistance, encompassed the degree of

encouragement, counseling, friendship, challenge, and the degree of visibility the protégé had. The third aspect of timing within the work environment depended on the stage of career and psychosocial development of both mentor and protégé (Phillips, 1977).

Phillips reported two types of mentors, primary and secondary (1977). Primary mentors were more invested in the protégé's development and made a concerted effort to advance the protégé's career. The primary focus was the protégé's best interest. The secondary mentor assisted the protégé's career on a less committed level and may not have had a deep influence on the protégé (Phillips, 1977).

The outcome of Phillips' study suggested women should take the initiative to further their career by choosing a mentor and planning what would be learned. The study also found that multiple mentors facilitated career mobility in management, education and counseling. Phillips suggested that further investigation of mentoring could study the effects of voluntary and involuntary mentoring relationships and outcomes (1977).

In 1982, Phillips-Jones wrote the first edition of her book based on the results of the author's earlier study of mentors and protégés. In the revised edition, a reflective statement summarized the changes (Phillips-Jones, 2001).

> When I wrote my dissertation . . . mentoring was not a household word. People were skeptical about the notion that mentoring could be planned and managed, and that mentees could have a say in the process. Yet, despite strong resistance the age-old concept of mentoring was changing (Phillips-Jones, 2001, p. ix)

Over the years, the traditional concept of mentoring has changed and garnered attention and strength. The concept became a household word and an industry that created hundreds of books, training literature, tapes, videos, and Internet sources.

Mentoring circles, young mentors with older protégés, and creative, innovative rules guided the process. "An effective mentor can help a protégé move from mediocre to excellent performance, from weariness to excitement and passion—even when the protégé hasn't had much success before" (Phillips-Jones, 2001, p. x).

Phillips-Jones cited further evolutionary changes in the mentoring concept (2001). They were: (a) protégés negotiated relationships, (b) multiple mentors were sought, (c) mentors affected all areas of the protégé's life, (d) mentors had higher expectations and standards, (e) women and culturally diverse individuals became mentors and protégés, and (f) relationships focused on skills and pragmatic issues. People became more mobile and interactions were shorter. Mentor-protégé etiquette emerged in response to the shorter periods of mentoring by incorporating the protocol of prompt response to all communication within 24 hours. The work of Phillips-Jones was significant because it provided a foundation for further growth and additional knowledge of mentoring (Phillips-Jones, 2001).

Effectiveness of mentors is evidenced by two major functions. The functions are activities that foster career and psychosocial development of the protégé. Kram (1988) found that career development functions included coaching to assist career progress and provided opportunities for visibility. Psychosocial functions were counseling, validation, modeling, and friendship (Kram, 1988).

Kram (1988) identified four phases of the mentor relationship as initiation, cultivation, separation, and redefinition. The phases are predictable indicators of progress and of the degree of support required to move through the phases important to individual and career development. The author believed that her work benefits

individuals at every career phase, specifically for individuals who want to advance. The work done by Kram (1988) provides a solid foundation for further study, clarification of the mentoring concept, and effective use of a mentoring relationship.

One study identified personality characteristics of mentors versus non-mentors and concluded that psychological profiles had no ability to predict who could or could not mentor (Alleman, 1982). The research answered questions regarding mentoring behavior, mentor personality, and the similarities of characteristics between mentor and protégé. She compared the results with the characteristics and personality traits between non-mentoring work pairs and mentored pairs of participants.

Alleman (1982) used a correlational descriptive design to compare 29 mentoring dyads with 21 non-mentoring dyads. Multiple linear regression was used to test the hypotheses. Mentoring behavior significantly differed from non-mentoring work dyads. However, no significant personality traits existed for mentor dyads compared to non-mentoring dyads. The researcher concluded that people could be taught to mentor. This finding had significant influence on the development of mentoring relationships. Alleman (1982) followed her study with the developed an instrument, the Alleman Mentoring Activities Questionnaire (1983) that takes less than 15 minutes to complete. There are 72 Likert-type items and 10 subscales that measure mentoring behaviors. Alleman (1982) was very clear and assertive about the mentoring process as quoted below:

> There is no confusion about mentoring. It is empirically established. Mentoring is a fascinating human dynamic. You know it when you see it. If the relationship is negative, it is not mentoring. Mentors hold protégés to higher standards than

subordinates do. They do not get off lightly (E. Alleman, personal communication, March 27, 2002).

Concept Analysis of the Phenomenon of Interest

Evolving Attributes

Attributes comprise the real definition of a concept and the clusters help identify appropriate use of the concept according to Rodgers and Knafl (2000). Four evolving attributes are discussed: (a) mentors as keepers of wisdom, (b) diversity mentoring, (c) mentorship, and (d) transformation. They have the potential to influence nursing.

Mentors As Keepers of Wisdom

The first evolving attribute was the mentor as keeper of wisdom. Koerner (1998) proposed the concept of mentor as wisdom keeper. The search for wisdom and mastery usually occurs throughout an individual's life. The process takes the learner into unexplored territory and stretches the boundaries of knowledge. The commitment to stay on the path, regardless of obstacles defines the journey to mastery. Therefore, the mentor or keeper of wisdom has weathered the journey and their mentorship will nurture and given direction to protégés, through shared wisdom. Wisdom is defined as a knowing unaided by technical knowledge. A second kind of knowing occurs when the knower or mentor becomes what others seek. The essence of a mentor's collected wisdom and experience is reflected in the growth and development of a nurse protégé (Koerner, 1998; Koerner & McWhinney, 1995).

The future advancement of the profession will require nurses to be proactive in devising changes. A vision for nursing future is in developing mentor wisdom keepers

who create an essential mass of nursing leaders who will facilitate the emergence of a new health care system (Koerner, 1998). Their collective influence and effectiveness in nursing could be significant. The lack of experienced and wise mentors within the professional is an untenable condition which has restrained the development of individuals and the profession as a whole (Koerner, 1998).

In summary, the mentor as keeper of wisdom concept has offered a different perspective on the mentoring process and an alternative to strategize about nursing issues. The projected benefits could accrue: (a) improved administration and delivery of health care, (b) a more seamless transition of new graduate nurses to the profession, (c) the recruitment and retention of nursing students and staff, (d) the development of scholars, researchers, and (e) accruing a more comprehensive body of nursing knowledge to meet future challenges.

Diversity Mentoring

The second evolving attribute was greater diversity in mentors. Twenty years ago several researchers questioned anecdotal stories that culturally diverse individuals did not receive mentoring as did non diverse persons. Consequently, these individuals did not advance professionally. Concern about diversity prompted researchers to compare the frequency and outcomes of mentoring for culturally diverse and non-diverse protégés (Alleman, Newman, Huggins & Carr, 1987). In a comparative study, the mentoring experiences for African American and Caucasian participants were analyzed for similarities and differences. Multiple regression statistics were used to test variance.

In the Alleman et al. (1987) study, participants were self- selected. African-American participants, (n=57) reported they had both African-American and Caucasian

mentors, compared with Caucasians (n=28) who had mentors with same cultural background. The African American participants reported higher levels of career satisfaction than did Caucasian subjects. When compared with studies on mentoring between individuals with similar cultural backgrounds no difference occurred. The study concluded that effective mentoring relationships are similar and have similar outcomes, regardless of ethnicity (Alleman et al., 1987).

Malone (1982) used a descriptive survey design to examine the relationship between mentoring and career satisfaction. Black female administrators (N=130) responded to the mentoring questionnaire. Eighty percent (80%) had experienced mentoring. The results showed that African American female administrators who had early family support, community support, and career mentoring were more satisfied in their careers. The non-mentored women had less opportunity for advanced levels of leadership in their careers (Malone, 1982).

Malone (1998) spoke of her personal experience with mentoring, “Mentoring is a song of power that becomes embedded in the very fabric of one’s existence. In your darkest night, it is the song that comes speaking of strategies, tactics, and visions of change” (p. 56). Malone further stated, “The song of mentoring needs to shake and shape the walls of the nursing profession to generate leaders for health care” (Malone, 1998, p. 60). The study verified that culturally diverse women greatly benefited from mentoring. Diversity in mentoring is evolving in the nursing profession (Vance & Olson, 1998).

Traditionally mentoring was between people who were similar in gender, ethnicity, and culture. The new mentors were more likely to be women and culturally diverse individuals who represent the growing trend of their increased numbers of

employment. Organizations were encouraged to recognize the wisdom of preparing women and culturally diverse individuals for leadership instead of adhering to the tradition of white male mentors (Phillips-Jones, 2001; Ragins, 1995; Vance & Olson, 1998).

Mentorship

A third evolving attribute was mentorship. The art and skills of mentoring activities comprise mentorship. Mentorship has been described as the essence of maturity that required a balance of heart, mind, spirit, wholeness (Bidwell & Brasler, 1989; Carr, deRosenroll & Saunders, 2001). Figaro (2001) believed the lack of discussion about mentorship in medicine existed because "At the heart of it, it's a relationship and as such . . . shrinks under microscopic examination" (p. 5). Although the characteristics of mentoring behavior were well delineated in literature, ethical behavior in the mentoring relationship had rarely been explored (Wilson, 2001).

According to Wilson (2001), literature has not discussed the ethical duties of those who mentor. The mentor's possession of honesty, character, wisdom, and principles is required to fulfill their ethical responsibilities. Integrity, courage, and caring in mentorship will deeply influence the effectiveness of mentoring. Wilson (2001) noted the lack of ethical guidelines for mentorship. Ethical principles to guide the process were proposed: (a) autonomy to encourage protégé independence, (b) non-maleficence to promote awareness and avoidance of deliberate harm, (c) beneficence to intentionally nurture protégé growth, (d) justice to facilitate equality of interaction regardless of ethnicity or gender, and (f) fidelity to promises made and commitment to the protégé (Wilson, 2001).

As early as the 1970s, a nursing editorial addressed the lost art of mentorship of the new graduate nurse, which could "bridge that awful gap" (Schoor, 1978, p. 1). New graduate nurses still need a mentor to bridge that stressful time between novice and expert. Nursing has the potential to be a standard bearer for the development of an evolving mentor model, which by inclusion of the essence of female values and skills would give a voice to nurses (Vance & Olson, 1998). The new mentorship for nursing students, teachers, practitioners, staff, and administrators has the potential to create new models of growth and development.

Transformation

A fourth evolving attribute of mentoring was the transformative nature of mentoring for both mentor and protégé. Literature regarding this attribute is scarce. Transformative mentoring occurs at a certain time within an individual's life when he or she is validated, granted permission to develop and empowered to merge inner wishes, intentions, and potential with action. The result is transformation of the protégé who could become a model of what others could achieve. The catalyst and transformer was the mentor. The benefit to nursing is transformative leadership and nursing care (Daloz, 1999; Vance & Olson, 1998).

Essential attributes of Mentoring

The six essential attributes of mentoring in nursing and multidisciplines found in the literature were: (a) teacher-learner interaction, (b) mutuality or reciprocity, (c) career and psychosocial development, (d) mentor-protégé differences, (e) time span, and (f) resonating phenomena.

Teacher-Learner Interaction

Formal mentoring models primarily focused on teaching organization norms and leadership skills for career development. Mentors analyzed protégé strengths, skills and undeveloped areas, gave challenging assignments, taught critical thinking, and counseled where needed. The protégé learned to analyze and break major project into smaller ones. Constructive feedback and motivation guided the learner (Koerner, 1998; Lewis, 2001; Parse, 1998).

The learning curve is accelerated when the protégé interacts with experts and mentors who have exceptional knowledge. The phenomenon is explained by the principle of induction in physics, which is a transfer of energy from one field to another (Koerner, 1998). " In the purest sense, induction is achieved by imitation as the mentor progressively draws the protégé into new patterns through a rhythm of taking in and letting go, or giving back" (Koerner, 1998, p.78). Each cycle of interaction etches the experience within the brain of the protégé and forms a different pattern of thinking, problem solving and behaving (Koerner, 1998; Parse, 1998).

In nursing education, mentors facilitate ethical decision-making, critical thinking, and scholarly activities. The mentor adds scholarliness such as risk-taking with ideas, conceptualization, and provides an expanded environment for learning (May, Melis & Windstead-Fry, 1982). Wocial (1995) believes that mentors promote the professional development of novice researchers, models honesty, accountability, integrity, and technical competency, which greatly decreases the incidence of scientific misconduct in nursing research. Nurse leaders have called for training of mentors and for public criteria to evaluate the mentors' qualifications. In addition, the value of mentorship needs to be

evaluated as a strategy that promotes the use of mentors to assist with the professional development and socialization process of the new graduate nurse learner (May, Melis & Winstead-Fry, 1982; Vance & Olson, 1998 Wocial, 1995).

Mutuality-Reciprocity

The second essential attribute of mutuality- reciprocity in mentoring is found throughout the literature. The influence of mutuality-reciprocity is key attribute of effective mentoring and should not be underestimated as an essential part of the relationship. Mutuality and reciprocity reflect the sharing of trust, learning and the enhance profession and personal development for both mentors and protégés. Regeneration of both individuals occurs within this attribute (Daloz, 1999; Vance & Olson, 1998; Phillips-Jones, 2001; University of Maryland, 2002; Zachary, 2000).

Mutuality-reciprocity occurs in a mentor protégé dyad when protégés have strengths their mentors lack. These qualities serve as a learning process for the mentor after the relationship is established (Kram, 1988). During the relationship, both mentor and protégé mutually give honest and constructive feedback to one another and enter into a respect for the other's growth to facilitate an effective relationship (Zachary, 2000). The protégé's success reflects favorably on the mentor who may acquire a reputation for developing people. The outcome of such relationships benefits the organization and attracts new protégés. The mentor's credibility is strengthened; management's perception of mentor judgment is enhanced as the protégé rises in achievement (Kram, 1988). A frequently cited mentor benefit is the satisfaction of passing on the torch to the protégé (Daloz, 1999; Phillips-Jones, 2001; University of Maryland, 2002; Vance & Olson, 1998; Zachary, 2000).

One example of mutuality was found in a northeast university peer mentoring manual based on the work of Zachary (2000). The peer mentoring program encourages "small talk" among faculty. Although the conversations may be perceived as superfluous, they are essential to build a sense of community. The Center for Teaching and Learning at the University of Maryland University College reported that the peer mentoring program empowers both experienced faculty and protégés in their professional development (2002). An increased collegiality, creativity and personal satisfaction are evidenced. The perspective of mentoring as gift giving and exchange is a recurrent theme throughout the mentoring literature.

Career and Psychosocial Development

Two major functions of the mentor relationship are career development and psychosocial functions (Kram, 1988; Phillips, 2001). Career functions of mentoring prepare the protégé for career advancement by providing visibility, protection, challenging projects, sponsorship, and coaching. Career development has several stages that significantly influence relationships and the developmental tasks differ at the early career, midlife, and late career stages. Four identified phases of the mentoring process include initiation, cultivation, separation, and redefinition, all of which represent turning points in the relationship (Kram, 1988).

Psychosocial functions develop a sense of proficiency, identity, and accomplishment in the profession. The activities provide modeling of professional behavior, ethical decision-making, provision of opportunities, guidance, validation, and friendship. Psychosocial functions affect the protégé on every level by building self-esteem within the organization and in personal life. The interpersonal relationship

develops mutual trust, respect and intimacy, thus facilitating protégé identification with the mentor (Kram, 1988).

Mentoring in organizations usually occurs as formal programs in which specific goals and objectives are defined, monitored, and assessed for levels of achievement. Rather than occurring spontaneously, mentors are chosen by the organization and paired with protégés. Formal mentoring programs typically focus on career development rather than personal development. The majority of business management literature supported career development functions and viewed psychosocial functions as incidental. The omission neglects the socialization and personal growth of the protégé (Phillips-Jones, 2001; Vance & Olson, 1998).

Although the foundational works of Phillips (1977) and Kram (1988) greatly benefit business, certain areas of business have yet to incorporate the mentoring process. Hegstad (1999) urged the adoption of mentoring as a strategy for human resource development. Research in the effectiveness of formal training of mentors would advance the state of human resource knowledge and contribute to the development of understanding in mentoring with diverse groups. Human resource managers were urged to begin to examine the use of mentors as a strategy for development.

Manch (1999) represented the legal profession and suggested that legal firms need to change and reinstate the mentor relationship. Informal mentoring was a tradition in which senior law firm members took the new lawyers under their “wings” and guided them. When that practice changed, a 43% attrition rate of new lawyers in the first years of practice threatened the future of law firms and the recruiting of talented professionals (Manch, 1999).

Dunnington (1996) believed that the golden age of medicine incorporated mentors who modeled professional behavior, socialized medical students into the profession, and taught critical thinking by the question-and-answer method at the bedside. Over time, mentors became ill favored and disappeared because medical leaders believed the best and brightest could find their own ways. Medical students have continued to lack the interactive process of clinical observation and feed back. Tosteson (1979) noted that all a mentor has to give is the self. Everything else is in the medical books. He called for reinstatement of faculty mentors to correct the current deficits in medical training.

Psychology literature viewed mentoring benefits as psychotherapeutic. Mentoring was also a means to increase spiritual well-being (Rodenhauser, Rudisill, & Dvorak, 2000). Education recognized both career and psychosocial functions as critical to junior faculty (Holloway, 2001; 2002).

Historical nursing leaders had mentors. Florence Nightingale was mentored by Sir Sidney Hubert; Linda Richards was mentored by Dr. Zakrzweska; Adelaide Nutting was mentored by Isabel Hampton Robb; and Annie Goodrich was mentored by Anna Maxwell (Fields, 1991). "They possessed the inner stuff in which greatness grew" (Fields, 1991, p. 41). These women had potential and demonstrated greatness in their accomplishments. Undoubtedly, they were achievers, and with the wisdom, power and guidance of their mentors they made notable contributions to nursing. The mentoring process has continued with contemporary nursing leaders.

The concept of mentoring first appeared in nursing literature early through the work of Vance (1982). Mentoring in nursing literature suggested mentoring is responsible for career advancement and leadership development (Bidwell & Brasler,

1989; Fields, 1991; Madison, 1994; Vance, 1982; Vance & Olson, 1998). Mentoring is a tool for training novice researchers and scholars at the doctoral level of education and to increase the accumulation of nursing knowledge (May, et al., 1982; Wocial, 1995). Psychosocial functions of caring and affiliation occur during the mentoring process and create networks to facilitate the development of the profession, health care systems, and society. Psychosocial functions also serve to socialize students into nursing, and provide nurturing to new graduates and nursing students (Fox, Rothrock & Skelton, 1992).

Changes in the mentoring concept have occurred since Vance (1982) first introduced the concept of mentoring. Major components of change are mutuality of sharing, learning, and satisfaction. Changes incorporate female values and skills. The new mentorship is more inclusive, mutual, and empowering than the exclusive, competitive, and power oriented traditional form (Vance, 1982, Vance & Olson, 1998).

Enhancement of professional and personal identity, growth, and connection with other nurses is attributed to the characteristics of the new mentoring. "From my own investigation I now consider the mentor relationship the most inclusive and influential type of support, with functions encompassing such roles as sponsor, teacher, guide, patron, advocate, benefactor, and advisor" (Vance, 1982, p. 8). As a nursing concept, mentoring has continued to evolve. It may facilitate mentoring as a standard practice on all levels, including culturally diverse new graduate nurses and their entry into professional status.

Mentor Protégé Differences

Traditional mentoring identified an age and experiential difference between protégé and mentor. Alleman (1982) held the view that a mentor has greater power,

skills, and experience than the protégé but did not designate the mentor as older in age. Mentors today are people who, regardless of age, experience, and influence recognize a person's potential and are in a position share, support, and guide the protégé (Phillips-Jones, 2001). Mentors do not have to be experts in a particular skill, "He can be a learning broker, accountability partner, cheerleader, and sounding board. She can engineer critical turning points" (Phillips-Jones, 2001, p. 21).

Time Span

In the past, friendship and professional collaborations evolved over time and lasted 30 to 40 years. Traditional mentoring often lasted decades, but currently mentors and protégés are more mobile and focused on identified skills and competencies. Phillips-Jones (2001) identified a shortened time in the new mentoring paradigm. The relationships are more powerful because they are achievement oriented. In summary, tradition has intermingled with the evolving mentorship and has become more flexible in meeting the needs of the protégé, mentor, and organization (Vance & Olson, 1998).

Resonating Phenomena

Anecdotal information shows that those who receive mentoring tended to mentor others, regardless of the discipline involved (Alleman, 1982; Allen, Russell & Maetzke, 1997; Allen & Poteet, 1999; Collins, Kamya & Tourse, 1997; Vance & Olson, 1998; Young, 2001). "Mentoring is a natural, professional nursing activity of caring, empowerment, and nurturance that must be provided nurse to nurse and leader to leader" (Malone, 1998, p. 60). Scant research on the phenomena was found in the literature on the phenomenon of resonation (passing mentoring to others) and represents a need for further study of the resonating attribute of mentoring.

Mentoring Definition

The following definition of mentoring was derived from a review of literature by this writer. The mentor is an individual who imparted wisdom, knowledge, and experience to another. Mentoring is a process of teaching, guiding, coaching, counseling, and sponsoring another individual who seeks excellence in a particular area. Mentoring is the process of interaction between the mentor and protégé that results in career and psychosocial development. In summary mentorship is the essence of the relationship formed by the mentor and protégé. It is the alchemy and syntheses of who they were and who they became in the process (Hart, 2002).

Antecedents

Antecedents are preexisting conditions necessary before the act of mentoring occurred (Rodgers & Knafl, 2000). Organizational culture and systems are critical features (Kram, 1988). The open system fosters new knowledge and feedback, facilitates communication across levels of management, and stresses the importance of relationships. The open system facilitates mentors and the mentoring process. In contrast closed systems limited mentors to role-modeling career development and neglected psychosocial mentoring. Another antecedent is awareness of the importance of relationships in facilitating career development. Professionals in the stages of mid-career often don't recognize what they can contribute to the growth of others. An open system encourages them to pass along their experience and wisdom through mentoring (Kram, 1988).

Additional antecedents found in the literature for the mentor are: (a) an open system, (b) self-awareness, (c) interpersonal skills, and (d) character virtues and self-actualization. Personal and professional antecedents for the mentor are: (a) power, (b) influence, (c) professional accomplishments, formal training, and (d) a career stage different from protégé. The protégé must possess: (a) potential, (b) ambition, (c) be teachable and (d) desire excellence (Allen & Poteet, 1999; Cannister, 1999; Kolias & Herb, 2001 & Madison, 1994).

Consequences

Many leaders stated that a lack of mentoring is a handicap and affects psychosocial and professional development (Kram, 1988; Phillips-Jones, 2001; Vance 1982; Vance & Olson, 1998). Benefits of mentoring are: (a) career development, (b) psychosocial development, (c) increased job satisfaction, (d) professional socialization, (e) scholarly development, (f) stability and continuity of profession through development of leadership and increased knowledge, (g) empowerment of women and minorities, (h) networks, and (i) a resonating phenomena (Alleman, 1982; Kram, 1988; Olliver, 1998; Phillips-Jones, 1982, 1983, 2001; Stewart & Krueger, 1996; Vance & Olson, 1998; Yoder, 1990).

Concepts Related to Mentoring

An evolutionary concept analysis of mentoring identified four concepts confused with mentoring. They are role modeling, precepting, coaching, and collaboration and will be defined for clarification of distinction between concepts. Role modeling occurs when a person identifies with an admired, respected individual, but has no interpersonal relationship. Precepting uses direct teaching and assessed learning in a clinical situation.

The relationship is usually short-term, but may become one of mentor and protégé. Coaching assisted an individual to develop skills through discussion and supervision. Collaboration establishes a partnership to accomplish specific goals. Mentoring encompasses all these concepts (Fox, Rothrock, Skelton, 1992; Stewart & Krueger, 1996; Yoder, 1990). The concept of precepting is frequently used in the nursing profession and therefore, further definition is warranted. See the following table for a definition and comparison of preceptors and mentors characteristics and functions.

Table 1.

Comparison of Preceptors and Mentors

Preceptor	**Mentor**
Relationship is formed as part of a prescribed period of orientation to the unit & hospital. There is a set period for skill development & achievement. The relationship is primarily concerned with procedural & technical knowledge, & achievements.	Relationship is on-going, with mutual trust, understanding, respect, and interest. The relationship influences professional and psychosocial decisions and development.
Precepting activities are teaching, coaching and assessing progress of skills development, knowledge of unit and hospital policies, and procedures.	The more experienced person guides, teaches supports, protects, and shows a deep interest in the welfare of the other. Mentoring activity is more comprehensive and includes precepting & coaching.
Relationship usually ends with completion of orientation and successful demonstration of skills & knowledge.	Relationship continues after the protégé has attained his or her goals.
The experience could include mentoring.	Relationship is described as a friendship by both parties.
Lacks extensive research defining components and benefits.	Extensive research documented the nature & benefits of mentoring.
Lacks a conceptual framework supported by research.	Mentoring has a strong historical context & conceptual framework supported by literature & research

Adapted from a table of comparison of role model, preceptor, and mentor. Fox, V. J., Rothrock., J. C., & Skelton, M. (1992). *AORN Journal, 56*(5), p. 861. Publisher permission. Author permission is pending.

Empirical Referents

Empirical referents are research that validate the definitions and functions of mentoring. Self-report is used frequently. Instruments that measure mentoring activities and benefits are:

- The Darling Measuring Mentoring Potential (Darling, 1984).
- Alleman Mentoring Activities Questionnaire (Alleman, 1983).
- Mentoring in Nursing Service Survey (Holloran, 1993).
- Mentor-Protégé Questionnaire (Spengler, 1982).
- The Kentucky Mentoring Survey (Fagan, & Fagan, 1983).

Experiential Context

The beginning of my professional interest in mentoring was in 1994. As a student at the University of Maryland, I lived and volunteered on a South Dakota Native American reservation for three summers. After graduation with a M.S. in nursing, I returned to teach associate degree Native American Nursing students in the tribal college. The experience led to a strong interest in mentoring for culturally diverse nurses.

As I interacted with the Native students, important differences in student learning needs unfolded. During one to one discussions in the privacy of an office, students exhibited a deeper grasp of information. When students could work together and the instructor had a less formal role, group interaction was more expressive and insightful. In formal situations, native people remain silent when a teacher or elder was speaking and remain so even when invited to speak out.

Students who received personal encouragement from instructors appeared more committed to graduating. Those who left the program were often unable to seek or accept encouragement. They cited conflicts between family and program expectations. Questions arose about possible mentoring benefits for these students. Literature offered scant information about the mentoring requirements of culturally diverse students and graduate nurses. I wondered if mentoring might influence Native American students.

During these teaching experiences, I realized that my lived experience with mentoring was with my Native American step-grandparents. I had never questioned the ethnicity of these grandparents who mentored and cared for me. Consequently, I approached others in the same light of caring they instilled in me. Upon reflection, I realized the deep influence their mentoring had on me.

During my teaching experience, a new faculty member arrived to teach in the tribal program. She had never worked with diverse students and a formal mentoring program was not available. A mentoring relationship developed between the new faculty member and me.

Two immediate concerns became evident to me during this time. My protégé needed to learn more about the students' needs and to refine her own teaching skills. We developed a learning agreement and scheduled meetings to assess Aly's (pseudonym) progress. One of the strategies for mentoring was teaching a course together. This provided an opportunity to model classroom teaching techniques and effective interactions with the students. She demonstrated the ability to be increasingly spontaneous and effective in the classroom. After teaching together, we walked around

the school grounds and discussed the events. This proved to be an effective and non-threatening strategy for giving her feedback.

Another professional influence occurred as a doctoral student at a South Florida University. A concept analysis of mentoring was accomplished using the evolutionary view concept analysis described by Rodgers and Knafl (2000). The analysis contributed to a deepening interest in mentoring.

Summary

Mentors have an ancient history of passing their own wisdom, knowledge, skills, and support to others. The influence of mentoring has been shown to continue long after the initial mentoring event. Mentoring has the potential to influence the pathway of individuals and organizations (Kram, 1988; Phillips-Jones, 2001). Indeed, nursing leaders have stated that the lack of mentoring represents a serious handicap for the leadership and the development of the nursing profession (Madison, 1994; Malone, 1998; Vance & Olson, 1998). This researcher's lived experiences were recounted. It is the belief of this researcher that mentoring culturally diverse nurses may support the professional goals of nursing to increase diversity in nursing. In addition, patient care may benefit.

CHAPTER III

Method of Inquiry: General

Introduction to Specific Method

"The method one chooses ought to maintain a certain harmony with the deep interest that makes one [a nurse] in the first place" (van Manen, 1990, p. 2). This researcher chose the phenomenological method because of her deep interest in and questions about the meaning of mentoring for culturally diverse new graduate nurses. Questions about meaning are appropriate to the phenomenological philosophy and method. Van Manen's method of researching the lived experience will be discussed.

Rational for Choosing the Method

Phenomenology is both a philosophy and method of study. The philosophical premises provided the conceptual framework of this study to explore and to understand the meaning of mentoring for culturally diverse new graduate nurses. The task of phenomenology goes further than traditional philosophy to make known and describe hidden connections and links in human experience (Diekleman, 2002). "Phenomenology is used to answer questions of meaning. This method is most useful when . . . a fresh perspective is needed. The journey led us to a place we neither controlled nor predicted" (Cohen, Kahn & Steeves, 2000, p. 3).

Phenomenological exploration is appropriate to nursing concerns about culturally diverse new graduate nurses. Nursing literature has addressed the mentoring needs of protégés without discussing this group of new graduate protégés. The apparent absence of diverse protégés raised questions about the perceptions and experiences of

mentoring for new graduate nurses who are culturally diverse (Allen, 2002; Cuesta & Bloom, 1998; Hayes, 1998**;** Gerrish, 2000; Matlock & Matlock, 2001).

Phenomenology has contributed to the evolution of practical health care information and nursing expertise by delineating the link between concepts and nursing action (Benner, 1994). The relevancy of qualitative research to nursing includes: (a) a focus on the personal lived experiences of others, (b) the knowledge of social and cultural contexts of others, (c) the understanding of daily lived experience, (d) the use of skilled listening, (e) the multiple layers of revealed meaning within nursing practice, and (f) the knowledge of how the other can be understood, a universal human need (Benner, 1994; Cohen, Kahn & Steeves, 2000; Diekelmann, 2002; Draucker, 1999; Rew, Bechtel & Sapp, 1993).

Background of the Method

Philosophical Origins of Phenomenology

The phenomenological approach has its roots in philosophy and developed in three phases: (a) the preparatory phase, (b) the German phase, and (c) the French phase. Each phase was characterized by evolving changes in philosophy (Cohen, 2000; Polkinghorne, 1983; Speziale & Carpenter, 2003; Spiegelberg, 1984).

In the first phase, Franz Brentano (1838-1917) and his student, Carl Stumpf, (1848-1936) sought to change philosophy and challenged religious views on truth (Cohen, 2000, Polkinghorne, 1983). Brentano used perception, judgment, and values to understand the lived experienced. He described intentionality as the core of consciousness which always refers to something. Stumpf contributed to the growth of

the phenomenological method through his research in psychology (Polkinghorne, 1983; Speziale & Carpenter, 2003).

Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976) were prominent in the German phase of the phenomenological movement. Husserl is known as the "father of the phenomenological movement" (Polkinghorne, 1983, p. 41). Husserl believed that innate understanding created insight into the meaning of lived experience. By intentionally reflecting on one's lived experiences and assumptions, insight brings to light the essence of the experience. "An essence is . . . a constant . . . the 'given' of consciousness" (Polkinghorne, 1983, p. 43). Thus, phenomenological reflection unveils what was hidden previously. The everydayness of living in the world is the focus of inquiry and the context for understanding life experiences (Heidegger, 1926/1962; Speziale & Carpenter, 2003; van Manen, 1990; Polkinghorne, 1983).

Husserl also addressed phenomenological research credibility. One of the criteria is to gather rich examples to support the phenomenon of interest. "The final criterion is the clarity of insight of the phenomenon's essence, for the insight itself is self-validating" (Polkinghorne, 1983, p. 45). Insight is based on interaction between individuals or groups because the essence of an experience is more clearly revealed through the interactive process. Thus, phenomenology is intersubjective. Husserl also developed three concepts: (a) essence, the core meaning of a phenomenon; (b) intuiting, an accurate seeing or logical insight; and (c) epoche, reduction to rich and deep examples, which are essential components (Cohen, 2000; Moustakis, 1994; Polkinghorne, 1983).

Heidegger was a student of Husserl and expanded the work of phenomenological philosophers by questioning the nature of being in the world, "Being is always the Being

of an entity" (Heidegger, 1926/1962, p. 29). The experience of Being is situated within a framework of time, a context for lived experiences. Benner and Wrubel (1989, p. 105) described temporality. "The experience of lived time is the way one projects oneself into the future and understands oneself from the past. Temporality is more than a linear succession of moments. It includes the qualitative, lived experience of time or timelessness" (Benner & Wrubel, 1989, p. 105).

Heidegger believed that thinking about the mystery of Being raised questions that enabled one to understand Being in the world. In addition, Beings are capable of answering those questions. The ability to ask questions implies that we can understand the answers. By questioning one's Being in the world a lucidity of understanding is entered. As if finding a meadow within a forest, the truth of experience is seen (Dreyfuss, 1993; Heidegger, 1926/1962).

The last or French phase, the phenomenological movement was led by philosophers, Gabriel Marcel (1989-1973), Jean-Paul Sartre (1905-1980), and Merleau-Ponty (1905-1980). Marcel (1950) believed the individual and the mystery of being were more important than objects. People must be involved with others to overcome the impersonalness of the modern world (Cohen, 2000 & Polkinghorne, 1983).

Sartre also emphasized the importance of individuals and that existence gave an inalienable right to be whomever the person chose. Existence implied the responsibility of using that freedom appropriately and not escaping into oblivion of mindless living (Speziale & Carpenter, 2003). Merleau-Ponty asserted that people are embodied and they cannot be understood separate from their context in time and space. He subscribed to the concept of individual horizons of experience, being, knowing, and understanding.

The concepts formed during the three phases of philosophical development contributed to the development of phenomenological research (Cohen, 2000; Moustakis, 1994). Heidegger's existential philosophy formed the foundation of van Manen's phenomenological research method (van Manen, 1990).

Outcome of the Method

Phenomenological Research Method

Phenomenology is located within the qualitative paradigm which includes naturalistic, interpretive, and existential hermeneutic phenomenology. In the interpretive paradigm ontology, truth is relativistic and composed of multiple realities based on contexts of language, social, and cultural experiences. Reality is interpreted and varies across time, culture, and context. Individuals and groups define a reality that may be shared by others. However, reality is not absolute and is open to change (Denzin & Lincoln, 1994).

Epistemologically, the researcher and participant act together during the research process to discover and understand the meaning of the participant's lived experience. The methodology includes entry into the naturalistic setting, interactive relationship with participants, purposive sampling, interpretive data analysis, and gathering of information into themes until all themes are exhausted (Benner, 1994; Cohen, Kahn & Steeves, 2000; Creswell, 1998, 2003; Denzin & Lincoln, 1994; Moustakis, 1994; van Manen, 1990).

" Phenomenology . . . is a descriptive method as well as human science movement based on modes of reflection at the heart of the philosophic and human science thought" (van Manen, 1990, p. 184). Phenomenology is a research approach that

entails a particular process. The goal is to discover and understand the essences of a phenomenon of lived experience from the participant's perception. According to van Manen (1990), six key tenets form the foundation of phenomenological research.

Van Manen's Method of Phenomenological Research

Van Manen's philosophy of phenomenology is revealed in the following statements. Phenomenology: (a) is the study of lived experience, (b) is the illumination of phenomena as embodied in consciousness, (c) is the investigation of the core meaning or essence of experience, (d) is the explication and description of an experience as it is actually lived, (e) is the human scientific study of phenomena, (f) is reflective and intentional thoughtfulness on one's assumptions and on the meaning an individual gives to an experience, and (g) is a study of what it means to be human.

Phenomenology as the Study of Lived Experience

The phenomenologist asks, "What is this or that kind of experience like" (van Manen, 1990, p. 9). It is the study of the world as we daily live it. We live daily life instinctively and do not analyze, conceptualize, or categorize it (Husserl, 1962; van Manen, 1990). The researcher studies the essences distilled from living and reflection upon meaning. Reflection is retrospective since an individual cannot reflect on meaning until afterward (Benner, 1994; Heidegger, 1926/1962; van Manen, 1990). The researcher seeks answers to what it means to be human. The inquirer enters into the complexity of the simple and disregarded. This is the everydayness of living. The phenomenologist inquires into the nature of our lifeworld and the goal is to gain insight and to understand the nature or meaning of everyday experiences. Phenomenologist's philosophy position

is that the possibility of credible insight "brings us in more direct contact with the world" (van Manen, 1990, p.1).

Phenomenology as Illumination of Phenomena as Embodied in Consciousness

Since consciousness is the only way humans experience the world, it is the possible focus of phenomenology. Whether or not the object of consciousness is real, imagined or personally felt, it can reveal the nature and meaning of Being in the world. What is significant to humans is of interest in phenomenology.

Phenomenology as the Investigation of Essences of Experience

Husserl defined the concept of phenomenological intuiting as accurate seeing or logical insight into the inner structure of meaning (Husserl, 1962; Merleau-Ponty, 1968). Phenomenology inquires into the nature of a phenomenon, for the essential and basic meaning without which the phenomena could not be the phenomenon. "The essence or nature of an experience has been adequately described in language if the description reawakens or shows us the lived quality and significance of the experience in a fuller or deeper manner" (van Manen, 1990, p. 10).

Phenomenology as the Description of Experiential Meanings We Live as We Live Them

Phenomenology focused on existential meanings and aimed for depth and richness in describing them. In this aspect, phenomenology differed from other forms of research because all lived experience is potentially phenomenon for investigation. Daily experiences are lived instinctively and thus, are taken for granted (Benner, 1994; Heidegger, 1926/1962; van Manen, 1990). "Phenomenology attempts to explicate meanings as we live them in our everyday existence, our lifeworld" (van Manen, 1990, p. 11).

Phenomenology as Human Scientific Study of Phenomenon

Phenomenology is a human science focused on the systematic study of phenomena. The method uses strategies of focused questions, reflection, intuiting, and interpretation to understand the subject matter. Phenomenology is self-critical. Goals, research process, strengths, and limitations are examined.

Investigation attempted to reveal the structures of meaning hidden within daily life experiences. "The basic things about our lifeworld such as . . . time, space, lived body, and lived human relation are preverbal and therefore hard to describe" (van Manen, 1990, p. 18). The most mesmerizing stories are those that bring to light deep insight into what was taken for granted and what affected us directly. The purpose is to validate, through subjective interaction with the participant, the meaning of those stories (Heidegger, 1926/1962; van Manen, 1990).

Phenomenology as Attentive Practice of Thoughtfulness

Thoughtfulness is a mindful attention and caring awareness, according to Heidegger, (1926/1962). It is a purposeful wondering about life and what it means. The practice of phenomenological research is a conscious attentive caring about the meaning of human experiences and focused attention to deepen understanding of what being alive means. Thus, a thoughtful, mindful, and caring person may be less susceptible to manipulation and control by others (van Manen, 1990).

Phenomenology as Search for What It Means to Be Human

The aim of phenomenological research is to have a deeper intuiting of being human, to be more fully who we are. As we explore the embedded meaning in the lifeworld of self and others, we come more fully to clarity of what it means to be in the

world as who we are. Through understanding who we are, we begin to understand the context of society, culture, and history and how it influences and gives meaning to being (van Manen, 1990).

Humans are self-interpreting and seek to broaden the horizon of understanding. Each new horizon of understanding of being human opens other horizons. Therefore, we never fully understand what it is to be human because we dwell in the midst of Being. We can only let life speak for itself. It is through interaction with others that we can come to know the meaning of being human (Heidegger, 1926/1962).

Intersubjectivity in phenomenological research was first defined by Husserl (1962). The concept of intersubjectivity or interaction between participant and research broadens the horizon of understanding. The process reveals and validates the nature of the phenomenon of interest. If the researcher had an experience similar to the participants, then delineation of researcher attitudes, interpretations, and expectations must be made to protect reliability of the study. After the delineations, the shared experience is set aside for the sake of rigor (Cresswell, 1998, 2003; Speziale & Carpenter, 2003; van Manen, 1990).

There is no method of hermeneutic phenomenological research, in the empirical research sense of the word. "There is tradition, a body of knowledge and insights, a history of lives of thinkers and authors, which . . . constitutes both a source and a methodological ground for present human science research practices" (Van Manen (1990, p. 30). Van Manen used a set of six principles to conduct scholarly research.

- Turning to a phenomenon that seriously interests us and commits us to the world.
- Investigating the phenomenon as it is lived, rather than as it is theorized.

- Reflecting on essential themes which characterize the phenomenon.
- Describing the phenomenon through the art of writing and rewriting.
- Maintaining a strong and oriented didactic relationship to the phenomenon.
- Balancing the research context by considering parts and whole.

The following is a representation of van Manen's method.

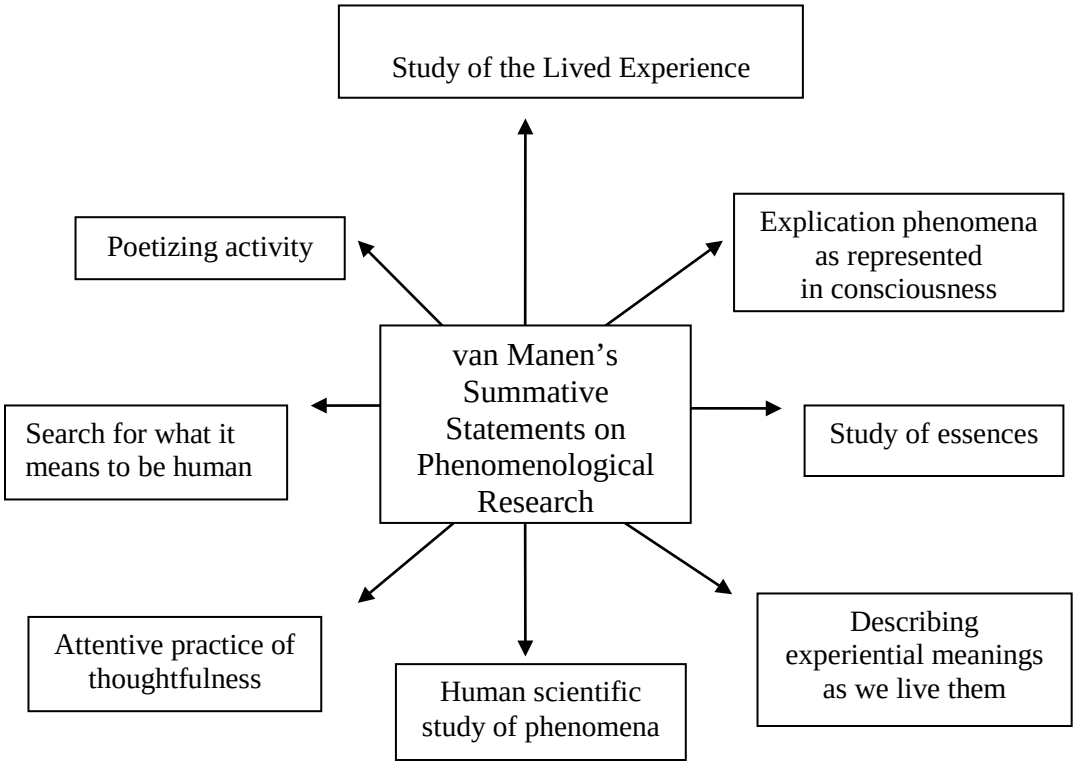

Figure 1. Van Manen's Lived Experience Research

The diagram of lived experience research is adapted from, van Manen (1990). *Researching lived experience*. Ontario: University of New York.

General Steps of the Procedure

Turning to the Nature of the Lived Experience

"To think is to confine yourself to a single thought that one day stands still like a star in the world's sky" (Heidegger, 1971, p. 4). Lived experience gathers phenomenological significance when the inquirer dwells in thoughtfulness and questions about the phenomenon of interest. Dwelling includes reflection conversations, meditations, and writing.

The challenge of phenomenology is to describe and interpret aspects of living in the world that defy our complete understanding. The basic structures that comprise every day life are innately understood but never exhaustively described. Van Manen (1990) believed one should pursue understanding of phenomena with a vital commitment while knowing the new understanding is incomplete.

"A research method is only a way of investigating . . . questions. The questions themselves, and the way one understands the questions, are important starting points, but they are not the method as such" (van Manen, 1990, p. 1). The question that motivated this study was, "What is the meaning of the lived experience of mentoring for new graduate culturally diverse nurses?" By dwelling with this question, "We 'live' this question . . . we 'become' this question. Is this not the meaning of research? By going back again and again . . . until . . . the question begins to reveal something of its essential nature" (van Manen, 1990, p. 43).

Existential Investigation

The starting point of all phenomenological inquiry is the lifeworld and lived experience of self and others. Lived experience is the heart of existential

phenomenological investigation. Lived experience is personal experience and speaks to the way a person understands, interprets, and assigns meaning to his or her world. The meaning of a phenomenon springs from direct experience.

Personal Experience as Starting Point

The researcher brings previous experience and knowledge to the study which could bias interpretation and understanding of the participant's lived experiences. The investigator makes explicit delineation of preunderstandings, biases, and assumptions that allow him or her to describe how the nature of the phenomena was concealed within the suppositions (Heidegger, 1926/1962; van Manen, 1990).

The value of the researcher's lived experience is that her own experience is the possible experience of others (van Manen, 1990). Understanding one's own lived experience of a phenomenon and the influence the experience had, opens the door to understanding others. In phenomenology, the researcher is both instrument and participant in the study (Munhall, 2001; Rew & Bechtel, 1993). The researcher's own lived experiences are examined and set aside, or bracketed.

According to van Manen (1990), the term "data" is not traditionally used and may be unclear in phenomenology. The term data is used to describe empirical research information but gives the wrong impression about the phenomenological nature of collected information. Gathering experiences of a phenomenon through conversations, poetry, reflection, the arts, and observations are examples of phenomenological research information. The gathered information is a reflection on personal experience and not the actual experience. Van Manen (1990) summarized the dilemma about the nature of the word to describe phenomenological information.

Oral and written accounts of experiences are not the same as the actual lived experience. "All recollections of experiences, reflections on experiences, descriptions of experiences, taped interviews about experiences, or transcribed conversation about experiences are already transformations of those experiences" (Van Manen, 1990, p. 54). An analogy is the beautiful seashell that glistens with life within the ocean water but when the beachcomber brings it to the surface, the shell quickly looses it vitality. The shell retains its essence but is changed by its removal from its sea home. Life experience can never be captured but can be understood (van Manen, 1990).

Literature Review

The literature review is addressed during the analysis process. As themes emerge, they are compared with literature for degree of convergence or divergence. Themes that diverge from literature were noted. Categories of themes were compared with the literature review for similarities and contradictions (Moustakis, 1994). Literature is a valuable guide to understanding what was previously known about the phenomenon of mentoring. Discovery of information that does not conform to the literature, but opens up possibilities for enhanced understanding, stimulates questions and offers paths for future study (Moustakis, 1994; van Manen, 1990).

Summary

In summary, the philosophical origin of phenomenology, including the research paradigm was described. Van Manen's (1990) method of research which included six steps was delineated for their purpose and outcome. The definition of major phenomenological terms is in Appendix G. The rationale for the phenomenological method described the nature of nursing which is concerned with the patient's world of

health and illness and those who provide care. The goal of this phenomenological study is the discovery and description of the meaning of the new graduates' lived experience with mentoring. This process may strengthen the bridge between nursing theory, practice, education, and policy.

CHAPTER IV

APPLICATION OF THE PHENOMENOLOGICAL METHOD

"We gather other people's lived experiences
Because they allow us to become
more experienced ourselves"
(van Manen, 1990, p. 62).

Turning to the Nature of Lived Experience

Whatever the goal of phenomenological research, the researcher remains open to seeking the deeper nature of lived experience and remembers that the nature of any phenomena has been a possible experience of others (van Manen, 1990). This chapter will describe how the phenomenological method of research was applied to this study.

Aim of the Study

The aim of this study was to explore the lived experiences and interpretations of mentoring for new graduate nurses from diverse cultures who have completed a mentoring program at their first place of employment. The phenomenological question guiding the study was, "What is the culturally diverse new graduate nurses' lived experiences of mentoring?"

This study was a continuation of the pilot study that was previously approved by the Barry Institutional Review Board (IRB) and the IRBs of two South Florida hospitals where the study was initially conducted. Three other hospitals were added to the study. Pertinent documents of approval, informed consent, and others can be found in the appendices. The study and implications are discussed below.

The purpose of the pilot study was to explore the lived experiences of new graduate culturally diverse nurses who experienced and completed a hospital mentoring program. The continuing study goal was to explore the phenomena on a broader level to provide a more definitive understanding of the new graduate nurses' professional and psychosocial mentoring needs. The goal was to create a deeper understanding of the mentoring needs of the participants. The new graduate nurse frequently experiences a challenging entry into nursing practice and mentoring eases the way. The phenomenological framework guided this research process (Benner, 1994; Denzin & Lincoln, 1994; Cohen, Kahn & Steeves, 2000; Creswell, 1998; Heidegger, 1926/1962; Slife & Williams, 1995; Van Manen, 1990).

Existential Investigation

Time Frame of the Study

Interviews began for the pilot study in the spring, 2005 and continued over a two month period. The present study was approved in the fall, 2005 and data collection was completed in the fall, 2006. Analysis, along with writing and rewriting was completed in the spring, 2007.

The design of this phenomenological research study incorporates several approaches to collecting information to describe newly graduated culturally diverse nurses' mentoring experiences. Prior to beginning the study, the writer had the opportunity to talk informally with culturally diverse nurses in social settings. Their stories highlighted the importance of supporting culturally diverse nurses at the entry level. Although the stories could not be included in the study and were set aside to prevent biased expectations, they encouraged and inspired the writer to proceed.

Nursing literature describing the new graduate's entry experiences offered information pertinent to this study. Phenomenological literature also contributed to understanding the philosophical premises and supported the goal of research. When the two sources of literature were combined with the lived experience of culturally diverse new graduates, a wealth of meaning emerged. The gathered information enabled the researcher to reflect more deeply on interpreting the experiences of diverse new graduate nurses.

Writing and rewriting integrated all the gathered information. Researcher biases and experiences were previously stated and the researcher bracketed her experiences during the study. The purpose of bracketing was to avoid bias so that interpretations and conclusions remained true to the data (Cohen, Kahn & Steeves, 2000; Munhall, 2001; Speziale & Carpenter, 2003). The culturally diverse, new graduate nurses' experiences resonated deeply within me and directed this study.

Sample of Participants

Purposeful sampling was used because of an identified dearth of mentoring studies for the culturally diverse new graduate nurse at the onset of the study. The strength of purposeful sampling was the creation of rich information from culturally diverse protégés. The participants provided insight and deeper understanding of his or her mentoring needs during the journey from nursing school to professional nursing practice. This writer assumed that participants in this study would have the knowledge and experience required to understand their experiences of being mentored during entry into practice.

Participants

The participant protégés met the following criteria: (a) new graduate registered nurses from a culturally diverse background, (b) employed for the first time and within two to three years of graduation, (c) English speaking, and (d) had experienced a mentoring program in one of five South Florida hospitals. Each protégé had completed the hospital mentoring program, had the time to be interviewed, and was willing to describe his or her experiences of being mentored. The pilot study conducted in the spring of 2005 included two culturally diverse protégé participants who had completed the mentoring program from two South Florida hospitals.

Saturation of data for the current study was achieved with the total number of 13 new graduate nurses, 12 women and one male and included the two new graduate nurses in the pilot study. Although 15 nurses volunteered for the study, after the interview two of them were not included in the findings. Their issues were not related to being diverse nurses and did not support the intent of this study which was to explore the mentoring experiences of culturally diverse new graduates.

Initially, the study criteria required a two-year period following graduation in order to qualify for the study. During the recruiting process, the investigator discovered that a period of six months to two years was optimal. This was determined during the contact conversation with participants in which questions regarding their qualifications were asked. A period of six months after graduation allowed completion of the person's hospital mentoring program, sufficient time to practice without a mentor while retaining the vividness of one's lived experiences. A period longer than three years post

graduation, the person's experiences had often changed from the entry process to issues regarding professional practice.

Access and Setting

Access to participants was gained through contacting the nursing research committee if available in the hospital. After the committees' approval, the hospital IRB received the research application for review. When approval was granted, the mentoring program coordinator was contacted. Access to participants included a list of new graduate names obtained from program coordinators or supervisors. Several hospital program coordinators contacted their new graduates and encouraged them to respond to the request for study participants. Four hospitals provided telephone numbers of each person's hospital unit of placement, and three hospitals provided email addresses and one hospital provided mailing addresses along with the previous mentioned contact information.

Recruiting

The investigator distributed personal letters and flyers to new graduates in one hospital and was invited to do a brief presentation of the study for new graduates in another hospital. After this meeting, the researcher provided a personal telephone number and e-mail address for further communication. A sample of the recruiting flyer is in Appendix E.

The researcher made approximately 15 to 20 attempts to contact each participant because of the difficulty inherent in their work schedules, busy personal lives, and individual perceptions of their availability to participate. From a list of approximately 50 potential participants, approximately 18 agreed to the interviews. Of these 15 kept

appointments for interviews. Two participants were disqualified because their interview did not indicate issues related to culturally diversity. The researcher accommodated the participants' time and travel requirements. This included their choices of meeting places which were often their homes. Four participants preferred to be interviewed in the researcher's home.

Phenomenological studies often are time and financially intensive (Cohen, Kahn & Steeves, 2000; Creswell, 1998; Packer & Addison, 1989a, 1989b; Patton, 2002). The main cost to conduct the study was the researcher's time that was required to contact participants, schedule interviews, and travel to the agreed upon places for interviews. In addition, transcription and analysis were time intensive. Car mileage and gas were not documented. Approximately 200 hours were required to conduct the research process of interviews, transcription, analysis, and writing.

Cost of postage and envelopes to mail transcripts for verification and return to investigator was approximately $70.00. Copy costs of multi-page applications to Barry University and hospital IRBs was approximately $20.00. Each participant received a stipend of $20.00. The estimated expense for the investigator was $400.00.

Human Subject Protection

The participant graduates were employed by and recruited from five South Florida hospitals following application and presentation to the appropriate research committees. Protection for research participants mandated approval from six institutional review boards. The pilot study had been approved 15 months prior to the present study. The present study protocol which followed that of the pilot study was approved by the

Barry University IRB, the hospital IRB, and Nursing Research Committees the fall 2005 (Appendix A).

Confidentiality

Anonymity could not be offered because of the nature of the study. Confidentiality was protected by a participant pseudonym. The interviewee appeared to enjoy choosing a name and using that name during the interview. The pilot study and the present study were approved as exempt because the protocol protected identifying information from discovery. Exempt status meant that no identifying information was collected. Human tissues, medical reports, and other critical information were not accessed. Pseudonyms were used during the taped interviews. The researcher is complying with the protocol for keeping all confidential information locked in a file for five years. Data is stored on a computer and memory stick. All interview tapes and all information containing possible identification content are kept separate from other data in the researcher's office in a locked file.

Informed Consent

The researcher presented an IRB approved informed consent that explained the purpose and procedure of the study (See Appendix B). Minimal risk to the participant was anticipated, but each one was informed that they may self-refer later for assistive counseling or the investigator would refer them to their employee assistance program if needed. Telephone numbers of employee assistance program and counseling programs that provided fee free services were listed. If the participant had questions about the study, each one was answered. Participants voluntarily signed and dated two consent

forms. The participant received an original copy and the investigator kept the second original.

Ethics

If the participant had emotional difficulty during the interview, this researcher would have assessed the ability of the participant to continue and obtained permission to continue if the participant was able to finish the interview. To maintain the ethical process of phenomenological research, authoritative researchers recommended that the investigator obtain ongoing process consent to continue interviews if the participants had difficulty with talking about their experiences. However, each interview was uneventful and handled well by the new graduates. The need to renew consent was not required. If the new graduates were unable to continue the interviews, they would have been offered the opportunity to stop and reschedule the interview if appropriate (Patton, 2002; & Denzin & Lincoln 1998).

Data Collection

Interviews

Narrative collection began in the field by entering the site and recruiting participants. The task of the inquirer was to establish a relationship with the interviewee while keeping a phenomenological alertness to underlying meaning of statements. The research process demanded the inquirer be both observer and participant. Furthermore, the interviewer maintained a cautious awareness against the tendency to inject the interviewer's own meaning into the interviews, the interpretive and reflective process.

The following is a list of equipment taken to interviews: (a) two tape recorders and two split cords with double plug extension cords, (b) two lapel microphones,

(c) backup tapes and batteries, (d) vinyl bound notebook, and (e) cloth pad to cushion microphone. Duplicates of data forms and informed consent forms were included.

Phenomenological interviews have two purposes. They serve to discover and gather narrative text that can enrich and deepen understanding of phenomena. In addition, interviews serve as an interactive conversation that develops understanding and comfort between the interviewee and inquirer (Kvale, 1996; van Manen, 1990).

Prior to beginning the first interview the participant' s expectations and questions were discussed. This provided an opportunity for clarification for both participant and investigator. Participants were interviewed in a private setting of their choice. The phenomenological interview questions were open-ended and made concrete by asking about specific instances or situations. Collection of concrete experience in personal life stories, anecdotes, and examples of lived experiences of being mentored were described. The researcher refocused the interviewee when necessary to keep the protégés focused on the purpose of the interview. This action kept the interview centered (Kvale, 1996).

At the first interview non-identifiable demographic data regarding age, gender, marital status, educational achievements, previous mentoring experience, and self identified ethnicity were collected (Appendix C). The form consisted of questions, eight of which required a check mark to select a category. Two questions required brief written responses. If the participant wanted to receive the findings from the study, she provided a mailing address. The form was approved for use in the pilot study and the present study. Minor adjustments without content change were made to enhance clarity. For example, educational categories were added.

After the participant gave informed consent, the demographic form was completed, the interview was tape recorded and then transcribed verbatim. Participants had the option of receiving study results. The participants' name and address was written at the bottom of the consent form by the participant, removed after the interview and stored in a sealed envelope for future mailing. All but one participant chose to provide their mailing addresses.

During the interviews participants wore a lapel microphone to provide a clearer recording. A backup tape recorder using the internal microphone was also used. In the initial, interview the participant provided information about their experiences, perceptions, and interpretations. The questions were open ended. For example, can you think back to the time when you had a mentor? What was that like? Can you tell me a story about how that experience influenced you? (Appendix D). At the end of the session, a second interview for checking the transcript was scheduled for approximately 10 days later.

The second interview was scheduled for the purpose of a member check of the transcribed data. A member check promotes trustworthiness and credibility of information (Moustakis, 1994; Speziale & Carpenter, 2003). However, the new graduates often worked the night shift, had personal obligations, or experienced conflicts with keeping the scheduled second interview. Approval was obtained to mail transcripts to be verified, signed, dated and returned by the participant. This procedure served as the member check. Participants were asked to read the transcript and make corrections, additions, or deletions to the recorded data, if they wished. Several stated they had not understood a particular question originally and added a more comprehensive answer.

During transcription, if questions arose for clarification, they were highlighted on the transcript for the interviewee to elucidate. Instructions were included with the transcript about how to answer highlighted information, how to make corrections and add or delete information.

One participant delayed the return of the transcript for four months. Multiple efforts were made by: (a) calling her work phone, (b) leaving messages on her cell and home phones, (c) e-mail messages, and (d) postal mail requesting the return of her validated transcript. A check with her hospital unit without revealing the purpose of the call or the researcher's identity verified she was still employed and living in the area. The transcript was eventually returned and the data contributed significantly to the study.

Journal notes were recorded to describe the context of the interview process and environment. Participant non-verbal behaviors were noted. Reflexivity refers to researcher's self observation, self awareness, and acknowledgement of feelings, attitudes, and perceptions (Patton, 2002). Researcher reflexivity was described in the reflexive journal, in which the researcher's experiences with participants were described in detail. The participant's demeanor as well as the environment, time of day, and weather conditions were recorded.

Analysis

During transcription, each line of data was numbered. After the final corrections of transcripts were made by participants and returned, each participant's transcript was analyzed for themes. The text was highlighted for significant statements. The statements were extracted and grouped into themes. A chart was made that listed each participant and theme to provide a cross check of who had contributed to the themes. Similarities

and dissimilarities were noted. Exemplars were selected and extracted to describe the lived experience of participants. A chart of individual themes was made for each participant. The participant data was entered under individual themes until all significant and relevant data was recorded. A grid of themes was composed with each participant's name and comment. A sample of the two types of analysis charts are found in Appendix G.

Nursing literature about mentoring was consulted to expand, deepen, and enrich interpretation. Literature served as a means of broadening understanding of mentoring relationships. The examples of mentoring contained in the literature expressed intense feelings and experiences, and contributed to phenomenological interpretation. Such literature ". . . can challenge and stretch our own descriptive or interpretive sensibilities" (Van Manen, 1990, p. 70).

Phenomenological Reflection

The purpose of phenomenological reflection is to understand the essence of meaning of mentoring experience in this study. The reflection is simple and complex according to van Manen (1990). The obvious phenomenon of mentoring is simple because it is a household word. The deeper meaning of mentoring is also complex because it is often mistaken for other phenomenon such as precepting, sponsorship, and role modeling as previously described. Thus, insight into the essence of mentoring requires a process of reflection, elucidating, and defining the basic structure of meaning of the lived experience. Meaning is never obvious and simple. Multiple layers and facets exist. Reflection is an essential element of phenomenological research and one in which the researcher must engage constantly.

Phenomenological Writing

"Responsive-reflective writing is the very activity of doing phenomenology" (van Manen, 1990, p. 132). The researcher was sensitive to the unspoken meanings, tones, and subtleties of the text. What was not said was as important as what was revealed by the participant. "Nothing is so silent as that which is taken for granted or self evident" (van Manen, 1990, p. 112). Implied in this statement is the fact that we often know more than we reveal. Writing and re-writing created deeper understanding of research text. It was not until words were written that this researcher could evaluate the meaning of what participants conveyed verbally. In writing we turn to "the things themselves" (van Manen, 1990, p. 128).

Narrative is the source of understanding the lived experience and the discovery of meanings. Re-writing created depth and richness. The going back and forth between text and literature created a circle of understanding. The weaving of data, literature, and emerging themes described the interpretive process and required moving from interview to transcribed text to participant and back to the texts until all possible themes were revealed. The "forward arc of projection and a return arc of uncovering, constitute a constant dialogical process of interpretation and evaluation" (Packer & Addison, 1989b, p. 275). "The hermeneutic circle provides philosophical underpinning for evaluation in interpretive research" (Benner, 1994, p. 78). Misinterpretation had to be guarded against by use of self-awareness, reflexivity, communication with committee members, and member checks from participants. Each one comprised part of the phenomenological circle. Staying true to phenomenological philosophy was vital throughout the study.

Participant narratives are the source to understand the lived experience of mentoring. By writing and re-writing the findings, the essence of the text was revealed and themes emerged. All cultural contexts are considered and understood including the participant, mentor, environment, and coworkers. A description that incorporated all possible and probable meanings, different perspectives, and references was written. "Phenomenological text succeeds when it lets us see that which shines through, that which tends to hide itself" (van Manen, 1990, p. 130). Writing and re-writing created depth and facets of meanings that accomplishes rich and informative text, the goal of interpretation (Benner, 1994; Creswell, 1998; Van Manen, 1990).

The methodology of analysis was writing and rewriting to achieve a progressive distillation of participant information into themes. Possible meanings were considered without prejudgment. The researcher's personal experiences were delineated as part of reflexivity. The phenomenological process created thick description by describing the lived experiences of participants to the fullest and most intricate degree possible (Cohen, Kahn, & Steeves, 2000; Creswell, 1998). "Responsive-reflective writing is the very activity of doing phenomenology" (van Manen, 1990, p. 13).

Guarding Credibility and Trustworthiness

Strictness adherence to the phenomenological method of study and remaining true to participant information supports the credibility and trustworthiness of the study. That is an important means by which peers and intended audience can assess the quality of research reports. Trustworthiness of research procedures support usefulness of study results and provide a template for future study replication and verification of the research phenomena. Methodological consistency, bracketing, and rigor are methods of bias

reduction (Cohen, Kahn & Steeves, 2000; Cresswell, 1998; Denzin & Lincoln, 1994; Patton, 2002; Rodgers & Cowles, 1993; Speziale & Carpenter, 2003).

Criteria for assessment of qualitative research are (a) credibility, (b) dependability, (c) confirmability, and (d) transferability or fittingness of the core data. As previously delineated, (Speziale & Carpenter, 2003) member checks, peer debriefings in which feedback was elicited regarding the research process and findings, committee members' communication, and literature reviews were a part of rigor in this study.

Credibility requires participants' verification that the research findings reflect their experience of the phenomena. Literature refers to this procedure as member checks of data. Dependability is based on the thoroughness of the research process. Thorough explanations and adherence to procedures appropriate for the research design support confirmability and dependability (Denzin &Lincoln, 1994; Speziale & Carpenter, 2003). Patton (2002) asserts that credibility depends on the ability of the researcher to learn how to improve the study process and apply the lessons to future studies.

Confirmability is the third criteria and refers to adherence to the appropriate research method. Comprehensive documentation establishes confirmability and promotes trustworthiness. Precise and clear documentation provides details of the process and is referred to as an audit trail of research decisions. Audit trails are the means of monitoring research accuracy, decisions, actions, and conclusions regarding data (Denzin & Lincoln 1994; Guba & Lincoln, 1985; Patton, 2002; Rogers & Cowles, 1993; Speziale & Carpenter, 2003). Ultimately the study data, "Should have the power to change practice" (Packer & Addison, 1989b, p. 289). Even when evaluating data, the results are always open to reinterpretation. "No interpretation is safe. Even after an

authentic projection has been drawn from primordial sources, we cannot assume it will be preserved" (Packer & Addison, 1989b, p. 290).

Transferability is the fourth criteria and implies that other investigators and readers will find the study results meaningful (Speziale & Carpenter, 2003). The usefulness of study will depend on how applicable the results are to other contexts of the phenomena of mentoring (Patton, 2002).

Patton (2002) offered concerns about researcher effect on participants. The reactivity of participants to the inquirer has to be taken into account during all interactions. The ability of the inquirer to develop rapport and credibility influences the quality of the research process. Upon the first contact this inquirer established credibility through credentials, years of nursing experience, and concern for the new graduate's entry into the profession. Personal information was limited to the writer's own objective reflections regarding past lived experiences of shift work, juggling family concerns, and present concern for easing new graduates' entry into nursing. Inquirer biases were clearly delineated and bracketed prior to undertaking the study. However, as the new graduates described lived experiences of being mentored the effect upon the inquirer was unexpected. The response was acknowledged silently and set aside. The response to new graduates was empathic and focused on eliciting further information. "An empathic neutrality would be perceived as caring about and interested in the people being studied but neutral about the content of what they revealed" (Patton, 2002, p. 569). The task was to maintain integrity and focus.

Journal notes provided thick description of research decisions, insights, and literature that stimulated further reflection (Benner, 1994; Cohen, Kahn & Steeves, 2000;

Patton, 2002). Journal entries served as documentation that contributed to rigor. Nonverbal behavior of informants, interruptions, and other events during the interview became journal entries. The setting in which interviews occurred and insights during transcription and analysis contributed. "All these notes serve as contextual data during the analytical phase .and add significantly to the thick description necessary in reporting qualitative research" (Rodgers & Cowles, 1993, p. 220).

Recording of decisions was made during the study. All influences leading to choices and evolving changes were dated, and described in detail (Benner, 1994; Diekleman, 2000; Kvale, 1996; Patton, 2002; Rodgers & Cowles, 1993). Recording of analytic data was another category of documentation. The process recorded the inquirer deliberations while comparing and contrasting texts, and the grouping of data into themes. "Regardless of how trivial or unrelated . . . [it] should be immediately and comprehensively recorded to insure a rigorous analysis" (Rodgers & Cowles, 1993, p. 222). During this process the inquirer posed questions regarding the textual meaning and reexamined previous notes to determine the fit of decisions. The goal of interpretation was to let things speak for themselves (van Manen, 1990).

Congruency of phenomenological philosophy, method, and analysis was accomplished by: (a) detailed description and richness of context or situatedness of participants, (b) saturation of information, (c) letting the text speak for itself, (d) agreement between text and analysis, (e) detailed accounts of researcher self awareness, and (f) generation of questions for future research. Final points were: (a) others with experience of mentoring would recognize the interpretations and (b) the circle of interpretation stayed in tact. The circle included inquirer, participants, text,

interpretations, and relevant literature. The phenomenon of mentoring new graduates from culturally diverse background was dynamic and meaning was delineated (Benner, 1994; Denzin & Lincoln, 1994; Diekelman, 2002; Dreyfuss, 1993; Guba & Lincoln, 1985; Patton, 2002; and van Manen, 1990).

Summary

This chapter has discussed the phenomenological study design. The researcher gained IRB approval from Barry University and from five South Florida hospitals. Thirteen participants were recruited with distributions of flyers, and a presentation of the study by personal contact. The hospital mentoring program coordinators assisted in the recruiting by providing participants' names and contact information. Informed consents forms were used. An original copy was given to the participant. The second original consent form was kept by the researcher. Interviews were conducted and transcribed verbatim. Transcripts were mailed to the participants to read, sign and date after making corrections. This served as a member check. Analysis was conducted as described in this chapter. Reading, reflecting, writing and re-writing created a gradual distillation of the essence of the narratives. Essential themes about the culturally diverse new graduate nurses' lived experiences were revealed. Chapter Five has a brief description of the 13 participants and discusses the findings of the study.

CHAPTER V

FINDINGS OF THE INQUIRY

"It is the things themselves,
from the depth of their silence
that it [phenomenology]
wishes to bring into expression"
(Merleau-Ponty, 1968, p. 4).

The purpose of this study was to explore culturally diverse new graduate nurses' lived experience of being mentored during orientation within one of five South Florida hospitals. The new graduates' voices and stories expressed the depth and meaning of their lived experiences. In the writing and rewriting, the researcher gained an understanding of graduates' journey from nursing school to nursing practice and the many challenges along the way. Each stage of the lived experience was marked by a sign post that identified the path to take. By naming the essence of a person's lived experience the individual is revealed to himself and to other human beings. In the process, the individual knows that he is known (Sartre, 1965).

The Circle of New Graduates

The study included 13 participants, 12 women, and one man. Two of the new graduates, Alicia and Felicia, participated in the pilot study. Two other participants were interviewed but not included in the study because their issues were unrelated to cultural diversity. During the interview the researcher discovered they did not self-identify as culturally diverse and their experiences were not congruent with the previous culturally diverse participants. To maintain confidentiality, a pseudonym was used during the interviews and in this written report. Each participant chose a pseudonym. They were

given the option of using a name chosen by the researcher. They preferred to use their chosen pseudonyms. A brief sketch will introduce each of the participants.

Adriana:

Adriana is a 37 year-old Hispanic nurse who was graduated from nursing school eight months ago with an A. D. She speaks Spanish. Her English is fluent and very rapid. Adriana holds a B. S. degree in another field. Her parents were born on a Caribbean island and migrated to the United States before her birth. During the interview the researcher asked for clarification frequently. During transcription of the data, the researcher regularly stopped and rewound the interview tape to grasp the content of the participant's sentences. She is the first of her family to be born in America. She recently moved her family from another state to Florida. Adriana is the caretaker of elderly grandparents. Nursing has been difficult since she entered as a new graduate and she has wondered at times if she made the right choice of professions.

Cari:

Cari is a 39 year-old Hispanic nurse who was graduated from nursing school nine months ago with an A. D. She speaks Spanish and her English is slightly accented. She also holds a M.S. degree in another field. Her parents were born on an island in the Caribbean and migrated to the United States before Cari's birth. She was confident and eager to share her views and lived experiences. Cari also was very expressive and enthusiastic about mentoring and the nursing profession. She believed mentoring was necessary for everyone who wanted to advance in his or her career and insisted on having more experience with her mentor before she started practicing on her own. Although she has worked as a staff nurse, she planned to mentor with administrators of hospital

departments such as medicine and business so she could learn more about how each influenced nursing.

Alexis:

Alexis is a 24 year-old nurse who was graduated six months ago with an A. D. She described her cultural background as West Indian. She was born and grew up on one of the Caribbean islands. She speaks accented English which is her only language. Alexis is graceful and soft spoken. She radiates confidence and speaks to the point about her experiences. Initially, she was formal in her responses to questions but began to share the difficulties of her experience as a new nurse. She said, "Being a new nurse was scary at first" and she described the experience as "a shock and mind blowing." Alexis also described an incident with a culturally diverse patient who wanted a non-diverse nurse. Alexis was surprised that her nurse manager granted the patient's request. She accepted the manger's explanation that it was best she not experience the prejudice.

Alicia:

Alicia is a 30 year-old Hispanic and Brazilian nurse who was graduated from nursing three years ago with an A. D. Although she graduated three years ago, her family situation required one year absence from nursing. She had two years experience as a new graduate nurse at the time she participated in the pilot study. Alicia was included in the study because her lived experiences converged with other graduates and added pertinent information to the study. She speaks three languages - Spanish, Portuguese, and English. She says she does fairly well with French. Alicia eagerly shared how this skill facilitated her nursing practice with culturally diverse patients. She expressed concern that all Hispanic persons are put in one category, but they are actually culturally different. Alicia

shared that her entry process into nursing was not easy. It was not the world she believed it was during her nursing school experience. The participant was two hours late for the interview. She called the researcher and asked for an extension of time.

Amy:

Amy is a 25 year-old Hispanic nurse who was graduated two years ago with a B.S. degree. Spanish is her primary language and she speaks fluent English. She is the first generation of her family to be born in the United States. Initially she seemed nervous about sharing her experiences. She carefully thought about the interview questions several minutes and occasionally asked for clarification. As the interview progressed, she relaxed and shared more readily. After the interview ended, she shared her concern about other new graduates she had worked with and situations they had experienced. Some had not had positive experience with their mentors. Her own mentoring experiences were positive which helped her cope with her early months as a new graduate. Amy stated that she had felt like a robot and was anxious all the time when she first entered nursing practice.

Christina:

Christina is a 42 year-old nurse who was graduated five months ago with an Associate Degree. She speaks Spanish and English. Christina holds a B.S. in another field. Initially she was reticent about granting an interview. The researcher offered her the names of her research committee members and their telephone numbers at Barry University. She agreed to the interview and was cooperative. She was verbal and straight forward during the interaction. She explained her desire to work more personally with people developed after her father died. She was his caretaker during his last illness.

The researcher waited for one hour for Christina to arrive because she was required to work overtime.

Felicia:

Felicia is a 22 year-old English speaking, African-American new graduate nurse who was graduated six months ago with a B. D. She participated in the pilot study. Felicia was a nursing assistant before she became a nurse. She was nervous and hesitant in answering interview questions at first. The researcher shared her personal concern for what new graduate nurses experience. Felicia became more relaxed and her responses flowed more easily during the interview. She said she is more comfortable taking care of others than sharing her personal experiences in nursing. As the interview progressed, she was verbal and expressed greater comfort in sharing her personal experiences in nursing. Felicia discussed her feelings of being overwhelmed and feeling unprepared to take care of patients. Her mentor was compassionate and inspired confidence to continue nursing. She said that practice is the real world of nursing.

Angie:

Angie is a 45 year-old nurse who was graduated three years ago with an A. She describes herself as a White Hispanic. She speaks fluent, accented English. Angie did not acknowledge her ability to speak another language. She was included in the study because of the relevance of her new graduate experience as a culturally diverse nurse. Angie described herself as a single mother and had difficulties learning the ways of a new country. In her country, she was a nursing assistant and said she always loved to take care of patients. Angie worked at her current hospital for seven years before becoming a nurse. Therefore, she was able to choose her own mentor. Her mentor was culturally

diverse and had to acclimate to a new way of life in a new country. She said she felt comfortable because he had similar experiences. Angie has mentored several nursing graduates.

Kevin:

Kevin is the only male in the study. He described himself as African-American and is 39 years-old. He was graduated six months ago with an A.D. He also holds an Associate Degree in a unrelated field. His language is English. Kevin depicted himself as having it easier than his female co-worker nurses. Kevin shared that he is treated differently by patients and coworkers because he is male. He stated, "Everyone wanted to help me learn. It is a physiological thing. The new grads say they didn't get the treatment I did." Kevin related that his nurse manager and coworkers expressed greater confidence in him because he is male. Because of his strength, he is frequently asked to lift patients and quickly learned to say "no". His clinical days in nursing school were laden with anxiety but he said, "Now I walk in confidence." He just finished his mentoring experience in June and was immediately transferred to nights. Kevin has requested and was granted the return to days because of his family commitments.

Michelle:

Michelle described her self as Caucasian and Native American. She is 37 years-old. She was graduated nine months ago with a B.S. in nursing. Her language is English. Michelle holds two non-nursing degrees, a B.S. and a M.A. in a different field. She is articulate, confident, and eager to share her experiences as a new graduate. She asserted, "Nurses eating their young is a common phrase and it happens a lot. I see it. I don't know how we can change it." She believed that nurses need to help new graduates see

the good side of nursing. Further, she was proactive about training mentors to support and teach new graduates. "Every mentor needs to go through the required coursework to gain necessary skills to be a positive mentor." Michelle believed that mentoring was vital to every nurse. She stated, "You just don't know what you don't know yet if you haven't experienced it with a mentor."

Sandra:

She is 30 years-old and was graduated eight months ago with a B.S. degree. She described her cultural background as Haitian. She has a B.S. and M.S. in another field. She is well- dressed, articulate, and speaks Creole as her primary language. Her English is accented. Occasionally she uses a Creole word and then searches for English. Her speaking is rhythmic, fluid, and difficult to comprehend at times. The researcher had to listen closely, ask for clarification, and verify her meaning. Transcription was challenging at times, required rewinding and apt attentiveness. Over all, her English was conversational and worked well for the study. She is confident and outspoken about the definition of mentoring. Sandra said her orientation was more of a preceptorship or coaching event. She defined the difference between mentoring and precepting. "Precepting is short term and mentoring is long term." She had two preceptors but the second one had more time with her. Her description of the relationship with the second preceptor aptly described the mentoring relationship.

Scully:

Scully is a 25 year-old nurse who was graduated about three years ago with a B.S. degree. She was included in the study because of her new graduate experiences coincided with that of other participants. She described herself as an African-American

and speaks English as her only language. She stated, “I get along with older caring women. My mentor was like another Mom.”

Scully initially questioned why she became a nurse and believes mentoring made a difference for her. One of her concerns for new graduates is that each has her own learning style and that becomes very important in less flexible environments like nursing. She expressed her feelings of eagerness to participate in the study because she felt new graduates need a great deal of support and she hoped that it would assist other new graduates similar to her.

Sasha:

Sasha is 35 years-old and was graduated six months ago with an A.D. She described herself as Haitian and born in the United States to Haitian parents. She speaks fluent English and is eager to share her stories of being a new graduate. While going to nursing school, Sasha worked on her unit as a nursing assistant and was able to choose her own mentor. Other new graduates were assigned mentors because they were new employees. Sasha had the opportunity to observe the behavior of the mentors and chose one who suited her. “I never observed her embarassing a new graduate.” Sasha stated, “Be sure to emphasize we need mentoring because its fish or cut bait and it’s dangerous.”

The circle of new graduates expressed themselves with intensity and a sense of deep understanding regarding their lived experiences. Their lived experiences gathered meaning as the participants described them. Their voices bore witness to the complexities and intricacies of their journeys. In an atmosphere of openness and interest on the part of the researcher, the participants found their voices and reflectively shared

their memories. Many said they did so with the specific intent of making the path to nursing practice an enriching experience for those who come behind.

Essential Themes: The Lived Experience of Being Mentored

Essential themes are the core or essence of an experience without which the experience would not be the experiences. Four essential themes emerged from the stories of the graduates' lived experiences. They were: (a) stumbling in the dark as they began the journey of change from students to nurses, (b) connecting with the mentor and through her with the team, (c) becoming through learning and experiencing, and (d) being on my own, being a real nurse. An emerging fifth theme was recognized and reflected an unexpected outcome of effective mentoring. The emerging theme was giving back the kindness, guidance, and support they had received from their own mentors. Out of the 13 participants, two had mentored - Angie and Sasha. Angie planned to continue mentoring new graduates. Three participants, Alicia, Cari, and Felicia expressed their intent to mentor. Plato said, "Those having torches will pass them on" (Daloz, 1999, p. 231).

Stumbling

Stumbling along in the dark was the first essential theme that emerged from the participants' stories. This was a time of unknowing in which they felt overwhelmed and disconnected from what they sought through out their educational preparation. They stumbled betwixt and between without realizing that, "Where we stumble therein lies our greatest treasure" (Campbell, 1991, p. 24).

One of the circle of culturally diverse new graduates stated succinctly what she and the other study participants had experienced during their entry into nursing. Amy said:

I was in complete shock. Oh, my God, what will I have to do tomorrow?

> I don't think I was prepared at all. Your license is on the line. You are putting yourself at risk to lose it quickly. You need someone there to help you out, explain things, why things are done. Without a mentor, I probably would have quit nursing.

The researcher acknowledged the expressed feelings and encouraged the participant to share further if they felt comfortable. Their stories revealed that even with a mentor, the unexpected encounters with the environment and demands of practice were at times overwhelming. Many lost sleep at night wondering if they could handle the illness of their patients for the coming day. They feared that their newly acquired license would be lost before they could even use it. The loss would occur because of harm unknowingly done by himself or herself to a patient.

Michelle said she was concerned about what she didn't know. "I worried that I was not doing everything I should be doing or doing things as well as I should. I am such a perfectionist . . . you practice blind." She feared that she couldn't stay in her chosen profession without help, and credited her mentor with keeping her in nursing. Alicia remembered:

> I was all thumbs. It was a very intimidating experience. In nursing school, everything looked pretty on paper. It is so far-fetched and is not what it is made out to be. Without mentoring you develop a backbone out of fear and intimidation. You have bad assignments, too many patients, and no guidance.

A feeling of shock permeated the entry into nursing. The new graduate stories revealed that the experience of shock was still prevalent in the beginning. Alexis declared, "It's a make or break time. Being a new nurse is scary. The exposure is a shock, mind blowing. You need a mentor to ease you into practice." Felicia added,

"Lots of things you are not exposed to in school and need help with. . . . It's different from what goes on in the real world. It's a shock. I freaked out sometimes and felt uncomfortable as a new graduate."

Amy compared the difference between student clinicals and being on the unit as an RN. She said:

> No matter how much you do in clinicals it doesn't prepare you at all for when you go to the floor. It doesn't, unfortunately. They try to shelter you a lot as a student. Once on the floor you go, huh? Can I do this? It's like you are belly flopped into the pool. It's like a big old shock. Whoa, wait a minute, we touched on this but not *all* of this (emphasis is participant). It was nine months to one year before I was 100% ok. I was still anxious.

The feelings of entry shock and stress were shared by the other participants. Adriana echoed:

> It was rough, scary, a major shock. It was not what I expected as a student. It was overwhelming. It's not what I went to school for. I'm in the wrong profession. I felt thrown to the wolves. I had a knot in my stomach and I was sick to my stomach before I came to work. I hardly slept the night before. It was all significant in a negative way. It was overwhelming. I am still a student.

Kevin shared, "You will have bumps. Nursing is not perfect. When things go wrong they could be little things, but it is always big to a new nurse. You want to show everyone you are capable. When things go wrong how do you come back?" Describing the stress and lack of knowledge Sandra said, "I have found myself in situations that I would describe as very stressful. Inside I am not stable because I know I really don't

know how I'm going to deal with this." Angie worked at her hospital for several years prior to entry into nursing. She stated, "My entry was not easy but it was not difficult. If I had gotten a different kind of person [mentor] and we didn't click, didn't understand how I think or do things, it could have been very difficult." Sasha who had worked at her hospital for 10 years declared she was lucky because she did not experience the same stress as other new graduates. When asked what she thought her entry would have been like without a mentor, she exclaimed, "Without mentoring? By myself? I'd have a nervous breakdown! It's very intimidating." Scully's greatest fear during this time was, "I could lose my license and go to jail."

Christina shared how she coped with anxiety, stress, and fatigue. She said:

> . . . this is very challenging. It's the lack of practical skills. Some days are more stressful. When I get home, I have to say, 'am I more hungry or stressed? Which is worse?' I go out on the porch and yell really loud across the lake. Then I come back in and eat. I took a class a long time ago. They said to stick your tongue out, roll your head back, and really yell loud. That is what I do.

Feelings of being unprepared for entry into practice generated shock, stress, and fear. Feelings of intimidation frequented the entry experience. Thoughts of leaving the profession intermingled with physical symptoms of stress such as inability to sleep the night before. The difference between clinical practice in nursing school and the responsibilities of practice in the real world of health care was overwhelming. Connecting with a key figure that had the power to intercede, advocate, encourage, and direct was the second essential theme.

Connecting

The theme of connecting underlined the new graduate and mentor relationship. Connecting with the mentor built a bridge that united graduate with the mentor, the practice environment, the team, and with patients. Ultimately, the graduate's relationship with the nursing profession was forged in those early days of orientation and mentoring. The process was facilitated by the mentor's professional and psychosocial interaction with the new graduate and required empathy, caring, and an intuitive understanding of the graduate's personality and ways of learning.

Developing rapport between mentors and new graduates was fostered by the mentors' ability to give caring feedback about what the protégés did well and what needed to be corrected. The mentors conveyed personal interest in the graduates' well-being and progress. Mentors' acceptance of all questions as important helped the graduates feel comfortable seeking answers. The graduates perceived the mentors as competent and knowledgeable. The mentors had their best interests at the forefront of teaching, advising, and demonstrating new procedures. Perception of similarities with the mentors was basic to the process of learning, in addition to growing professionally and personally.

The term preceptor instead of mentor was used predominantly by the hospitals. Consequently, some of the participants stated that they were confused by the term mentor. The researcher explained the definition, role, and outcome of the mentor protégé relationship. The majority of participants acknowledged that their preceptors incorporated the mentoring role in their relationship. However, several new graduate preceptors remained assessors and instructors without the psychosocial relationship of

mentoring. The preceptors were described and valued for their assistance with skills development and professional accomplishments. The participants expressed satisfaction with their learning. However the psychosocial relationship of nurturing, friendship, and on-going relationship with the preceptor was absent in the participant's description. The majority of participants' experiences demonstrated the relationships between mentors and protégés.

Participants described similarities between themselves and their mentors. Angie described herself as White Hispanic and her male mentor was Indian. They did not share the same culture. Instead, they shared similar cultural experiences. She said:

> I worked in my hospital for several years and I chose my mentor. I could relate to him. He took a personal interest in me and said he felt privileged I chose him. He thought I would prefer a female of light color. We are both from different cultural backgrounds but had the similar experiences in acclimating to a new country. I am White Hispanic and he is from India. I speak with an accent, and he does, too. We know how hard it is in the United States to adjust to new customs. We had a lot in common. As professionals, we think the same. He is down-to-earth and made me feel myself. He is sensitive and caring and so am I.

Other participants also experience a culturally diverse mentor whose culture was different from their own. Sandra had a preceptor whose cultural heritage was different. Sandra said:

> I had two preceptors. The first one was short term. I had the opportunity to spend more time with the second preceptor. She influenced me because I see myself practicing and just remembering her. It's as if she stays in my head. We were well-

> matched. We had good rapport, like an older friend. We still relate to one another. She was African-American. I am Haitian. She is Black. I am Black. That is a good thing. I never left her.

Several of the mentors shared the same culturally diverse background of the new graduate. They expressed the significance for them. The same cultural background between her mentor and herself was important to Scully. Scully also iterated the importance of being able to ask questions of an empathic mentor. She said:

> She was the same as me, a minority. She was another mom, sort of. I felt connected. She had a sense of knowing what I needed as a brand new graduate. She was very empathic with me, understanding. I could ask her any question and I wouldn't get the look like, 'Why are you asking that?' She was open minded, very comforting and willing to give me any type of knowledge or explanation I ask for.

Cari also shared a culturally diverse background with her mentor. She said:

> She was Latin like me. We had more things in common. . . . we had a mutual personal interest. She also had another career before nursing. She seemed older, like a mother who is teaching, do this or do that. She would say don't do this because this will happen. It was guiding me in the right direction. I would quit nursing without a mentor.

Adriana expressed the need to identify and connect with the mentor. Sharing the same cultural background was not important to her. Rather, a sensitive mentor who remembered where she came from was important to her. She said:

> My first mentor was too disorganized for me and there was so much to learn. I requested a unit change. My second mentor was someone like me. She reminds me

> of me and works like I do. She was sensitive to new graduates and remembered where she came from. She filled in the blanks. I am still a student.

Alicia described her mentor. "She was an angel who stayed with me in a crisis. She filled in the blanks." Alexis stated her preceptors were there for her and they were honest and caring. Amy said, "My mentor was very shy. She was very funny when she broke out of her shell. . . . she was like me. Over all she is a very good friend."

On the other hand, Sasha connected with the differences between herself and her mentor. Sasha worked in her hospital as a unit clerk prior to becoming a nurse. After graduation, the nurse manager gave her the opportunity to choose a mentor. Her choice was motivated by her needs as a new graduate. Sasha commented:

> I needed the discipline and she could stand up to me. Our personalities fit and we could communicate well. She never rolled her eyes, made fun of, labeled, criticized, made snide comments, or talked about her new graduates like the other nurses did. The other nurses don't remember where they came from because they are "super nurse" now.

In summary, the essence of connecting was found in the description of the mentor protégé new graduate relationship. The effective mentor was empathic and sensitive to the new graduate. They remembered what they experienced on their entry into nursing and supported their protégé toward professional growth and socialization into the nursing profession. The mentors were intuitive about the new graduates' psychological and professional needs. They were open to questions because no question was superfluous. The graduates credited the mentors for the development of competency, stability of their practice, and commitment to nursing. The effective mentor served as a role-model for

empathy, compassion, and critical thinking. Although the effective mentor was described as a good friend, "like a mom and someone like me", simultaneously the relationship was professional. The graduates as a group believed they would have quit nursing if they had not had a mentor with whom they could identify and connect. In turn, the effective mentor helped them connect with the team, environment, and patients. Michelle summarized the importance of connecting:

The environment is so stressful and fast-paced that many new graduates leave. It [mentoring] is a way to develop and keep nurses. I think they would say [without mentoring] that this is too much to handle. It is the key to getting a good quality nurse and keeping them.

Becoming

Becoming emerged as the third essential theme but was not obvious at first. Through reflecting, reading, and rereading the vitality of the process became clear. This is a time of becoming when a new graduate is doing, learning, understanding, but not yet, in their words, a real nurse. They are fledglings whose ultimate goal is being a real nurse, but are not ready to leave the nest to be on their own. The third essential theme described the essence of becoming by learning, growing, stumbling, and staying the course. The act of acquiring skills, preparing for the working world, and fitting in with the team characterized professional and psychosocial growth. Felicia described her lived experience of becoming. She shared:

> Mentoring allowed me to do enough stuff on my own and I had someone I could go to when I was unsure about something. I knew I didn't have to deal with it alone. I learned critical thinking, confidence, and became knowledgeable. My mentor

> taught me to be affirmative, positive about my observations. I learned nursing is something you really have to love doing because some days you won't want to be there.

Adriana described her becoming:

> I learned with her [mentor] help. She provided learning opportunities and I met my professional goals. She talked me through procedures, and oriented me to the unit. [My mentor] prepared me for the working world. She helped me with paperwork, clarifications of meds and procedures. I learned that getting to know your patient is very important. I grew professionally. The team environment helped me fit in socially. You need to feel part of the team and unit.

Fitting in and feeling like a team member was significant to the new graduates. Alexis shared, "[I learned] to affiliate with the hospital setting, policies, diversity of patients and to orient to nursing practice. Amy believed that mentoring helped her " to assimilate into a full nurse. Mentoring helped me get used to the floor little by little. It doesn't slam you in there. It helped me see why you are doing what you are doing. Also I got to know the unit and . . . team."

Kevin said:

> My mentor helped me grow by helping me to learn to prioritize and handle critical things first. Knowing when to act is important. [I learned] the role of a nurse. Without mentoring, you fail and you are not coming back because you want to do well. It's somebody's life.

Scully declared, "I learned the background, basis, and knowledge to feel confident. I was oriented to how things work. I learned skills, fitting in, and strength for personal

growth. *My mentor shaped the foundation of my nursing career. Without her, I wouldn't be the nurse I am today"* [participant emphasis]. Angie added, "Mentoring helped me go from nursing school to real life. . . . to teach me everything to do with patients." Cari asserted, "I would have quit nursing without a mentor. I learned professional conduct. I learned the politically correct way of doing things like when JCAHO came… or what to wear on the unit. I learned this without the nurse manager saying something to me."

Christina said, "My mentor helped me grow by telling me what I was doing right. It helped me grow from student to practice in real life. Sandra shared, "The most important thing is for someone to help you build a routine. My mentor did that. It facilitated my growth and helps me remember things from nursing school and put it together."

This was a time of learning to see the big picture of health care and learning what to do, how to do it, and why. Hospital and unit norms became important to navigate the workplace, to understand the culture of nursing. The graduates were developing confidence about their abilities and how to use their personal skills to interact with the patients and team members. This was a time of becoming and to grow into being on their own as a fully functioning member of the health care team.

Being

The fourth essential them is golden ring on the journey from nursing school to practice, to being a real nurse. The characteristic the new graduates valued in their mentors emerged as their own. Empathy, caring, sensitivity, and relating guided their relationship with their patients. Adriana elaborated:

> There are two parts to nursing, the technical part, and the caring part. The caring part is important. They [patients] don't want to be treated like machinery, fix it, and get out. Every patient I look at I say, 'ok what if this were my grandmother, mother, or child? I ask how would you feel if you were lying there and no one is giving you the time you need. You need time to be present with them. Being sensitive helps them heal faster.

Just as connecting with the mentor defined the beginning of becoming a nurse, connecting with the patient defined the beginning of independence. Alicia described a poignant connection with a culturally diverse patient:

> I speak three languages. I can fend with a fourth. One gentleman was from India and was not eating. Everyone kept thinking something different about why he wasn't. When I met him, I sensed a lot of sadness. He immediately started crying when I talked to him. He said that he hadn't spoken to his family in six months. Their visas were denied. In addition, he worked nights and didn't eat in the daytime. So, I asked about his breakfast. He had not had his [cultural] food in six months. By lunch time, he had a plate of authentic Indian food.

Alicia made a difference with her culturally diverse patient. Her sensitivity, diversity, understanding and knowledge improved his health care. She wants to pass on to new graduates what she learned from her mentor. She shared, "I have the skill and practical end of knowledge. It's nice to be on the other end. I will mentor with the kindness I was shown." She is proud to be on her own, competent and to confidently use her professional and personal skills.

Acceptance and respect of the staff, physicians, and family were experienced at this level of being a nurse. Amy described extensively an experience she had with her co-workers. She said:

> Some of the nurses were wary of me at first. They weren't sure of my skills. As I progressed, they became more open to me to help them out. They finally accepted me. I felt their acceptance. I was called at home to come and help them with a procedure. I know the rationales of interventions and how to evaluate them. I'm thinking like a nurse and before I wondered how I would get it. I had one patient the night nurse said was ok. It didn't sit well with me, so I went in to see her. I asked her how she was feeling because she looked bad. I spoke in Spanish. She could barely stop breathing to answer. I immediately called respiratory and her pulmonologist. My co-workers helped me out. My mentor was on the floor, too. The doctor said I did a good job. Later, the family thanked me.

Cari said:

> I learned to understand, get acquainted with, and feel more comfortable with all kinds of things. I still have my mentor in the wings. When a patient went bad somehow she knew and came. I feel confident now. I had an incident with a doctor where I handed him the phone to call another doctor with whom he was arguing, and told him to make that call. He did. He respected me.

Angie described the respect she gets now. She said,

> My mentor tells me he is so proud of me. He asks me questions and when I answer he says, "How do you know that? I didn't teach you that!" We laugh. It's important to have a good mentor that is there for you, even afterwards. You always

> have questions. I still go to him and ask whatever. He will tell you the right thing. We trust each other. I am a mentor now on my own.

Felicia shared:

> Mentoring helped me make connections between theory and practice. Theory is nice but it is not realistic. That's where critical thinking comes in. You have to figure out, 'Ok, how do I adjust this?' I would like to be a mentor and to be able to give back a little bit.

Kevin described being on his own. He said:

> It's scary. You no longer have a preceptor to go to. You are actually THE [Kevin's emphasis] nurse. It's like starting all over again. It's your name and your license. Running a code is my MOST [Kevin's emphasis] intimidating factor. You have to raise your hand and give an account of everything that happened. It's frightening, shakes your confidence and it's a good experience. It forces you to be a nurse.

Sandra believed that knowing you are responsibility is important. She asserted:

> At some point, people need to be on their own. They need to have their heart pounding knowing that whatever happened, you are responsible for your patient at this point. People say I like a challenge but I don't like to believe it. When the mentor is gone, it's like starting all over again. What helps is building rapport with other new graduates so you can share experiences. You will know you are not alone. You will build a network.

Sasha said:

> I was scared being on my own. Even with mentoring, the thought of being on my own was scary. I kept pushing it off until they told me my mentor couldn't be a

> crutch. She checks in with me and asks if I am ok. She said I could come get her if I needed anything.

Many participants described an ongoing relationship with their mentor which served as a link to having answers from someone who was trustworthy, supported them, and continued a friendship.

Although the other participants described their observation of disrespectful behavior directed at other new graduates, the following lived experience was the exception. The other participants clearly stated that they felt lucky in their mentoring experience. Christina described staff behavior that was directly uncomfortable for her. She said:

> I still have questions about the socialized part [of nursing]. There is a little group of nurses and a nursing assistant . . . not comfortable with me. I don't know if it is something I am doing or not. They are different and difficult to deal with. They talk about you. They say things. I opted to ask them directly what I am doing wrong. I said please tell me because I want to do the right thing. One nurse started easing up. Her friend, the nursing assistant doesn't seem to want to work with me. If you need help at 9 a.m. and he shows up three hours later, what kind of help is that? I was clear with him about why I ask him for help. I don't know if he will change. He does things to bother me. If I am preparing meds, he will come and make loud noises to scare the heck out of me.

Christina was the only participant who experienced marginalization and the direct lack of acceptance by team members. Her telling was poignant and alarming. It was poignant because she wanted the acceptance and respect of her co-workers and made overtures to connect with them. It is alarming because of overt behavior on the part of

the nursing assistant who doesn't answer her calls for assistance and is disruptive. Significantly, his direct disruption is a safety issue when Christina is pouring medications. The patient is at risk to receive the wrong medication or wrong dosage. Medication errors comprise a major health risk for patients. Christina's performance evaluation would also be affected if medication errors occurred. After the interview, Christina promised to speak with her nurse manager regarding the disruptive behavior.

Being, the fourth essential theme marked the end of the journey from nursing school to practice. The mentoring experience contributed significantly to the professional and psychosocial growth of the culturally diverse new graduates. Each facet of the journey had sign posts clearly marking the way. The sign posts read, "stumbling", "connecting", "becoming", and "being". A fifth facet of the journey for four of the participants was giving back the mentoring they had received. Each facet revealed the essence of their lived experience of being mentored and achieving professional practice.

Emerging Theme: Giving

Giving back or passing on to others did not have the support of data to be an essential theme because only five of the thirteen participants expressed their intent to pass on the mentoring they received. The implications of this emerging theme for the profession and health required that giving back to others be recognized for its potential. Several participants clearly expressed their intent to give back the kindness, acceptance, support, and teaching they had received. Alicia said:

> Definitely [I am] kinder to . . . new nurses. I really understand where people are coming from. I had the opportunity to precept. I love teaching. It was reassuring

> to say hey, you know what, I've been there. And now I am here. I do it with the same kindness I was shown. I hope.

Angie had the opportunity to mentor new graduates. She shared:

> Personally, I am on the fourth student [new graduate] that I have mentored. When they are on their own they say, "we are so proud to have had you as our mentor because you taught us the right way." It's important to have a good mentor and to have a person that is there for you, even afterwards.

Cari who graduated nine months ago shared her intent to mentor:

> [My mentor] still has me under her wing. I wish to be a mentor like her. When I am a mentor I will think of instances of how she acted and how I should act [because] it's so scary to be a new nurse."

Felicia who graduated six months ago was quoted earlier as wanting to mentor others, " to give back a little bit." To elaborate further on her intent, she said, "I've already talked with my manager about moving up to that level [to mentoring] and what classes need to be taken. It's important for graduate nurses to have that kind of assistance, since they are coming straight from nursing school."

The five new graduates implied their recognition that other new graduates experienced the same shock, stress, and need to fit in. Their goals embodied the intents to mentor with the kindness, encouragement, and acceptance that enabled them to become effective nurses and team members. While the other graduates did not discuss their plans to mentor, they firmly declared their recognition for the need for mentoring all new graduates. Sasha shared that she had mentored new unit clerks. Sasha did not speak

about mentoring others but said, “When they t hrow a new graduate out there [instead of helping] they are throwing her [or him] to the patient. That is dangerous.”

Phenomenological Reflection

The participants’ narratives are poignant and their significance cannot be ignored if the nursing profession seeks to increase cultural diversity. The plight of all new graduates needs to be reconsidered by nursing leaders, decision makers, managers, and the nursing team. Supporting mentoring may mediate the entry process into nursing. Several of the participants spoke passionately about their intents to mentor so that others will experience the kindness and guidance they did. Mentoring is vital to the profession.

Summary

The rite of passage into professional nursing practice is laden with fears, anxiety and distress. Stumbling blindly in the darkness is painful. Fear of losing one’s new license before one learns to practice creates doubts about the wisdom of choosing to be a nurse. While some stress and anxiety accompanies new situations, the degree to which participants expressed their distress is of major concern. The profession has set goals to increase the diversity of nurses. Measures to support new graduates need to be a primary concern to educators, administrators, managers, and all practicing nurses. The consensus of the culturally diverse new graduates is clear. Connecting with an effective mentor who believes in them and teaches them how to be in the world of nursing makes all the difference.

“Mentors give us the magic that allows us to enter the darkness; a talisman to protect us from evil spells, a gem of wise advice, a map, and sometimes simply courage” (Daloz, 1999, p. 18).

CHAPTER VI

REFLECTION ON THE FINDINGS

"Answers may change.
Only questions remain eternal."
(Kopp, p. 3)

Phenomenological reflection on the data and writing and rewriting revealed four essential themes, plus one emerging theme. They were: (a) stumbling, (b) connecting, (c) becoming, (d) being, and (e) the emerging theme, giving. Giving emerged as the fifth theme but did not qualify as an essential theme based on the fact that only five of the participants had mentored or indicated their intents to give back the mentoring they received. The remaining seven participants recognized that the climate of nursing practice for new graduates is challenging, but did not express a commitment to help them adjust to the nursing profession. Each theme will be discussed.

Phenomenological Writing on Meaning of Participant Experience:

Stumbling

The first essential theme is stumbling. The graduates' experiences of entering nursing were poignant and created concern on the part of the researcher for the participants. During their initial entry into practice they had experiences of fear, anxiety, stress, and questioning their choice of nursing. With phenomenological reflection upon each graduate's description of his or her experiences in practice, the first essential theme was named as entering. Identifying and naming an experience permits one to begin understanding one's experience. "There is something significant in naming. . . . Naming becomes a gateway or a pathway to understanding" (Benner, 1994, p. 136). However,

entering did not capture the shock, stress and dismay the culturally diverse graduates revealed about their early experiences. The experiences themselves were intensely distressful and indeed, Adriana had said that entry was significantly negative for her.

The researcher wanted to acknowledge the emotional trauma embodied within their stories while indicating the ultimate outcome was positive. After considering 30 names for the first essential theme, stumbling was chosen. Stumbling means to walk precariously or encounter a hindrance to one's beliefs (Merriam-Webster, 2007). Stumbling is an awkward movement toward a goal and implies that a fall is possible but has not occurred. A second connotation is the ability to recover balance and continue moving forward. Stumbling in courage, conviction, and confidence can raise fears of losing something priceless. For the new graduates fears of losing their nursing licenses and identity as nurses was foremost.

A second meaning for stumbling was to encounter a hindrance to one's beliefs. The graduates' beliefs about their abilities to practice nursing met with the exacting demands of actual practice. They had expected to slip seamlessly into their chosen profession. Seamlessness required knowledge and experience. As students they had believed that the academic world prepared them for the demands of the nursing profession and the demands placed upon them would be within their abilities. Each participant indicated that she felt totally unprepared for what they faced. Feeling overwhelmed, intimidated, and fearful of losing their licenses because of something they didn't know created stress and physical symptoms. The physical symptoms were described as a knot in the stomach and inability to sleep at night because they were wondering if their next patient's illness would be beyond their skills. The stress level of some new graduates reached proportions

that required action to counteract the effects. Christina described how she released her anxiety by yelling on her back porch.

Two participants, Angie and Sasha had insider knowledge of the workings of the hospital which seemed to lessen the shock of entry. Angie had worked about seven years as a nursing aide at her hospital and shared that she knew where to go to get help as a new graduate. She also chose her mentor. Sasha had worked at her hospital as a unit clerk for ten years and had mentored new unit clerks. The experience proved useful when Sasha chose her mentor. Both graduates were able to observe and chose a mentor whose mentoring style was a good fit for them. The two nurses also reported a lesser degree of stress as a new graduate but still experienced adjustment challenges.

The stumbling entry into the unexpected was heartrending for many of the participants and for the researcher who listened. All was not lost, however. A lifelong student of mythology, Campbell (1991) noted that stumbling often led the seeker to a more beneficial outcome than was anticipated. He said, “It’s by going down into the abyss that we recover the treasures of life. Where you stumble there lies your treasure” (Campbell, 1991, p. 24). To stumble along in the dark is to walk clumsily past unfilled expectations to connect with others and become the professional nurse the participants had envisioned when they entered nursing school. Connecting, the second essential theme will describe the mentor protégé relationship.

Connecting

Connecting with a mentor clearly emerged from the transcribed texts as a key turning point and therefore, of critical importance to the participant. A leader in education commented on the important role of mentors. “If mentors did not exist we

would have to invent them. Mentors give us the magic that allows us to enter the darkness . . . but always the mentor appears near the outset of a journey" (Daloz, 1999, p. 17). A nursing leader highlighted the mentor's significant role relevant to the initiation process. Initiation signals a major period of personal and professional growth, and needed guidance to find one's place in the world. "When the mentor appears it is a sure sign the initiatory process is in full bloom. Affinement and attunement . . . is an essential component of the . . . process. This kind of . . . work takes guts and the mentor is the patron of such an endeavor" (Kobor-Escobar, 2002, p. 42). Each quote captured the mentors' inherent psychological influence in addition to their work in guiding the protégé through the darkness of the unknown. When applied to the plight of new graduates, the role of the mentor takes on vital importance to the nursing profession in developing competent, compassionate, and committed nurses for health care and future growth of the profession.

When the new graduates arrived on their assigned units, they entered a critical juncture in their careers and found themselves unable to navigate their ways alone. At the outset, connecting with the mentor was key to developing the link between graduate, the health care team, and patient. The mentor's appearance signaled his role as the navigator. She would lead, teach, and encourage the graduate through his stumbling and into professional and psychosocial growth vital to skilled nursing practice and profession. The effective mentor began the work required for the new graduate to practice independently by creating a climate of trust, offering encouragement, presenting challenges for learning, and nurturing a vision for the future. In the process the protégé's fears abated (Daloz, 1999).

The factors that facilitated the protégés' successful relationship with their mentors were: (a) protégés' perceived similarities with mentors (b) mentors' sensitivity to graduates' distress and needs, remembering where they came from, (c) mentors' confidence in protégés, (d) mentors' willingness to answer questions without judgment (e) positive communication between protégés and mentors, (f) mentors' availability, having time, (g) mentor's protecting, nurturing, guiding and encouraging, and (h) mentors' interest in protégés' professional and personal progress.

Perceived similarities fostered the bonds between mentors and protégés in this study. Having a mentor with the same cultural background was helpful to some of the participants in creating a bond, but lacked significance for others. This compared favorably with the literature that indicated culturally diverse protégés received equal if not greater benefit from mentoring even with a mentor who had a different cultural background (Alleman, Newman, Huggins, Carr, 1987; Bailey & Cervero, 2002; Collins, Kamya, Tourse, 1997; Ragins, 1997). In contrast, matching cultural backgrounds between mentor and protégé is important (Villarruel & Peragallo 2004).

What was critical for new graduates to bond with the mentor was perceived similarities. Adriana could not relate to her first mentor who was less organized than she was. This increased her sense of not fitting in or belonging and consequently, she felt that she was in the wrong profession. Connecting did not occur because of the dissimilarity and Adriana felt that her stress level increased. She requested relocation to another unit and connected with the second mentor who was more organized like her. Things went more smoothly. Perceived personality and work style similarities between herself and her second mentor made the difference.

Perceived similarities varied with the other participants. Cari related to her mentor through the same cultural background as well as personality similarities. Sandra and her mentor represented different cultures. Sandra perceived cultural similarities between herself as a Haitian woman and her African American female mentor. Angie's mentor was male and had a different cultural background. Similarities in adjusting to a new country in addition to speaking accented English created shared commonalities. Sasha related that her mentor's ability to provide discipline and structure created a good match with her own personality. Others connected through the mentor's compassion, competence, and personal interest. Amy believed that her mentor was interested in her progress and was a positive role model for her nursing practice.

Effective mentors are identified by the protégé as being like themselves. Each participant identified similarities in either personality, ways of working, or with cultural backgrounds. The effective mentor was trusted, respected, competent, communicated in a positive manner, and conveyed personal interest in the growth of the protégé. For new graduates, the mentors made a world of difference for them.

Confusion regarding the meaning of mentor versus preceptor arose during the interviews. During the interview several participants indicated confusion about the difference between a preceptor and a mentor. Since the hospitals generally used the term preceptor the researcher offered a definition of a mentor and mentoring relationship. A mentor was defined by the researcher as someone with whom you have an interactive relationship. You trust and respect that person. He or she cares about your best interest, supports, encourages, and guides you. The person has or had a significant influence on

your accomplishments because she believed in you (Dingman, 2002; Hom, 2003; Hurst & Kopin-Baucum, 2003; Phillips-Jones, 2001; Vance & Olson, 1998).

Dingman (2002) made a comparison of mentors and preceptors. Preceptors have assigned work during orientation to teach specific tasks, procedures, and policies. They also influence how the staff and patients perceive the new graduate. Mentors use multiple roles, coaching, and precepting. Mentors use their connections and influence to facilitate the professional and psychosocial growth of their protégés. See Table 1., Chapter II, P. 48, for a comparison of preceptor and mentor characteristics and functions

Sandra revealed that she had two preceptors and disclaimed that they met her description of a mentor. She has continuing relationship with one. The first preceptor was with her three months and the second preceptor continued their relationship past another three month orientation. Sandra described her second preceptor as being like an older friend who influenced her and with whom she had good rapport and communication. She identified with her through their different cultural background which incorporated a basic similarity. She said, “We were well matched [personality]. It’s important if you are putting two people together for one to influence the other. We are both black. That is a good thing.” Sandra acknowledged an ongoing relationship with her preceptor and still relies on her. Based on the literature review Sandra and her preceptor developed a mentoring relationship (Daloz, 1999; Fox, Rothrock, & Skelton, 1992; Kram, 1988 Phillips-Jones, 2001; Vance & Olson, 1998).

Connecting with the mentor constituted a significant role in the successful professional and personal growth of the culturally diverse new graduate. They felt connected with someone similar to themselves who represented who they could become.

Felicia stated, “I am what I am today because of her.” Without the mentors the graduates declared they would have quit nursing. The mentors provided a realistic preview of what it means to be a nurse. The mentors were empathic, intuitive, and offered positive feedback and encouragement. The mentors instilled in the protégés a sense of belonging to the nursing profession, confidence in their abilities and strengthened the commitment to become a real nurse. Becoming will describe the third essential theme.

Becoming

The third essential theme is becoming. The graduate is connecting with the mentor, unit, and health care team. She has entered the phase of becoming while still connecting. Connecting with the mentor helped to abate the new graduate’s fears but the new graduate has entered into a period of change and has to cope with the new world of practice. She finds herself in water over her head which triggers fear, but signals the beginning of learning. In effect the bottom dropped and she has to let go the status of being a student while not yet being an independent nurse. In the chaos of change she is required to see herself and her chosen profession in a different light. The situation can be described as, “You can’t move the same way when the water is over your head as you do when it isn’t” (Daloz, 1999, p. 134). A sense of being lost competes with her desire to be a nurse. Chaos seems to abound and chaos is usually equated with a disorganized and negative situation. This idea can be disputed and reframed as a positive condition. “Chaos is not a mess, but rather it is the primal state of pure energy to which the person returns for every true new beginning” (Bridges, 2003, p. 119). The new graduate begins to accommodate his environment. This is the state of becoming.

Becoming what one will be and whom one will be within the nursing profession and within the health care environment required courage to change. The graduate leaned on the mentor's direction, feedback, and support while learning the role of the nurse, professional conduct, and coping with expectations of other team members. Participants described how he or she experienced their learning and becoming. It was a time of adjusting their own expectations and accepting the demands of practice.

The graduates described their need at this time to learn the following: (a) prioritizing and knowing when to act, (b) knowing how to talk with physicians, (c) getting to know the patient, seeing the big picture, (d) critical thinking, (e) time management, (f) developing a work routine, and (g) how things work on the unit. Their self-assessment correlated with nursing literature describing the primary skills new graduates needed to develop.

In a qualitative study a focus group was used with 44 participant nurses who had been in nursing from one to ten years and had worked with nurse graduates. The group identified weaknesses and strengths of new graduates. The weaknesses were: (a) prioritization, (b) lack of confidence connecting with people including physicians, (c) lack of organizational skills, and (d) inability to see the big picture of a patient's problem. The study concluded that the ideal new graduates needed the following skills: (a) prioritizing, (b) decision making, (c) connect with people, and (d) apply the nursing process. (Mallory, Konradi, Campbell & Redding, 2003).

Fear of physicians was cited in a study by Duchscher (2001). A phenomenological study focused on five nurses within their six-month period post graduation. The nurses experienced verbal abuse by physicians but did not report it to their managers. They

avoided annoying the physician. "They simply adjusted . . . learning new ways to manipulate the situation so they could get what they needed" (Duschscher, 2001, p. 428).

Nurses in this current study did not report verbal abuse. They experienced anxiety because they did not know how to communicate with physicians. For example, Kevin related that calling doctors was one of his most challenging tasks. "He wants my intuition and knowledge about the patient. He will ask me what I think. What does that mean? That's scary." Kevin also experienced the need to learn how to prioritize which his mentor helped him achieve. Adriana added, "I learned that getting to know your patient is very important."

Mentors also taught the study participants how to make decisions using critical thinking, assessment, intervention, and evaluation. Alexis said, "I learned to watch for changes. They taught me what to expect and walked me through it. I learned implications of certain interventions." Alicia described learning to see the big picture and how to use personal skills. Cari declared that she learned professional conduct and became more comfortable with sick people. Learning occurred in other areas such as how to multi-task through developing a routine and getting to know the unit and team. Amy said, "Mentoring helped me get used to the floor, little by little. It helped me see why you are doing what you are doing and get to know the unit and team."

Coping with change was another learned skill. Coping with change was addressed by Angie who said, "Mentoring helped me go from nursing school to real life." Scully summed up her becoming through mentoring. She said, "I learned the background and knowledge to feel confident. I learned skills, fitting in, and strength and confidence for personal growth."

While the process of becoming a safe and competent nurse can be an awkward and anxious experience, graduates described with pride what they had learned with their mentors and concluded they would have quit nursing without their support. Nursing literature on the new graduate nurses' experience of becoming independent contained conclusions that mentoring was necessary to reduce stress, develop competency for safe practice, and promote transition into the nursing role. The time of becoming required the nurturing, teaching, and high expectations of mentors for the professional and personal growth of the new graduates. These experiences could be described as the time of becoming only after living through the experience and looking back (Beecroft, Santner, Lacy, Kunzman & Dorey, 2006; Boswell, Lowry & Wilhoit, 2004; Bowles & Candela, 2005; Casey et al., 2004; Delaney 2003; Duchscher, 2001; Ferguson & Day, 2004; Grindel, 2004; Halfer & Graf, 2006; Mallory, Konradi, Campbell & Redding, 2003; North, Johnson, Knotts & Whelan, 2006; Pinkerton, 2003; Thomka, 2001).

In summary, the time to learn and grow while giving nursing care under the aegis of a competent and caring nurse mentor made a difference for the circle of graduate protégés. They described several features of significance: (a) learning the role of a nurse, (b) learning to prioritize and when to act, (c) learning how to deal with the patient's illness, (d) learning through doing and redoing, and (e) learning commitment.

Being

Being emerged as the fourth essential theme and represented a time when mentoring had officially ended. The graduate nurses had a full patient assignment and were adjusting to being on their own. Each participant spoke with satisfaction about their

ability to be on their own. Yet, they still relied on their mentor and other staff to assist them in a crisis. The sense of accomplishment was interwoven with strands of anxiety.

The respect and acceptance by other nurses was a prime requirement for the new graduates. Amy had experienced the distance and questioning on the part of her colleagues. She said, "They were wary of me. They weren't sure of my skills but [they] became more open. I felt their acceptance." Alexis stated, "I am proud I can answer [questions] and carry a full load [patients]. I use good nursing judgment." Angie, Cari, and Kevin spoke about having the respect of the team and doctors.

Adriana who had learned the importance of knowing her patient expressed empathy, caring, and sensitivity for their well being. Time to be present for them was an issue for her. She believed that having time and being sensitive helped patients to heal. Alicia talked about connecting with her patient because of her cultural diversity and language skills. Alexis, to the contrary, shared her experience with cultural bias on the part of her African American patient. She said she had been prepared for non-diverse patients to rebuff her but not another culturally diverse person.

Michelle expressed anxiety about being on her own. Initially she wondered if she would be able to handle the demands of practice by herself. Sasha and Kevin also shared that even with the mentoring relationship it was scary being on their own. Sandra expressed the opinion that people needed to experience the anxiety because they are totally responsible for their patient. She said, "It's like starting all over again." She advocated connecting with other new graduates for support.

The mentoring relationship continued with each protégé during this time.

Being on their own and totally responsible for their patients was ameliorated by having their mentor in the wings. Sasha said that she had prolonged the time with her mentor until her manager told her she was using the mentor as a crutch. She knows her mentor is there for her if she needs her. Sandra who believed that prolonging the time with the mentor only prolonged the misery stated, "I have never left her [mentor]. If she is on the floor I am going to her [for help]. I transformed the precepting relationship into a mentor relationship."

Each participant described an ongoing relationship with his or her mentor. Simultaneously, protégés were carrying the same number of patients as more seasoned nurses and functioning as a member of the team. They were also connecting with team members who came to their assistance when a patient's condition rapidly deteriorated. The protégés believed that having their mentors in the wings offered the help they could trust and count on when they were dealing with a patient crisis. This knowledge served as a stabilizing force for them. As the participants emerged from stumbling to connecting with their mentor, to becoming by learning and do, they reached their professional and psychosocial goal of being a nurse. Some looked back to see where they had started and wanted to give the gift of their lived experience of mentoring to other new graduates.

Emerging Theme: Giving

Giving is an emerging fifth theme in this study. Less than half the graduates indicated their intention to mentor others like themselves. The length of time in practice did not appear to influence the decision to mentor. Three participants, Alicia, Sasha, and Angie had mentored others. Angie and Alicia planned to continue mentoring. Two other participants, Felicia and Cari expressed their intent to mentor. Alicia had practiced for

two years, Angie for three years and Sasha for nine months. However, Felicia and Sasha had practiced for six months and Cari had practiced for nine months. The question arose regarding the differences between the graduates who wanted to mentor and those who did not express that intent. The fact that Cari and Felicia had the same amount of practice time as the other new graduates raised another question as to the reason they volunteered their goal of being a mentor and the other participants did not express the intent. The difference needs further exploration in a new study.

An example of the gifting power of the mentoring relationship can be found in the lived experience of one mentor and protégé. Their story contributes poignancy and deep meaning to their mentor protégé relationship. To mentor another, to watch them progress is to create eternally resonating moments according to the mentor. He said:

> Teaching [mentoring] is one of the greatest relationships of life. It equals lovers, mother, and child. It is a very powerful relationship. We are all trying to transcend this world beyond ourselves. To me that is the most beautiful thing that can happen in life. I had this mission to teach her all I knew and she had the mission to receive it in her heart and to carry it on" (Shaffer, 2004).

Literature Review

Nursing Middle Range Theory of Transition

Nursing leaders have just begun to consider the changes in health as a transitional process and therefore, may be a core concept or nursing. A proposed middle range theory of transitions explains situational changes in health. The concept includes: (a) the nature of transitions, (b) facilitating and inhibiting factors, (c) outcome criteria, and (d) nursing therapeutics (Meleis, Sawyer, Im, Hilfinger, & Schumacher, 2000).

Transitions arise in: (a) human development, (b) health and illness, (c) situations, and (d) organizations. The patterns of transitions are observed as: (a) singular or simple, (b) multiple, (c) sequential, (d) related, and (e) unrelated. Properties of transitions are: (a) awareness, (b) engagement, (c) change and difference, (d) time span, and (e) critical points. Facilitating and inhibiting factors include: (a) personal, (b) community, and (c) society characteristics. Patterns of response (process indicators) are: (a) feeling connected, (b) interacting, (c) developing confidence, and (d) coping. Outcome indicators are: (a) mastery, and (b) reformation of identity (Meleis et al., 2000).

Transition is an emerging theory within the nursing profession and has gained attention as the theory was tested in research (Kralik, Visentin, & van Loon, 2006; Messias, 1997; Skarsater & Willman, 2006). The theoretical concepts of the nursing theory are not fully developed. Therefore, they did not appear to provide a definitive explanation for the findings of this study. The theoretical guidelines for personal meaning regarding the transition process, personal responses to transition, and mastery criteria offer the possibility of evaluating the protégé nurses' progress through transitions. A rich potential exists for future research.

Review of New Graduate Literature

The review of new graduate literature supports and verifies the findings of this study. This current study corroborated the findings in literature regarding the experiences of all new graduates: (a) initial stress and lack of self confidence, (b) need for acceptance and respect of team members, (c) a learning period of integrating academic knowledge with practice, (d) not feeling prepared for nursing practice, and (f) the need for support. The cultural background of participants in the studies was not specified. The word

transition was used in the majority of the literature to describe the period between nursing school and independent practice (Beecroft et al., 2006; Boswell, et al., 2004; Bowles & Candela, 2005; Casey et al., 2004; Delaney, 2003; Duchscher, 2001; Ferguson & Day, 2004; Gerrish, 2000; Halfer & Graf, 2006; Hayes, 1999; Hom, 2003; Hurst & Koplin-Baucum, 2003; Mallory, et al., 2003; Mitchell, 2004; Ronsten, et al., 2005; Thomka, 2001; Winter-Collins & McDaniel, 2000;).

Only one qualitative study considered transition theory as applicable to new graduates' experiences (Delaney, 2003). The study referred to the nursing theory of transition but used the definition provided by Bridges, 2003. The researcher sampled ten (N=10) new graduate nurses who had completed an orientation program in their hospital. The researcher concluded that the orientation period entailed an ending and a beginning. No other information was reported (Delaney, 2003).

One study discussed the importance of peer mentoring for nursing students in clinical situations (Sprengel & Job, 2004). The study results suggested nursing education should incorporate mentoring as: (a) an important strategy to reduce student anxiety, (b) foster increased student interaction, and (c) serve as a model for collegiality in later professional career. While minority students were not specified in the Sprengel and Job (2004) study of 64 students, the results may apply to students in general.

The following study describes the reality shock of entry into practice, job satisfaction, and mentoring. In a study of new graduate experiences of reality shock, the researchers sought to examine whether a connection existed between reality shock, a lack of confidence and work related stress. The study (Winter-Collins & McDaniel, 2000) found a sense of belonging and job satisfaction strongly related to and emphasized the

need for mentoring of new graduates. A total of 250 new graduates were randomly chosen from a Midwestern state Health Professions Bureau mailing list of new graduates who had received a license to practice within the last 18 months. The anonymous survey response rate was 43%, (n=107) surveys.

The Mueller-McCloskey Satisfaction Scale measured Job satisfaction. The instrument reported internal consistency coefficients of 0.89 and 0.9. The sense of belonging was calculated using a modified Hagerty Patusky Sense of Belonging Instrument (content validity index = 0.83; reliability analysis of $\alpha = 0.86$). The scale contained Likert type questions. Pearson's correlation measured the relationship between a sense of belonging and job satisfaction (Winter-Collins & McDaniel, 2000).

Results of the study were: (a) Participants were most satisfied with coworkers; (b) The Obstetric nursing unit had the longest orientation (16.4 weeks); length of employment, 8.4 months and had the highest score for sense of belonging; and (c) Home Health nurses reported the highest sense of belonging. Several significant correlations were found: (a) sense of belonging and interaction opportunities ($p < .01$, $r = 0.38$) and (b) coworkers ($p < .01$, $r = 0.33$). The strongest correlation was between a sense of belonging, and new graduate total satisfaction ($p < .01$, $r = 0.40$). The study supported mentoring and nurturing of new graduates (Winter-Collins & McDaniel, 2000). In conclusion, "There is no shortage of nurses, but a shortage of environments that nurses want to work in" (Kramer & Schmalenberg, 1991, p. 50).

Cuesta and Bloom (1998) found greater job satisfaction in mentored nurses. Job satisfaction was defined, "the degree to which one's work meets personal needs, desires, wishes and goals" (p.112). The study investigated the connection between mentoring and

job satisfaction in recently certified nurse midwives. The sample was first year eligible members (N=466) of the American College Nurse Midwives (ACNM). Surveys were mailed and included a demographic data questionnaire, Job Satisfaction Survey, and Quality of Mentoring tool. The response was 68% (n = 317). Twenty six (8%) were mentored as students in a non ACNM mentoring program. In the mentoring experience, the following mentor qualities were prominent: (a) model, (b) supporter, (c) envisioner, and (d) investor. Job satisfaction was reported by 81% of respondents (n = 249). Job satisfaction and quality of mentoring showed a significant but low relationship ($r = .16$, $p = .03$).

Cuesta and Bloom (1998) concluded that organization structures that supported mentoring could lead to job satisfaction. They also concluded that mentoring was significant to career and psychosocial development of nurse midwives and newly certified nurse midwives. They required mentoring to improve their skills and increase job satisfaction. "The . . . knowledge and skills of new graduates are maximized and their potential contributions to the profession and practice are facilitated [by members of the profession]" (Cuesta & Bloom, 1998, p.116).

Theoretical Framework of Transitions

"It isn't the changes that do you in.
It's the transitions."
(Bridges, W. 2003)

Bridges theory of transition influenced the interpretation of the findings in this study (2003). The nursing theory of transition did not provide a strong connection with the essential themes of the study. In phenomenological studies the goodness of fit is essential to the interpretation of the findings (Cohen, Kahn & Steeves,

2000; Munhall, 2001; Patton, 2002). Bridges' phases of transition and how they connect with the essential themes are discussed.

Transition and change are not synonymous but the terms are frequently interchanged. "When change happens without people going through a transition, it is just a rearrangement of chairs" (Bridges, 2003, p. 3). The old adage that the more things change the more they stay the same aptly describes change. Transition as a process is deeper and involves a psychological reorientation that demands adjustment and management of change. The choice to change is not optional during a transition (Bridges, 2003).

Bridges defined transition as a situational process consisting of three definitive phases that require understanding and support for those who are engaged (2003). The three phases are ending, fallow and new beginning. All transition starts with a change which is an ending of the familiar and the inherent beginning of loss of identity. Letting go is followed by a new beginning and the forming of a new identity. These three phases of transitions are not necessarily sequential and can occur simultaneously. During phase one people need guidance to adjust to whatever losses they have sustained. Phase two is the fallow zone. Critical psychological shifting occurs while change is settling into place. This phase can be compared to winter when the earth appears dormant. Phase three is the new beginning where the person has let go of the old identity and accepted the new identity. A new purpose has evolved. People have gone through the loss of the familiar and engaged with the new (Bridges, 2003).

"The fallow zone is both a dangerous and opportune place and it is the core of the transition process" (Bridges, 2003, p. 9). The fallow phase constitutes the most difficult

period of transition and requires active intervention. Unless the psychological affects of loss are recognized and support sought or provided to those affected, the transition will be extremely difficult and will be aborted. "Unmanaged transitions make change unmanageable" (Bridges, 2003, p. 7).

Bridges believed that all three phases of the transition process are needed to create and renew (2003). Transitions require understanding and management of the process. An effective transition through the three phases requires support from others. Speaking of transitions Bridges said, "There is no way to avoid it. But you can manage it. And if you want to come through in one piece, you *must* manage it" (Bridges, 2003, p.141).

Connecting Essential Themes and Theory of Transition

Transition involves change that creates a sense of loss, alteration of the known, and anxiety regarding the future. The theory of transitions connects with culturally diverse new graduates' lived experience of loss and unexpected change regarding their future (Bridges, 2003). The transition was situational, meaning change had occurred when they left nursing school as students and entered nursing practice as nurses. The transition was situational because no other type of transition such as stages of human development transition were involved (Bridges, 2003).

Phase One: Ending

The new graduates entered transition without an understanding of the transition process. The lack of awareness and preparation for transition makes the mentors' role pivotal in the graduates' success. In phase one, ending is synonymous with loss, disruption, and disorientation. This connects with the essential theme of stumbling.

Phase Two: Fallow

Phase two, fallow is equivalent to a state of limbo in which remnants of the old are vanishing but the horizon of the new is hidden. This phase correlates with essential themes, connecting and becoming.

Phase Three: Beginning

Phase three is the beginning of the new identity. Purpose emerges from the ashes of loss. The new vision and purpose of the transition becomes clearer. This last phase of transition connects with the essential theme of Being. See Figure 2. which is a synthesis of the essential themes and the connection with Bridges Theory of Transition (2003).

The Essential Themes in This Study and Theory of Transition Discussed

Essential Theme Stumbling: Phase One, Ending:

Stumbling signals the beginning of phase one, an ending (Bridges, 2003). The study participants had experienced graduation and recognition of their accomplishment along with successfully testing for licensure. Their confidence and self expectations had been bolstered. The graduates characterized their entry into nursing as a period in which they encountered a lack of preparedness for practice and experienced a sense of loss.

The loss of student status disrupted their confidence in their abilities as nurses, expectations of themselves and nursing practice. This loss of the familiar further affected their identity as nurses. They felt displaced in that they did not fit in with the demands of professional practice. Dismay, shock, anxiety, and distress resulted. Increased vulnerability was reflected in the feeling that they did not have the knowledge and skills to cope with the transition. They considered leaving the profession. The increased vulnerability represented a potential loss to the nursing profession which has recently

been addressed with mentoring programs. The new graduates' transition was inhibited by a lack of awareness and understanding about what they would face upon entry. They also did not have the knowledge required of them to effectively deal with the psychological affects.

The graduates became aware of their lack of preparation. They experienced anxiety and stress at being unable to engage effectively in nursing practice, or with the nursing team members who were potential resources. The graduates believed that they did not measure up. This was enhanced by the wariness of the team members who were potential sources of support for their transition. The inhibited sense of identification with the professional team members fostered the sense of not fitting in with the team. Transition was inhibited by the graduates' lack of preparation and knowledge regarding the transition process, and feelings of being marginalized by the community represented by team members. The gap between the two identifies of student and professional contributed to their distress. Also affecting a successful transition was the length of time required to transition from nursing student to professional nurse and the approximate time required to develop the needed skills.

Essential Themes Connecting and Becoming: Phase Two, Fallow

The second and third essential themes indicate phase two of the transition. Transitions are not linear and frequently overlap. Phase one, the loss of identity overlaps with phase two, the fallow phase. Bridges (2003) described the fallow period as the "betwixt and between . . . . where critical psychological realignment and repatternings take place (p. 5). The fallow stage is a dormant time when the transitioning new graduates felt a lack of progress which also increased their anxiety. The sleepless nights

spent wondering if they could cope with the illness of their next patient is an example of not being there yet. The event or turning point in the transition process was connecting with their mentors.

In phase two connecting with the mentor and becoming real nurses were critical points for the new graduates. The critical turning point involved a greater sense of stabilization and awareness of growth. With the mentors' support and direction they began putting together what they had learned in nursing school with the actual care of patients. They were in preparation for the working world and beginning to fit in with the team which characterized professional and psychosocial growth.

The participants continued to have days in which they felt accomplished and days in which they felt unprepared. One participant offered that when he made mistakes he returned the next day because his mentored accepted his feelings of wanting to quite and said that bad days are normal. The mentor acknowledged that all nurses have days when patient care is difficult and demanding. Felicia shared that she had to love nursing because some days she did not want to be there. The fallow phase two of emptiness marched along side the enduring sense of identity disruption of phase one.

Essential Theme Being: Phase Three, Beginning

The fourth essential theme of being a real nurse signaled a new beginning and occurred in the last and third phase of transition. Being a real nurse represented the end of the mentoring period for the new graduate. Fortunately, the majority of mentors continued the relationship while the graduate worked independently. The new identity was forged. The graduates related with pride how they handled the crises of their patients and finally understood the nursing process of assessment, intervention, and evaluation.

"A successful transition is one where feelings of distress are replaced with a sense of well being and mastery of a change event" (Kralik, Vissentin, & van Loon, 2006, p. 321). The new graduates integrated their student learning and hands on patient care.

The new graduates referred to the last stage of transition into independent practice as a second transition. They experienced a lessened but renewed anxiety about being completely responsible for their patient. The feelings of pride combined with accountability and a new found confidence. The transition to independence represented the new beginning described by Bridges (2003). The letting go and acceptance of change led to the development of a new identity, commitment to the nursing profession and personal growth.

In summary, the new graduates had found a new way of being in the world. Mentors and mentoring activities played a major role during the transition process. The mentor has served as a support system to aide the new graduate moving between the worlds of nursing student and nursing professional. The outcome was accomplished by: (a) providing knowledge and understanding of how to find their place in nursing, (b) realigning the graduate's expectations of themselves and nursing practice, (c) developing connections with team members and patients, (d) supporting acceptance of demands of nursing practice, (d) nurturing the emergence of a new identity and sense of well being, and (e) fostering commitment to nursing through compassion and caring which became part of the graduates' relationship with patients.

Without the mentoring relationship the new graduates considered leaving nursing. With the mentoring relationship they successfully transitioned what seem insurmountable in the beginning. Five of the new graduates, Angie, Alicia, Cari, Felicia, and Sasha had

mentored or intended to pass on the mentoring to other new graduates in transition. Perhaps the desire to give back represents the higher levels of mastery and integrative identity.

An unpublished poet echoed the themes of transition. "What is life without renewal? Letting in and letting go are clearly our best tools. To live life we have to find the miracles hidden inside the profound paradox, achingly bittersweet" (Kangas, 2006, p. 1).

In summary, "Transition periods can be the most productive periods of our lives, if we understand that letting go is not dismissing what has happened. . . . instead, we accept what has happened and we search for the path to follow forward. That search can lead us to new and creative ways to live our lives" (Densmore, 2000, p. 1).

Hart's Model of Mentoring In Transition to Professional Nursing Practice

In figure 2., the synthesis of the essential themes of the study and the theory of transition are depicted. The model is derived from this phenomenological study and the theory of transitions which influenced the interpretations of the findings (Bridges, 2003). The circle of arrows represent the four essential themes and three phases of transition. The arrows fade into the next phase and represent the simultaneous and ongoing nature of transition. In addition, as nurses grows professionally and change roles, they may encounter the same process of transition. Professional Nursing is at the center and represents the goal of Being a professional nurse throughout the nursing career.

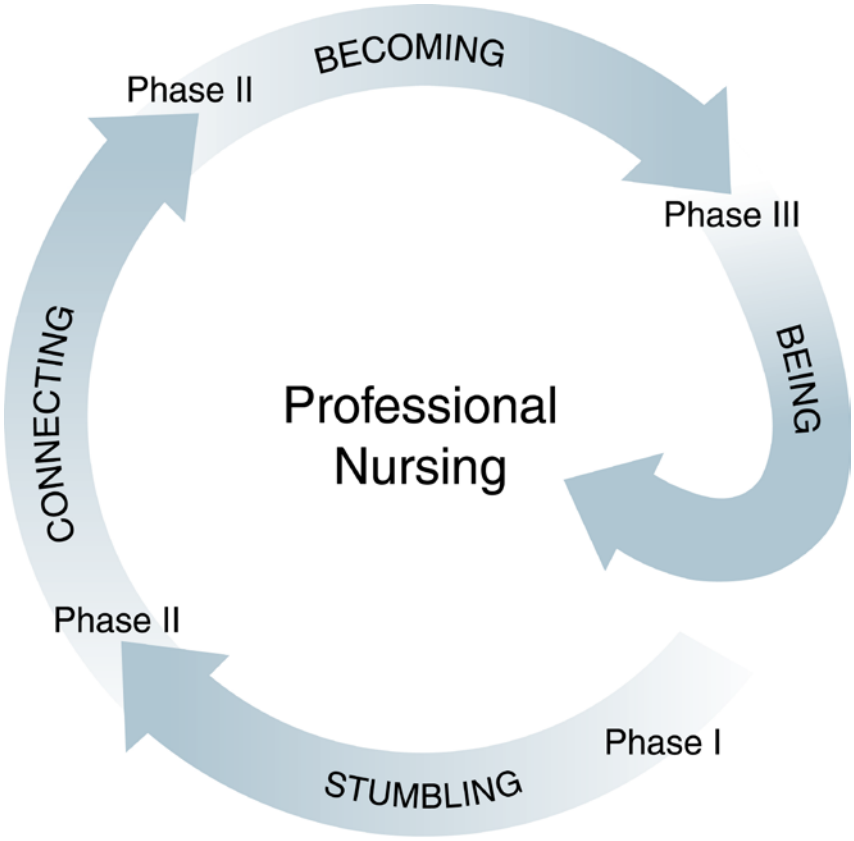

Figure 2. Hart's Model of Mentoring in Transition to Professional Nursing Practice.

This model is adapted from the theory of transitions. Bridges, W. (2003). *Managing transitions: Making the most of change* (2nd ed). Cambridge, MA: Perseus.

Preconceptions of Study Outcomes

The researcher expected to find positive outcomes of the mentoring relationship for culturally diverse new graduates. This expectation was met. A second expectation was that hazing of new graduates would be reported as a direct experience. Although each graduate reported direct observations of negative mentoring, only one new graduate, Christina shared a personal experience that could be described as hazing. A third expectation was that mentoring is a vital strategy to create job satisfaction and to support new graduate commitment to nursing. The essence of the new graduates' experiences supported the study. Graduates voiced their appreciation and dependence on their mentor for their professional and psychosocial growth. Felicia and Scully shared that they are who they are now as nurses because of their mentor.

Study Limitations

A limitation of the study is that the phenomenological method does not allow generalization or prediction. In summary, the limitations of this study are (a) gaining access to new graduates who do not have positive mentoring relationships, (b) second interviews with the study participants were not possible because of their work demands on time, (c) mailing transcripts for them to read, validate, and return, (d) meeting directly with only one of the five orientation mentoring program coordinators, (e) allaying the fears of program coordinators about the outcome of the study, (f) limiting the study to five hospitals in one metropolitan area, (g) the mixture of cultural backgrounds of the participants prevented the study of specific cultures and how they may respond to the mentoring relationship and transition process, and (h) mentor's experience of the relationship was not explored.

Another limitation of this study is the lack of participants who had experienced unsuccessful mentoring. The graduates who experienced successful mentoring volunteered for this study. Only one participant shared a story of what could be described as hazing by a co-worker. Anecdotes from the study participants conveyed their observations of the effect of unsuccessful mentoring on culturally diverse new graduates with whom they had worked. In some instances, the new graduates left the profession.

Study Strengths

The results of the study provide insights into the lived experience of culturally diverse new graduates with being mentored and the nature of their transition into practice. The study expands understanding of the significance mentors and their role in preparing culturally diverse new graduates for nursing practice. The selection of graduates from five hospitals provides a broader base for inferences and increases the trustworthiness of the study. The theory of transition provides a framework to understand the graduates' experiences. The theory of transition indicates that greater awareness of the psychological demands of transitions support the ability to cope with change. Further research and development of the nursing middle range theory of transition may offer a method to evaluate progress and a foundation to develop further interventions.

Nursing Implications

Nursing leaders have advocated an increased diversity of nurses which would provide more culturally appropriate health care for minority patients. Nursing literature supported the use of mentoring for all new graduate nurses during their orientation period. The studies did not indicate whether culturally diverse participants were

included. This phenomenological study found effective mentoring outcomes for the culturally diverse new graduate nurse participants during their transition. The implications are important for nursing education, practice, policy, and health care.

Nursing Education

A paper published by the Joint Commission on Accreditation of Healthcare Organizations (2005) addressed the issues that nursing graduates felt ill prepared to enter nursing practice and the length of transition time into practice was deemed too short and more time was needed for internship and mentoring during orientation (JCAHO, 2005). The report described the division between nursing education and nursing practice which contributed to the transition problems of new graduates. Communication between nurse educators and nurse clinicians was supported. Internships were suggested to smooth the transition and increase confidence and nursing skills. Collaboration between nursing education and hospital would be necessary to develop a structured internship program.

This researcher advocates preparation and knowledge for transition to begin during the senior year of nursing school. Preparation for the transition experience would include knowledge about what to expect during the first year of practice. Information about the nature of transitions, the psychological affects and stages, plus what constitutes successful outcomes. The information would serve as an inoculation against the stress and anxiety during the stumbling phase. Information about what to expect would help to mitigate the feelings of loss by informing and stressing their temporary nature. Preknowledge about the benefits of mentoring and self care would assist with the transitions.

Nursing Practice

A second option to facilitate transition and reduce the psychological responses that inhibit transition into skilled and safe health care would require collaboration and planning (Dingman, 2002; Hayes, 1998, 1999; Hurst & Kopin-Baucum, 2003; Owens, Turjanica, Scanion, Sandhusen, Williamson, Hebert & Facteau, 2001; Pinkerton, 2003). A group of hospitals developed an internship curriculum that was successful for the new graduates. Culturally diverse nurses were not specifically addressed in the literature. The program taught practical skills, interpersonal communication skills and provided peer support. Continuous assessment of progress allowed instructors to evaluate learning needs. The purpose was to increase retention which was successfully achieved.

The results of this study could assist hospitals in planning the preparation of mentors. Knowledge about the trauma culturally diverse new graduates experience during the first phase of transition would permit mentors to plan interventions for their protégé graduates. Pacing the graduates based on their personal responses patterns to transitions could possibly shorten the transition process. Knowledge of the process indicators would provide mentors with opportunities to address and support the level of engagement with others, promote feelings of connectedness, and development of confidence, and coping skills.

Knowledge on the part of nursing staff regarding the transitional process as defined by the theory of transition would begin creating a climate of mentoring in practice. A culture of mentoring within a hospital would normalize the mutual learning experience and benefit the patient as well. The marginalization reported by one participant would not be possible in a culture of mentoring. For example one of the

study participants, Kevin shared that the nursing team mentored him whenever they perceived the need. He compared his experience to a village raising the child.

Nursing Policy

A commitment to increasing diversity and mentoring new graduate nurses has to be firmly anchored in policy, incorporated in the vision and purpose statements (Grindel, 2003, 2004). Several issues that inhibited mentoring and learning were raised by participants. These could be effectively addressed by administrative policy such as: (a) reduced patient assignment to allow adequate time for mentoring and facilitating graduate transition into independent practice, (b) allowing time for mentors to remain with protégés at shift's end, (c) inconsistent training of mentors that resulted in a lack of consistency about what skills the protégé learned, and (d) matching mentor and protégé to facilitate mentoring process.

Several participants cited difficulty connecting with mentors because of mentors' patient assignments. This resulted in the mentors being unable to give the protégés the time necessary for connecting with the mentors, learning needed skills, and being socialized into the profession. A second obstacle was the mentors' drive to be finished and out of the hospital on time. One participant noted that his mentor never left work with him. In effect the protégé was left behind. Although he did not encounter patient issues, he missed being able to discuss and wrap up the shift. Inconsistency in what was taught caused one new graduate to seek other mentors after the formal period of mentoring finished. Mismatching of mentor and protégé resulted in increased anxiety, distress, and delayed progress for one new graduate.

Health Care

Administrators are aware of the high rate at which new graduates leave but may not be aware of the effect on health care. Administrators are aware that the job satisfaction of nurses is important for retention but would be more attentive to the cost of replacement versus savings of retention according to Grindel (2004).

Some estimates placed the rate of loss of new graduates at 55% to 60% (Casey et al., 2004; Winter-Collins, McDaniel, 2000). One report cited the cost of replacement averaged $46,000 per nurse. With an estimated turnover yearly rate at 20% the cost is $5, 520,000 yearly. Reducing the yearly rate to 15% turnover the direct savings would be $1,380,000 per year.

Literature is abundantly available about finances, but the cost to the patient gets lost in the smoke of battle. An interesting outcome in hospitals with a nurse turnover yearly rate of 12% is these hospitals had the lowest risk adjusted mortality scores. Patients benefit from hospitals that create a culture of retention (JCAHO, 2005; VHA, 2002). Patients also benefit from a concerted effort to recruit and retain culturally diverse nurse to provide appropriate and culturally competent care.

Nursing Research

A body of research on the new graduate's transition into practice already exists and can be built upon for further explorations. Certainly, future research needs to be focus on the culturally diverse new graduates' experiences of being mentored during their transition in order to gain further understanding of their needs. Graduates who experienced ineffective mentoring need to be included in research. The mentor's role with culturally diverse new graduates needs further study. The emerging theory of

transition needs further clarification. Applicability of the nursing transition theory to new graduates progress should be studied. In addition, a follow up study of the participants in this study would provide insights into the long-term influence of mentoring.

Unanswered questions are: (a) what is the mentor's experience of mentoring culturally diverse new graduates, what are their insights and recommendations, (b) what preparation does the mentor received prior to mentoring and how does it influence the mentoring outcome with culturally diverse graduates, (c) do participants with the same cultural background respond differently to mentoring than participants from a variety of cultural backgrounds, (d) who among the culturally diverse new graduates go on to mentor others and why, and (e) would graduate's and mentor's preparation and preknowledge facilitate smoother progress of the new graduate's transition from nursing school to professional progress?

In closing, mentoring programs can be developed between nursing education and hospitals to enhance the transition by shortening the first stage of transition which is the loss of identity, expectations, and visions of their role in nursing. Mentoring clearly guided the culturally diverse new graduates through their losses and brought them into their new identity as professional nurses. The major concern for this researcher is regarding the future of culturally diverse new graduates as they transition and how smoother transitions can be facilitate by nursing education and hospitals.

Conclusions

This phenomenological study has explored the culturally diverse new graduates lived experience of mentoring. The participants indicated that without mentoring they probably would not stay in nursing. Each graduate indicated positive outcomes of being

mentored. Several new graduates planned to pass on to other new graduates the benefits of mentoring. If one-third of new graduates returned the gift of mentoring, it would have the potential of changing the future of nursing by creating a climate of mentoring in practice.

A climate of mentoring would contribute to a decrease of marginalization as reported by one participant. Greater acceptance and support by the team during the transition process which would facilitate professional and psychosocial development. Acceptance of new graduates into a team that is supportive and helpful would also benefit the patient.

There exists a potent possibility of affecting change in the culture of nursing as new graduates become mentors themselves. Passing on the kindness, support, guidance and friendship received as a new graduate may create a gentler journey for future nurse as they progress from student nurse to professional nurse status.

Mentoring supported the transition of the culturally diverse nurse participants. If the nurses remain in nursing, it may result in more culturally diverse nurses to provide health care to those like themselves. A follow-up study of who remained in practice over a five-year period may provide answers to the mentoring need of the new graduates.

The unexpected finding was the applicability of the theory of transition to explain the distress and anxiety that haunted the new graduates upon their entry into practice. Questions for future research using the theory arose. Pre-knowledge and preparation at the senior year may offer unexplored and far-reaching benefits. Further study is necessary.

Summary

The purpose of this phenomenological study was to explore the culturally diverse new graduate nurses' lived experience of being mentoring. Thirteen culturally diverse new graduate nurses who had completed a mentoring program were recruited from five South Florida hospitals. The findings of the study emphasized the importance of mentoring for culturally diverse new graduates as they stumbled through the early days of transitioning from student nurse to professional nurse. Mentoring support on some level for the new graduate may be important after they began to practice independently. The participants indicated their mentors waited in the wings to assist. What is unknown is the meaning of that support for their delivery of culturally competent health care.

Four essential themes of being mentored emerged. The first theme, stumbling reflected the distress, dismay and disruption the graduates encountered upon entry into practice. The second theme, connecting occurred between mentor and protégé graduate and alleviated the physical and psychological distress caused by the disruption and distress of lost expectations, confidence, and identity. Becoming a nurse was the third theme. The mentor taught, guided, and nurtured the participant as they learned by doing and getting the big picture of nursing. The fourth essential theme was being a real nurse and on their own. Formal mentoring had ended. After the formal period of mentoring ended, the graduates felt the continued support of knowing their mentor was available and would respond to their need for help.

The theory of transition provided a framework for understanding the nature of the life altering change. Concepts included facilitators and inhibitors, patterns of response and outcome indicators. The nursing theory of transitions needs further study to be

clarified and support research. The potential exists for the theory to assist in the preparation of culturally diverse graduating nursing student's transition into professional practice.

The findings of this study indicated the need for a strong partnership between nursing education and hospitals employing new graduates. Administrators play a key role in supporting mentoring programs. Knowledge about the lived experience of the culturally diverse new graduates as they transition with the help of mentors could inform hospital policy regarding the development of mentoring programs. Nursing research could explore the questions raised by the study and thereby contribute to the professional development of culturally diverse new graduates and appropriate mentoring programs. Application of the transition theory to issues within the nursing profession such as education and practice would build an advanced knowledge base for practice and education.

This study was informed by the concern for health care disparities in culturally diverse populations and the fact that low numbers of culturally diverse nurses and other health care professionals contributed to the disparities as reported by federal agencies and professional health leaders (*Healthy People 2010*; HRSA, 2005; Institute of Medicine, 2003; Spratley et al., 2000; Sullivan Commission, 2004; U.S. Census 2002).

Implied in the recommendations of the above agencies was the critical role of mentoring in increasing the number of culturally diverse professionals in all aspects of health care. Nursing leaders began exploring ways to develop methods to increase the numbers of minority nurses at all levels of nursing. Mentoring for culturally diverse health care students emerged as a strategy for recruiting and retaining.

The transition process was difficult in the early period of nursing practice as implied by transition theorist Bridges (2003). Mentor protégé relationships in this study were successful for the culturally diverse new graduate nurses. Mentoring facilitated their transition from students to practicing nurses. This study does not support the assumption that mentoring will keep nurses in nursing. The stories of the participant culturally diverse new graduates do resound loudly that mentoring contributed significantly to keep the new graduates in nursing through their transition. What is not known is how long mentoring keeps the graduates in their place of employment and in the profession. What is known is that mentors "bridge that awful gap" (Schoor, 1978, p. 1).

Reflections on the findings of this study raised more questions about the mentoring needs of culturally diverse new graduate nurses. Answers dwell for a while and satisfy the mortal mind, then become compost for creating further questions. In the process the knowledge gained in this study may change and that is the nature of all knowledge.

References

Alleman, E. (1982). *Mentoring relationships in organizations: Behaviors, personality characteristics and interpretive perception.* Unpublished doctoral dissertation, University of Akron, Akron, Ohio.

Alleman, E. (1983). *Measuring mentoring, a manual for the leadership development questionnaire.* Mentor, OH: Leadership Management Consultants.

Alleman, E., Newman, T., Huggins, H., & Carr. L. (1987). The impact of race on mentoring relationships. *International Journal of Mentoring, 1*(2), 20-23.

Allen, S. L. (2002). Mentoring: The essential connection. *AORN, 75*(3), 440-446.

Allen, T. D. & Poteet, M. L. (1999). Developing effective mentoring relationships: Strategies from mentor's viewpoint. *The Career Development Quarterly, 48*(1), 59-73.

Allen, T. D., Russell, J. E. A., & Maetzke, S. B. (1997). Formal peer mentoring: Factors related to protégé's satisfaction and willingness to mentor others. *Group and Organization Management, 22*(4), 488-507.

American Association of Colleges of Nursing (AACN) (2001). Effective *strategies for increasing diversity in nursing programs.* Retrieved July 3, 2005, from http://www.aacn.nche.edu/publications/issues/dec01

American Association of Colleges of Nursing (AACN) (2003). Building capacity through hospital and university school of nursing partnerships. Retrieved January 1, 2007, from http://www.acn.nche.edu/Publications/Whitepapers/Building Capacity.htm

American Nurses Association (ANA) (1998). *Ethics and human rights position statement: Discrimination and racism in health care.* Retrieved September 9, 2005, from http://www.nursingworld.org/readroom/position/ethics/ctdisrac

Appleton, J. V. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advanced Nursing Science*, *20*(2), 13-22.

Atwood, A. H. (1979). The mentor in clinical practice. *Nursing Outlook, 27*(7), 714-717.

Atwood, A. H. (1986). *Mentoring: A paradigm for nursing.* Los Altos: National Nursing Review.

Bailey, J. J., & Cervero, R. M. (2002). Cross cultural mentoring as a context for learning. *New Directions for Adult and Continuing Education,* 96(15), 15-26.

Beecroft, P. C., Santner, S., Lacy M. L., Kunzman, L., & Dorey, F. (2006). New graduate nurses' perceptions of mentoring: Six year progamme evaluation. *Journal of Advanced Nursing, 55*(6), 736-747.

Benner, P. (Ed.). 1994. *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness.* Thousand Oaks: Sage

Benner, P., & Wrubel, J. (1989). *The primacy of caring.* Reading, MA: Addison Wesley.

Bellamy, V. B. (1983). This I believe about nursing: Verdelle B. Bellamy. In H. S. Miller & E. D. Mason (Eds.), Contemporary *minority leaders in nursing: AfroAmerican, Hispanic, Native American Perspectives* (pp. 12-13). Kansas City: American Nurses' Association.

Bessent, H. (1983). This I believe about nursing: Hattie Bessent. In H. S. Miller & E. D. Mason (Eds.), *Contemporary minority leaders in nursing: Afro-American,*

Hispanic, Native American Perspectives (pp. 12-13). Kansas City: American Nurses' Association.

Bidwell, A. S., & Brasler, M. L. (1989). Role modeling versus mentoring in nursing. *Image: The Journal of Nursing Scholarship, 21*(1), 23-25.

Borbasi, S.A. (1996). Living the experience of being nurses: A phenomenological test. *International Journal of Nursing, 2*(4), 222-228.

Boswell, S., Lowry, L. W., & Wilhoit, K. (2004). New nurses' perceptions of nursing practice and quality patient care. *Journal of Nursing Care Quarterly, 19*(1), 76-81.

Bowles, C., & Candela, L. (2005). First job experiences of recent rn graduates: Improving the work environment. *Journal of Nursing Administration, 35*(3), 2005.

Bridges, W. (2003). *Managing transitions: Making the most of change* (2nd ed.). Cambridge: Perseus.

Cameron-Jones, M., & O'Hara, P. (1996). Three decisions about nurse mentoring. *Journal of Nursing Management, 4*(4), 225-230.

Campbell, J. (1991). *Reflections on the art of living: A Joseph Campbell companion*. (D. K. Osborn, Ed.). (1991). New York: Harper Perennial.

Cannister, M. W. (1999). Mentoring and spiritual well-being of late adolescents. *Adolescence, 34*(13), *761-780.*

Carr, R., deRosenroll, D., & Saunders, G. (2001). *Peer Resources: Profile of peer resources.* Retrieved July 18, 2002, from http://www.mentors.ca/profile.html

Carroll, K. (1994). Mentoring: A human becoming perspective. *Nursing Science Quarterly, 17*(4), 2004.

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303-311.

Cirgin, E. (2002). Introduction to qualitative research. *Gastroeneterology Nursing*, 25(1), 10-14.

Cohen, M. Z. (2000). Historical Sketch. In M. Z. Cohen, D. L. Kahn, & R. H. Steeves Hermeneutic *phenomenological research: A practical guide for nurse researchers.* Thousand Oaks: Sage.

Cohen, M. Z., Kahn, D. L., & Steeves, R. H. (2000). *Hermeneutic phenomenological research: A practice guide for nurse researchers.* Thousand Oaks: Sage.

Collins, P.M., Kamya, H. A., & Tourse, R. W. (1997). Questions of racial diversity and mentorship: An empirical exploration. *Social Work, 42*(2), 145-152.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among traditions.* Thousand Oaks: Sage.

Creswell J. (2003). *Research design.* Thousand Oaks, CA: Sage.

Cuesta, C. W., & Bloom, K. C. (1998). Mentoring and job satisfaction: Perceptions of certified nurse midwives. *Journal of Nurse Mid-Wifery, 43*(2), 111-116.

Daloz, L.A. (1999). *Mentor: Guiding the journey of adult learners.* San Francisco: Jossey Bass.

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

Delaney, C. (2003). Walking a fine line: Graduate nurses' transition experiences during orientation. *Journal of Nursing Education, 41*(10), 437-443.

Densmore, B, (2000). *Change vs transition.* Retrieved December 17, 2006, from http://www.awakening-intuition.com/Changevstransition/html

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research.* Thousand Oaks: Sage.

Denzin, N. K., & Lincoln, Y. S., (Eds.). (1998). *The landscape of qualitative research.* Thousand Oaks: Sage.

Diekelmann, N. (2002). Nursing 701: Interpretive Research: Fall 2002. Retrieved January 4, 2003, from University of Wisconsin at Madison web site: http://www. Academic. Son.edu/diekelmann/courses/701

Dingman, S. K. (2002). Mentoring connections: Learning relationships. *Creative Nursing, 8*(3), 9-11.

Draucker, C. B. (1999). The critique of Heideggerian hermeneutical nursing research. *Journal of Advanced Nursing, 30*(2), 360-373.

Dreyfuss, H. L. (1993). *Being in the world: A commentary on Heidegger's being and time.* Cambridge: MIT Press.

Dunnington, G. L. (1996). The art of mentoring. *The American Journal of Surgery, 17*(6), 604-607.

Duchscher, J. E. (2001). Out in the real world. *Journal of Nursing Administration, 31*(9), 426-439.

Duchscher, J. E., & Cowin, L. S. (2004). The experience of marginalization in new nursing graduates. *Nursing Outlook, 52*(6) 289-296.

Evers, C. (2000). Helping new nurses succeed. *Gastroenterology Nursing, 23*(6), 288-289.

Fagan, M. M., & Fagan, P. D. (1983). Mentoring among nurses. *Nursing and Health Care, 4*(2), 77-82.

Ferguson, L. M., & Day, R. A. (2004). Supporting new nurses in evidence based practice. *Journal of Nursing Administration, 34*(11), 490-492.

Fields, W. L. (1991). Mentoring in nursing: A historical approach. *Nursing Outlook, 35*(1), 257-261.

Figaro, K. M. (2001). On mentoring: A minority mentee's perspective. *Surgical Gastro Intestinal Medicine Forum, 24*(8), 5-11.

Fox, V. J., Rothrock, J.C., & Skelton, M. (1992). The mentoring relationship. *AORN, 56*(5), 858-867.

Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing, 32*(2), 473-480.

Gonzalez, R. (1999). Ethnic representation: ANA advocates more diversity in nursing. *American Journal of Nursing, 99*(11), 24-25.

Gloria, A. M., & Kurpius, S. E. (2001). Influences of self belief, social support, and comfort in the university environment on the academic nonpersistence decisions of American Indian undergraduates. *Cultural Diversity and Ethnic Minority Psychology, 7*(1), 88-102.

Gonzales, R. I., Gooden, M. B., & Porter, C. (2000). Eliminating racial ethnic disparities in health care. *American Journal of Nursing, 100*(3), 56-58.

Grindel, C. G. (2003). Mentoring managers. *Nephrology Nursing Journal, 30*(5), 517.

Grindel, C. G. (2004). Mentorship: A key to retention and recruitment. *Medsurg Nursing, 13*(1), 36-37.

Grindel, C. G., & Roman, M. (2002). Nurses nurturing nurses: A strategy for new Nurse development and retention. In J. A. Tyler (Ed.), Dean's *Notes, 23*(5), (*2002). National Student Nurses Association, Inc.*: New York: Jannetti.

Guba, E., & Lincoln, Y. (1985*). Naturalistic Inquiry*. Thousand Oaks: Sage.

Hagerty, B. (1986). A second look at mentors: Do you really need one to succeed in nursing? *Nursing Outlook, 34(1), 16-334.*

Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of the work experience. *Nursing Economics, 24*(3), 150-155.

Harper, E., (2001). *Etymology online dictionary.* Retrieved March 23, 2007 from http://www.etymoline.com/index

Hart, M. F. (2002). Evolutionary concept analysis of mentoring. Unpublished manuscript.

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

Hayes, E. F. (1999). Athena found or lost: The precepting experiences of mentored and non-mentored nurse practitioner students. *Journal of the American Academy of Nurse Practitioners, 11*(8), 335-342.

Healthy People 2010, (n.d.). *Healthy people 2010: Understanding and improving health.* Washington, DC: January 2000. Retrieved August 30, 2002, from http:www. health.gov/healthypeople/about/hpfact.htm

Hegstad, C.D. (1999). Formal mentoring as a strategy for human resource development: A review of research. *Human Resource Development Quarterly, 10*(4), 383-390.

Heidegger, M. (1926/1962). *Being and Time.* (J. Macquarrie & E. Robinson, Trans). San Francisco: Harper. (Original work published 1927).

Heidegger, M. (1971). *Poetry, language, thought.* New York: Harper.

Holloran, S. D. (1993). Mentoring: the experience of nursing service executives. *Journal of Nursing Administration, 23*(2), 49-54.

Holloway, J. H. (2001). Who is teaching our children? *Educational Leadership, 58*(8). Retrieved March 13, 2002 from http://www/ascd.org/reading/edlead/00105 holloway.html

Holloway, J. H. (2002). Mentoring for Diversity. *Educational Leadership, 59*(6), 88-89.

Hom, E. (2003). Coaching and mentoring new graduates entering perinatal nursing practice. *Journal of Perinatal and Neonatal Nursing, 17*(1), 40-49.

Homer (n.d). *The odyssey* (Robert Fagles, Trans.) (1996). New York, NY: Penguin Group. (Original work published n.d.)

Hurst, S., & Kopoin-baucum, S. (2003). Role acquisition, socialization and retention. *Journal for Nurses in Staff Development, 19*(4), 176-180.

Husserl, E. (1962). *Ideas: General introduction to pure phenomenology and into a phenomenological philosophy. Edmund Husserl collected works.* (W. Gibson, Trans.). New York: Macmillan.

Institute of Medicine (IOM) (2003). *Unequal treatment. What healthcare providers need to know about racial and ethnic disparities in healthcare.* Washington, DC: National Academy Press.

Ironside, P. M. (2001). Creating a research base for nursing education: Interpretive reviews of conventional, critical, feminist, postmodern, and phenomenologic pedagogies. *Advances in Nursing Science, 25*(3), 72-87.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (2005). *Health care at the crossroads: Strategies for addressing the evolving nursing crisis.* Retrieved November 9, 2006, from http://www.jointcommission.com

Kangas, P. (2006). *Letting in and letting go.* Unpublished Poetry.

Kobor-Escobar, C. M. (2000). The soul of mentoring and the mentoring of soul. *Dissertation Abstracts International, 62, 10B.* (UMI No. 4791).

Koerner, J. (1998). Tapping into uncommon wisdom through mentorship**.** In C.Vance & R.K.Olson (Eds.), *The mentor connection in nursing* (pp. 77-83). New York: Springer.

Koerner, J., & McWhinney, W. (1995). *Uncommon wisdom: Experiences with remarkable people on the road towards mastery.* San Francisco: Center for Nursing Leadership.

Kolias, J., & Herb, T. A. (2001). That which does not kill us only makes us stronger. *Journal for Nurses in Staff Development, 17*(2), 94-97.

Kralik, D., Visentin, K., & van Loon, A. (2006). Transition: A literature review. *Journal of Advanced Nursing, 55*(3), 320-329.

Kram, K. E. (1988). *Mentoring at work.* Boston: University Press of America.

Kramer, M., & Schmalenberg, C. (1991). Job dissatisfaction and retention. *Nursing, 3*(1), 50-55.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousands Oaks: Sage.

Lewis, J. (2001). The spirit of mentoring: Getting the most out of your mentor. *Urological Nursing, 21*(6), 378-382.

Madison J. (1994). The value of mentoring in nursing leadership: A descriptive study. *Nursing Forum, 29*(4), 16-23.

Malone, B. (1982). A study to determine nurse administrators' perceptions of the mentoring relationship and its effect on their professional lives. *Dissertation Abstracts International, 43*(1), 558B.

Malone, B. (1998). *Mentoring: A song of power.* In C. Vance & R. K. Olson (Eds.), *The mentor connection in nursing* (pp. 56-60). New York: Springer.

Mallory, C., Konradi, D., Campbell, S., & Redding, D. (2003). Identifying the ideal qualities of a new graduate. *Nurse Educator, 28*(3), 104-106.

Manch, S. G. (1999). Mentoring programs: The first step in keeping associates with the firm. *Practical Lawyer, 45*(3), 15-21.

Matlock, M. S., & Matlock, J. (2001). Promoting understanding of diversity through mentoring undergraduate students. *New Directions for Teaching and Learning, 85*(75), 75-84.

May, K. M., Meleis, I. M., & Winstead-Fry, P. (1982). Mentorship for scholarliness: Opportunities and dilemmas. *Nursing Outlook,* 30(1), 22-28.

Meleis, A. I., Sawyer, L. M., Im, E. O., Hilfinger, D. K., & Schumacher K. (2000). Experiencing transitions: An emerging middle range theory. *Advances in Nursing Sciences 23*(1), 12-28.

Merriam-Webster Online Dictionary (2007). *Protégé.* Retrieved March 21, 2007, from Merriam-Webster web site: http://www.m-w/dictionary

Merleau-Ponty, M. (1968). *The visible and the invisible* (C. Lefort, Ed., A. Lingus Trans.). Evanston, IN: Northwestern University Press.

Messias, D. K. (1997). Narrative of transnational migration, work, and health. The lived experiences of Brazilian women in the United States. (Doctoral Dissertation, University of California, 1997). *Dissertation Abstracts International, 58,* 08B.

Mitchell, G. J. (2004). The mentoring of nurses: Possibilities for times of transition. *Nursing Science Quarterly, 17*(4), 317.

Moustakis, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Munhall, P. L. (2001). *Nursing research: A qualitative perspective* (3rd ed.). Boston: Jones & Bartlett.

Munhall, P. L., & Boyd, C. O. (1999). *Nursing research: A qualitative perspective.* New York: toExcel.

Munhall, P. L., & Oiler, C. J. (1986). *Nursing research: A qualitative perspective.* Norwalk: Appleton Century Crofts.

National Advisory Council on Nurse Education and Practice (NACNEP) (2004). *A national agenda for nursing workforce racial ethnic diversity: Issues related to diversity in nursing education and practice.* Bureau of Health Professions. Washington, DC: Department of Health and Human Resources.

National Institute of Standards and Technology (NIST) (n.d.). *NIST pilot mentoring program.* Retrieved October 29, 2004, from http://www.nist.gov/admin/diversity handbook.02

North, A., Johnson, J., Knotts, K., & Whelan, L. (2006). Ground instability with mentoring. *Nursing Management, 37*(2), 16-18.

Nugent, K. E., Childs, G., Jones, R., Cook, P., & Ravenell, K. (2002). Call to action: The need to increase diversity in the nursing workforce. *Nursing Forum, 37*(2), 28-32.

Oak Ridge National Laboratories (ORNL). (2004). *Mentoring slide show.* Equal Employment Opportunity Diversity Programs. U.S. Department of Energy. Retrieved October 29, 2004, from http://www.ornl.gov/adm/hr_ornl/mentoring

Office of Minority Health. (2005). Race *and ethnic populations.* Retrieved September 5, 2005 from http://www.cdc.gov/omh/populations/populations.htm

Olliver, J. D. (1998). *Mentorship as a tool to enhance student success within a nursing faculty environment. A literature review.* Unpublished manuscript, Victoria University of Wellington, New Zealand.

Owens, D. L., Turjanica, Scanion, M. W., Sandhusen, A. E., Williamson, M., Hebert, C., & Facteau, L. (2001). New graduate rn internship program: A collaborative approach for system wide integration. *Journal for Nurses in Staff Development, 17*(3), 144-150.

Packer, M. J., & Addison, R. B. (1989a). Evaluating an interpretive account. In M. J. Packer & R. B. Addison *(Eds.*), *Entering the circle: Hermeneutic investigation in psychology* (pp. 275-292). Albany: State University of New York Press.

Packer, M. J., & Addison, R. B. (1989b). Introduction. In M. J. Packer & R. B. Addison *(Eds.*), *Entering the circle: Hermeneutic investigation in psychology* (pp. 13-36). Albany: State University of New York Press.

Parse, R. R. (1994). Nursing science: The transformation of practice. *Journal of Advanced Nursing, 30*(6), 1383-1387.

Parse, R. R. (1998). *The human becoming school of thought* (Rev. Ed.). Thousand Oaks: Sage.

Parse, R. R. (2004). A human becoming teaching learning model. In S. S. Bunkers (Ed.), Teaching learning processes: New ideas for teaching learning. *Nursing Science Quarterly, 17*(1), 33-35.

Pascoe, E. (1996). The value to nursing research of Gadamer's hermeneutic philosophy. *Journal of Advanced Nursing, 24*(6), 1309-1214.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks: Sage.

Phillips, L. (1977). *Mentors and protégés.* Unpublished doctoral dissertation. University of California, Los Angeles.

Phillips-Jones, L. (1982). *Mentors and protégés.* New York: Arbor House.

Phillips-Jones, L. (1983). Establishing a formalized mentoring program. *Training and Development Journal, 37*(2), *38*-42.

Philips-Jones, L. (2001). *The new mentors & protégés: How to succeed with the new mentoring partnerships* (3rd ed.). Grass Valley, CA: Coalition of Counseling.

Phillips-Jones, L. (2002). *The Mentoring Group.* Retrieved October 29, 2004, from http://www.mentoringgroup.com/details

Pinkerton, S. (2003). Mentoring new graduates. *Nursing Economics, 21*(4), 202-203.

Polkinghorne, D. (1983). *Methodology for the human sciences.* Albany: State University of New York Press.

Ragins, B. R. (1997). Diversified mentoring relationships in organizations: A power perspective. *Academy of Management Review, 22*(2), 489-516.

Rew, L., Bechtel, D., & Sapp, A. (1993). Self as instrument. *Nursing Research, 42*(5), 300-301.

Rodenhauser, P., Rudisill, E., & Dvorak, R. (2000). Skills for mentors and protégés applicable to psychiatry. *Academic Psychiatry, 24*(1), 14-28.

Rodgers, B. L., & Cowles, K. V. (1993). The qualitative research audit trail: A complex collection of documentation. *Research in Nursing and Health, 16*(3), 219-22.

Rodgers, B. L., & Knafl, K. A. (2000). *Concept development in nursing: Foundations, techniques and applications.* Philadelphia: Saunders.

Rodriguez, Y. E. G. (1995). Mentoring to diversity: A multicultural approach. *New Directions for Adult and Continuing Education, 66*(16), 69-77.

Ronsten, B., Andersson, E., Gustaffson, V. (2005). Confirming mentorship. *Journal of Nursing Management, 13*(4), 312-321.

Sartre, J. (1965). *What is literature?* (B. Frechtman, Trans.). New York: Harper & Row.

Schoor, T. M. (1978). The lost art of mentorship. *American Journal of Nursing, 78*(4), 1973.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human science. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (pp. 120-135). Thousand Oaks: Sage.

Shaffer, B. (Producer), (2004). *Mr. Mergler's gift* [Motion picture]. Montreal, QC: National Film Board of Canada. (Available from Spiritual Cinema Circle, C/0 4th Way Fulfillment, P.O. Box 5106, Oxnard, CA, 93031.

Simmons, F. (2002). Leading the way: Developing a diverse nursing workforce. *The Society of Gastroenterology Nurses and Associates, 25*(6), 263-266.

Skarsater, I., & Willman, A. (2006). The recovery process in major depression. An analyses employing Meleis' transition framework for deeper understanding as a foundation for nursing interventions. *Advances in Nursing Science, 29*(3), 245-259.

Slife, B. D., & Williams, R. N. (1995). *What's behind the research: Discovering hidden assumptions in the behavioral sciences.* Thousand Oaks: Sage.

Smith, B.A. (1999). Ethical and methodologic benefits of using a reflexive journal for hermeneutic-phenomenologic research. *Image: The Journal Nursing Scholarship, 31*(4) 359-363.

Spengler, C. D. (1982). Mentor protégé relationships: A study of career development among female nurse doctorates. Unpublished doctoral dissertation, University of Missouri, Columbia.

Speziale, H. J., & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative.* Hagerstown, MD: Lippincott, Williams & Wilkins.

Spiegelberg, H. (1984). *The phenomenogical movement: A historical introduction (*3rd ed.). The Hague: Martinus J. Nijhoff.

Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W. (2000). *The registered nurse population: Findings from the national sample survey of registered nurses.* U.S. Department of Health and Human Resources, Bureau of Health Professions, Division of Nursing. Retrieved January 29, 2005, from http://www.bhpr.hrsa.gov / healthworkforce/reports/rnsurvey/mss.

Sprengel, A., & Job, L. (2004). Reducing student anxiety by using clinical peer mentoring with beginning nursing students. *Nurse Educator, 29*(6), 246-250.

Stewart, B. M., & Krueger, L. (1996). An evolutionary concept analysis of mentoring in nursing. *Journal of Professional Nursing, 12*(5), 311-321.

Sullivan Commission. (2004). Missing *persons: Minorities in the health professions: A report of the Sullivan commission on diversity in the healthcare workforce.* Retrieved January 20, 2005, from http://www.sullivancommission.org

Thomka, L.A. (2001). Graduate nurses' experience of interactions with professional nursing staff. *The Journal of Continuing Education in Nursing, 32*(1), 15-20.

Thorpe, K., & Kalischuk, R. G. (2003). A collegiate mentoring model for nurse educators. *Nursing Forum, 38*(1), 5-15.

Tosteson, D. C. (1979). Learning in medicine. *New England Journal of Medicine, 301*(2), 690-694.

University of Maryland University College. (2002). Peer *mentoring program manual and supplement.* College Park, MD: Office of Distance Education and Lifelong Learning, Center for Teaching and Learning.

U.S. Census Bureau. (2000a). Census *2000: Profiles of general demographic characteristics.* Retrieved August 2000, from http://factfinder.census.gov/bf/lang=en_vt_name=dec_2000_sf3_u_gctp14_us14_g

U.S. Census Bureau (2000b). *Overview of race and hispanic origin.* Retrieved September, 12, 2005, from http://www.census.gov/prod/200/pubs/cskbr01-1.pdf

U.S. Census Bureau. (2002). *The face of our population.* Retrieved January 30, 2005, from http://www.factfinder.census.gov

U.S. Central Intelligence Agency. (2005). *Ethnic groups.* Retrieved September 10, 2005, from http://www.cia.gov/cia/ppublications/factbook/geos/us.html

U.S. Health and Human Services (HHS). (2003). *Changing demographics and the implications for physicians, nurses, and other health workers.* Bureau of Health Professions. Retrieved September 25, 2005, from http://bhpr.hrsa.gov/ reports /changedemo/composition

U.S. Health Resources and Services Administration (HRSA). (2002). *The key ingredient of the national prevention agenda: Workforce development. A companion document to Health People 2010.* Bureau of Health Professions. Retrieved September 24, 2005, from http:// eric.ed.gov/ ericdocs/data/ ericdocs2/content _storage.pdf

Van Manen (1990). *Researching lived experience*. Ontario: University of New York.

Vance, C. N. (1982). The mentor connection in nursing. *Journal of Nursing Administration, 12*(4), 7-13.

Vance, C., & Olson R. K. (Eds.). (1998). The *mentor connection in nursing.* New York: Springer.

VHA. (2002). The *business case for work force stability*. Retrieved November 12, 2006, from http://www.vha.com/public

Villarruel, A. (2002). Recruiting minority nurses: We're asking ourselves the wrong questions. *American Journal of Nursing, 102*(5), 11.

Villarruel, A. M. (2004). Health disparities research: Issues, strategies and innovations. *Journal of Multicultural Nursing and Health*. Retrieved September 9, 2005 from http://www.findarticles.com/p/articles/mi_qa3919/is_200407/ai_n9438476/print

Villarruel, A. M., & Peragallo, N. (2004). Leadership development of hispanic nurses. *Nursing Administration Quarterly, 28*(3), 1-18.

Walters, A. J. (1995a). A Heideggerian hermeneutic study of the practice of critical care nurses. *Journal of Advanced Nursing, 2*(3), *492-497.*

Walters, A. J. (1995b). The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing, 22*(4), 791-799.

Washington, D., Erickson, J. I., & Dimotassi, M. (2004). Mentoring the minority nurse leader of tomorrow. *Nurse Administration Quarterly, 28*(3), 165-169.

Wilson, A., Sanner, S. J., & McAllister, L. E. (2003). *Diversity Resources: Building diverse relationships. Diversity White Paper.* Retrieved January 20, 2005, from The Honor Society of Nursing, Sigma Theta Tau Web site: http//www.nursing society.org/about/diversity-paper.pdf

Wilson, P. F. (2001). Core virtues for the practice of mentoring. *Journal of Psychology and Theology, 29*(2), 121-129.

Winter-Collins, A., & McDaniel, A. M. (2000). Sense of belonging and new graduate job satisfaction. *Journal for Nurses in Staff Development, 16*(3), 103-111.

Wocial, L. D. (1995). The role of mentors in promoting integrity and preventing scientific misconduct in nursing research. *Journal of Professional Nursing, 11*(2), 276-278.

Wunder, L. J. (2002). Indian health initiatives: A nursing practice model. In G. J. Mitchell (Ed.), Human science practice models: Developing the art of nursing science. *Nurse Science Quarterly, 15*(1), 32-35.

Yoder, L. (1990). Mentoring: A concept analysis. *Nursing Administration Quarterly, 15*(1), 9-19.

Young, C. Y. (2001). Mentoring: The components of success. *Journal of Instructional Psychology.* Retrieved October 20, 2004, from http://www.findarticles.com

Zachary, L. J. (2000). *The mentor's guide: Facilitating effective learning relationships.* San Francisco: Jossey Bass.

Appendix

Appendix A

Barry University

Institutional Review Board
Office of the Provost and Senior Vice President
for Academic Affairs

11300 NORTHEAST SECOND AVENUE
MIAMI SHORES, FLORIDA 33161-6695
Direct (305) 899-3020
Fax (305) 899-3026

Research with Human Subjects
Protocol Review

To: Ms. Margaret Hart
1470 NE 123 St #112
North Miami FL 33161

From: Ann Gibson, Ph.D., Chair

Date: November 15 , 2004

Protocol Number: 04-10-074

Protocol Title: A phenomenological pilot study of the mentoring experiences of newly graduated registered nurses from different cultures

Dear Ms. Hart:

The Board has received the revisions you submitted and you have satisfactorily responded to the concerns addressed during the October 20th meeting of the Institutional Review Board.

You may proceed with data collection using the enclosed stamped Informed Consent Form, which please remember to sign.

You will be sent an annual report yearly until the study has been completed. Please notify the Board in writing should you have any changes to the proposal and remember to refer to #04-10-074 when writing. Thank you.

Regards,

Ann Gibson

Ann Gibson, Ph.D.
Department of Sport and Exercise Sciences
Barry University
11300 NE 2nd Avenue
Miami Shores, FL 33161

Barry University
Institutional Review Board

11300 NORTHEAST SECOND AVENUE
MIAMI SHORES, FLORIDA 33161-6695
Direct (305) 899-3020
Fax (305) 899-3026

Research with Human Subjects
Protocol Review

To: Margaret Hart

From: Doreen C. Parkhurst, M.D., FACEP
Chair, Institutional Review Board

Date: November 15, 2005

Protocol Number: 04-10-074
Protocol Title: A Phenomenological Study: The Mentoring Experiences of Newly Graduated Registered Nurses form Diverse Cultures

Dear Ms. Hart:

Thank you for your letter informing us that you would like to make the following changes to your protocol # 04-10-074:

1- Continuation – change end date to November 15, 2006
2- Change title to: A Phenomenological Pilot Study of the Mentoring Experience of Newly Graduated Registered Nurses from Different Cultures to: A Phenomenological Study: The Mentoring Experiences of Newly Graduated Registered Nurses form Diverse Cultures
3- Change Research Supervisor to Dr. Jessie Colin

The changes are accepted and you may continue with your study.

Sincerely,

Doreen C. Parkhurst, MD, FACEP

Doreen C. Parkhurst, M.D., FACEP
Chair Institutional Review Board
Assistant Dean, SGMS &
Program Director, PA Program
Barry University
Box SGMS
11300 NE 2 Avenue
Miami Shores, FL 33161

If you have any questions, please contact Nildy Polanco at: 305-899-3020

****

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

South Miami Hospital
BAPTIST HEALTH

November 16, 2004

Margaret Hart, RN, MS
Doctoral Nursing Student at Barry University
1470 NE 123rd Street,
Apt 112
Miami, FL 33161

Dear Ms Hart,

The South Miami Hospital Research Committee thanks you for presenting your application to conduct research at South Miami Hospital. This letter is to inform you that the Research Committee has approved your study entitled *A Phenomenological Pilot Study of the Mentoring Experiences of Newly Graduated Nurses from different Cultures*. Kathy Sparger, RN, MSN SMH VP/CNO has also given her approval. We understand that your SMH sponsor will be Sandra Walsh, RN, PhD.

To proceed to collect data, you must seek and receive Baptist Health Institutional Review Board approval to conduct your study. I will e-mail the application form to you. In order for your study to meet exempt status, you must explain how your interviews will be recorded in such a manner that participants cannot be identified. Your contact for the IRB is Maria Arnold, 786-596-8680 or MariaArn@baptisthealth.net.

At the completion of your research project you are required to provide a written report summarizing your findings to the Research Committee and we would be most interested in a presentation at a research committee meeting as well. If the study takes you longer than one calendar year from the date of this letter, you must provide a report of your progress to the Research Committee and IRB.

We wish you well as you progress on your research project. If you have any questions or concerns, please contact us.

Sincerely,

Pat Collins

Pat Collins, RN, MSN, AOCN
SMH Research Committee
Phone: 786-662-8120 e-mail:pcollins@baptisthealth.net

cc: Kathy Sparger, RN, MSN, VP/CNO
Sandra Walsh, RN, PhD

Baptist Health
South Florida

8900 North Kendall Drive
Miami, Florida 33176-2197
Tel: 786-596-1960
www.baptisthealth.net

February 2, 2005

Margaret Hart, RN
1470 NE 123rd. Street Apt 112
North Miami, FL 33161

RE: BHM 04-090: A Phenomenological Pilot Study of the Mentoring Experiences of Newly Graduated Registered Nurses from Diverse Cultures (Sandra Walsh, Ph.D.)

Dear Ms. Hart:

A member of the Baptist Hospital of Miami/South Miami Hospital Institutional Review Board reviewed your protocol and has been determined that this study qualifies as exempt in accordance with DHHS 45 CFR 46.101 (b)(2), "Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation."

Thank you for keeping the board informed of your activities.

Sincerely,

Maria J. Arnold, CIP, Clinical Research Manager
Baptist Hospital of Miami/South Miami Hospital
Institutional Review Board

Baptist Hospital of Miami

8900 North Kendall Drive
Miami, Florida 33176-2197
Tel: 305-596-1960
www.baptisthealth.net

December 7, 2005

Margaret Hart, RN, MS
119 Harvard Rd.
Hollywood, FL. 33023

Dear Ms. Hart:

The Baptist Hospital of Miami Research Council (RC) wishes to inform you that the Research Council approved your amendment to the study, "A Phenomenological Study: The Mentoring Experiences of Newly Graduated Registered Nurses from Diverse Cultures."

We are aware that you have received exempt status to conduct your research at South Miami Hospital. Please contact Maria Arnold, Clinical Research Manager at 786-596-8680 to determine if there are any other IRB requirements for you to conduct your study at Baptist Hospital of Miami. Joan Clark, Vice President for Patient Care Service and Chief Nursing Officer, can provide administrative approval to conduct the study at Baptist Hospital. Please contact Ms. Yvonne Thelwell, 596-786-7186 or yvonneth@baptisthealth.net to assist you in enrolling interviewees into your study.

At the completion of your research project you are required to provide a written report to the Research Council. We also ask that you present your findings at Baptist Hospital. If the study takes you longer than one calendar year from the date of this letter, you must provide a report of your progress to the BHM Research Council.

The BHM Research Council wishes you well as you progress on your research project. If you have any questions or concerns, please contact Carolyn L. Brown, Chairperson, Research Council.

Sincerely,

Carolyn L. Brown

Carolyn L. Brown, Ph.D., RN
Chairperson, Research Council
786-596-3549.
e-mail: carolbro@baptisthealth.net

cc: Joan Clark. Maria Arnold

Baptist Hospital of Miami

8900 North Kendall Drive
Miami, Florida 33176-2197
Tel: 305-596-1960
www.baptisthealth.net

December 7, 2005

Margaret Hart, RN, MS
119 Harvard Rd.
Hollywood, FL. 33023

Dear Ms. Hart:

This letter serves to affirm that I am aware of and support your research project as outlined in your application for study approval and amendment to the study dated November 21, 2005.

Your project, "~~Intervening~~ CB A Phenomenological Study: The Mentoring Experiences of Newly Graduated Registered Nurses from Diverse Cultures," should provide valuable information regarding the experience of the new graduates working in Baptist Health hospitals. I look forward to seeing your study results.

Sincerely,

Joan Clark

Joan Clark, RN, MSN, CNAA
Vice-President, Patient Care Services
Chief Nursing Officer

cc: Carolyn Brown, Nursing Research, Baptist Hospital of Miami
Maria Arnold, IRB

Baptist Health
South Florida

8900 North Kendall Drive
Miami, Florida 33176-2197
Tel: 786-596-1960
www.baptisthealth.net

December 15, 2005

Margaret Hart, RN
1470 NE 123rd. Street Apt 112
North Miami, FL 33161

RE: BHM 04-090: A Phenomenological Study: The Mentoring Experiences of Newly Graduated Registered Nurses from Diverse Cultures (Sandra Walsh, Ph.D.)

Dear Ms. Hart:

A member of the Baptist Health South Florida Institutional Review Board has reviewed your revisions to the protocol and consent form for the study listed above. The requested revisions have been approved. This type of revision qualifies for expedited review under DHHS 45 CFR 46.110 (b)(2) regulations.

You are granted permission to conduct your study as revised effective immediately. The date for continuing review remains unchanged at February 1, 2006, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported to the IRB for approval. You may contact the Institutional Review Board at 786-596-4491 if you have any questions or require further information.

Sincerely,

Maria J. Arnold, CIP
Clinical Research Manager
Baptist Health South Florida
Institutional Review Board

Baptist Hospital

BAPTIST HEALTH

FAX COVER SHEET

March 9, 2007
11:56 AM

From:	Naira Armenteros	To:	Margaret Hart, RN
Department:	IRB	Company:	
Telephone No.:	786-596-8454	Telephone No.:	(410) 340-6580
Fax No.:	786-596-2973	Fax No.:	(410) 352-5519

MESSAGE

Per our telephone conversation, you requested a copy of the continuing approval letter for South Miami Hospital.

Please note that your Performance Site approved by our IRB is Baptist Hospital and South Miami Hospital. Therefore the Baptist approval letter for Continuation of the study is for both Baptist and South Miami Hospital.

I am attaching a continuing approval letter dated 09/01/06 and other letters for your records.

Please do not hesitate to call me at 786-596-8454 if you need further assistant or e-mail me at NairaA@baptisthealth.net.

Thank you and have good day.

Naira Armenteros
Baptist Health South Florida
Institutional Review Board (IRB)

Number of pages including cover sheet: 5

8900 North Kendall Drive
Miami, Florida 33176

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE
MEMORIAL MANOR

December 13, 2005

Margaret F. Hart, RN, MS
119 Harvard Street
Hollywood, Florida 33023

RE: **MH# 205.004** A Phenomenological Study: The Mentoring Experience of Newly Graduated Registered Nurses from Diverse Cultures

Dear Ms. Hart:

Your research project was received and was reviewed. This study involves survey and no subject identifiers will be collected. Upon review of your protocol and your information sheet to potential subjects, this study was found to meet the criteria for an exemption from Institutional Review Board review. Also received was your completion certificate for NIH Training.

This study meets this exemption because it involves survey, and none of the following conditions exist: (a) responses are recorded in such a manner that the human subjects can be identified, directly or through identifiers linked to the subjects, (b) the subject's responses, if they became known outside the study could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability, and (c) the research deals with sensitive aspects of the subjects own behavior such as illegal conduct, drug use, sexual behavior or use of alcohol. Your project does not involve any aspects, which would prohibit it from being exempt from IRB review. Any subsequent publication generated by this research should not identify the name of this hospital unless specific permission is obtained from the research office.

You may proceed with your project under the above conditions.

Sincerely,

Wayne G. Riskin, M.D., FACP; Chairman
Memorial Healthcare System
Institutional Review Board

WGR/ja

Holy Cross
Hospital

4725 North Federal Highway
Fort Lauderdale, Florida 33308
www.holy-cross.com
954-771-8000

June 5, 2006

Margaret Hart, RN, MS
119 Harvard Road
Hollywood, FL 33023

Re: 06-01 N - A Phenomenological Study: The Mentoring Experience of Newly Graduated Registered Nurses from Diverse Cultures

IRB Approval

Dear Ms. Hart:

The Institutional Review Board (IRB) met on June 5, 2006 to review the referenced study, as well as the Informed Consent. You will be pleased to know that the protocol has received approval for a period of one year. Additionally, the Informed Consent was reviewed and approved.

Enclosed please find the "stamped" IRB approved Informed Consent. The IRB has chosen to waive the IRB Administrative fee.

Holy Cross Hospital's IRB is organized and operates according to Good Clinical Practice (GCP) and applicable laws and regulations as defined in [21CFR] parts 45, 50, 56, 312, as well as ICH GCP guideline Section 3.0. Please keep this Board informed regarding the study and report any Adverse Events or significant new findings.

Should you have any questions, please do not hesitate to contact me at (954) 776-3239.

Sincerely yours,

Janice Schuck, CIM, MBA, CIPP
IRB Director

Enclosure

Appendix B

Barry University
Informed Consent Form

Your participation in a research project is requested. The research is being conducted by Margaret Hart, a doctoral student in the School of Nursing at Barry University. Ms. Hart is seeking information that will be useful in the field of nursing practice and nursing education. The title of the study is: *A Phenomenological Study: The Mentoring Experience of Newly Graduated Registered Nurses from Diverse Cultures.* The aims of the research are to discover the meaning of mentoring experiences for multicultural newly graduated registered nurses, and to address a gap in mentoring research literature. We anticipate the number of participants to be 10 (ten).

If you decide to participate in this research, you will be asked to do the following: complete a one (1) hour tape recorded interview with the researcher and a one (1) hour follow up interview with the researcher at the end of the study. You will be interviewed in a setting and time of your choice. Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects on your employment. Your employer/instructor/supervisor will not be informed about your participation.

There are no known risks to you for your involvement in this study. However, it is possible you may experience psychological discomfort about previously unpleasant mentoring experiences. If this occurs you may self-refer or you may be referred by the researcher to counseling available through the employee assistant program (South Miami Hospital: 786-662-8106; Baptist Hospital: 786-596-2323). The participant will be responsibility for any costs related to referral and counseling. The benefits to you will be $20.00 for travel and time for participating in this study. It is hoped that we will gain increased understanding of mentoring needs of registered nurses.

As a research participant, information you provide will be held in confidence to the full extent permitted by law. No names or other identifiers will be collected on any data. You can choose an alternate name or the researcher will give you one prior to the interview. All data will be transcribed verbatim. Any published results of the research will refer to common themes and only pseudonyms used in the study. Data and audiotapes will be kept in separate locked files in the researcher's office for 5 years and then destroyed by the researcher. Your signed consent form will be kept separate from the data and secured in a locked file in the researcher’s possession.

If you would like Ms. Hart to inform you of her findings, you will provide your name and address to Ms. Hart at the time you sign the consent form. This information will also be kept separate from the data and immediately destroyed upon mailing the findings to you. It is anticipated that a summary of the findings will be mailed to you during the Fall of 2006.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Margaret Hart at (954) 967-6100 or my supervisor, Dr. Sandra Walsh at (305) 899-3810, or the Barry University Institutional Review Board point of contact, Ms. Nildy Polanco, at (305) 899-3020 or the Baptist/South Miami IRB point of contact, Maria Arnold, at (786) 596-8680. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I was informed of the nature and purposes of this study by Margaret Hart, and that I have read and understand the information presented above. I have received a copy of this form for my records. I give my voluntary consent to participate in this study.

_____ _____

Signature of Participant *Date*

_____

Printed name of participant

_____ _____ _____ _____

Researcher *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

Appendix C

Culturally Diverse Newly Graduated Nurses' Lived Experience of Being Mentored

DEMOGRAPHIC SURVEY FORM

This form is to be completed before starting interviews. You may leave blank any question on this form, if you choose to do so. *Only the researcher will see the information you provide.*

1. Gender _____ Female _____ Male

2. Cultural background: (circle one) African American, Hispanic, Jamaican, Haitian, Islander, Native American, Other (please specify)_____.

3. Marital status (circle one) Single, Married, Divorced, Widowed, Single in a significant relationship.

4. Age _____.

5. Education: (check all that apply) Health Care Worker ____ LPN ____ AD ___ Diploma ___RN ___ BS ___MS___.

If you hold a degree in another field please specify _____.

7. How long have you been in practice since graduation? _____.

8. Have you had previous mentoring experiences? ___Yes ___No.

(***Mentoring is defined as an interactive relationship with a respected person who was concerned about your best interest in life and supported, encouraged, guided you. The mentor had a significant influence in your decisions because he or she believed in you).***

9. Would you describe the previous mentoring experiences as: ___Helpful ___ Not Helpful?

10. Do you want to receive findings from this study? ____Yes _____No.
If yes, please write your name and address below for the researcher.

Appendix D

Interview Questions	Date: Participant:
How would you describe your mentoring experience since you have begun practice as a Registered Nurse?	
What words would you use to describe your mentor or mentors?	
What specific examples can you share about when this mentor or mentors was helpful? Not helpful?	
What specific examples can you give about how your mentor/ mentors made a difference for you since you began work as a registered nurse?	
How did your mentor take a personal interest in your progress?	

Appendix E

Attention: RNs needed to participate in a research study to explore the mentoring experience*.

Requirements to participate in the study:

- ☐ Graduated from nursing school within the past two years
- ☐ Participated in the mentoring program
- ☐ Currently employed at Baptist Hospital
- ☐ Come from a diverse culture

General Information:

- Confidentiality will be protected by Human Rights Research federal regulations.
- A $20.00 stipend is offered.

Please contact Margaret Hart, RN, MS (Doctoral student at Barry University) at 954-967-6100 or E-mail mfhart@att.net

* Mentoring is defined as an interactive relationship with a respected person who was concerned about your best interest and supported, encouraged, and guided you. The mentor had a significant influence in your decisions because he or she believed in you.

Appendix F

Completion Certificate

This is to certify that

margaret hart

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 09/11/2004.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
http://www.nih.gov

Appendix G

Grid of Theme Development: Essential and Emerging Themes

Participant	Stumbling	Connecting	Becoming	Being	Giving
Adriana	It was rough, scary, a major shock, overwhelming. I felt thrown to the wolves. I'm in the wrong profession.	My 1st mentor was disorganized. I relocated. The second mentor was like me. She is sensitive, filled in the blanks.	She provided learning opportunities. I grew professionally. I learned getting to know your patient is important.	They don't want to be treated like machinery. I look at patients & I put myself in their place.	
Alicia	Intimidating experience. You develop a backbone out of fear & intimidation. Its like throw to the wolves, now claw your way out.	My mentor was an angel who stayed with me in crisis. She filled in the blanks.	You grow a backbone a little more aligned. I was constantly learning, what to look for, the big picture.	I have the skill & practical end of knowledge. It's very nice to be on the other end.	I'm definitely kinder to new nurses. I love to teach I will do it with the same kindness shown me.
Alexis	The exposure is a shock, mind blowing. It's make or break time. You need a mentor to ease you into practice.	My preceptors were there for me.	They taught me intervent ions, process, & implications. I learned how to handle diversity of patients.	The staff asks me questions now. I am proud I can answer. I feel independent.	
Amy	You are belly flopped into the pool. I was in complete shock. It's mind blowing, without a mentor I would quit nursing.	I trusted her like a friend. We still have good rapport & chemistry. She prepared me for reality.	Mentoring helped me get used to the floor little by little. It doesn't slam you in there. Helped me get to know unit & team	I was called at home to come help the staff with a procedure. I think like a nurse. I intervened with a critical patient.	

Grid of Theme Development: Essential and Emerging Themes

Participant	Stumbling	Connecting	Becoming	Being	Giving
Cari	What you learn in school is not the same. You have sick people crash on you all the time.	My mentor is like a mother who is teaching do this, don't do that. She is Latin, too. We have a mutual personal interest.	I learned politically correct way to do things, professional conduct, & feel more comfortable with sick patients. I would have quit without a mentor.	I feel confident now. I stood my ground with a MD and he respected me for it.	I wish to be a mentor like her. When I am a mentor, I will think of instances of how she acted and how I should act. It's so scary to be a new nurse.
Christina	Some days are stressful. I go out on the back porch & scream. It's the lack of practical skills.	My preceptor is sensitive & knows when I'm worried.	Mentoring helped me grow from student to practice in real life. She helped me grow by telling me what I did right.	I had a patient yesterday in crisis. I stayed with him. I still have questions about the socialized part.	
Felicia	I freaked out sometimes. It was emotionally rough, scary dealing with people's lives. School is different from real world.	My mentor made a difference. I feel connected to her. I give her credit for where I am today.	I learned critical thinking & what I did right. I learned nursing is something you have to love.	I am almost out of new grad role. I am confident now about my critical thinking.	I've already talked with my manager what classes need to be taken. It's important for new grads.
Angie	You don't know everything & it's important to ask questions. Without the right mentor, it's hard.	We had a lot in common. My mentor is sensitive & caring. Different cultural background but same experience. He is Indian.	Mentoring helped me go from nursing school to real life, how to handle everything.	I was a PCA. When the doctors see me [as a nurse] now they respect me [my decisions].	I am on my fourth [new grad] that I have mentored. They come back and say, "we are so proud we had you as our mentor You taught us right."

Grid of Theme Development: Essential & Emerging Themes

Participant	Stumbling	Connecting	Becoming	Being	Giving (emerging)
Kevin	I've had bad days and wondered how I would come back. But I do.	I had a great mentor. She was protective about my learning. She was honest. I appreciated her.	I learned to prioritize & handle critical things first. Without mentoring if you fail, you aren't coming back because it's somebody's life.	Running a code is my most intimidating factor. It forces you to be a real nurse. It's scary & almost like starting over again	
Michelle	I was so worried I was not doing the right thing. You practice blind. You don't know what you don't know yet without a mentor.	Mentors should be people persons. Mine was. She put herself in my shoes. No question was ever stupid.	I have been pushed to excel & continue to educate myself in order to prove the most value to my patients. The environment is so stress-ful that new grads would leave without mentoring.	My nurse manager made it a point to tell me it's going to get better. The first week on my own, I came home wondering if it would get easier. It did.	
Sandra	It's a matter of putting it all together. In the beginning, you can't do it. You heart is pounding.	We were well matched. We had good rapport like an older friend. She is black & I am black. That is a good thing to influence one another	The most important thing is for someone help you build a routine. My mentor helped me grow & remember nursing school & put things together.	You need to have your heart pounding knowing you are responsible for the patient. It's like start-ing over. You build a network of new grads	
Sasha	Learning all the things was hard. I can't imagine being thrown in there. It's scary	Our personalities worked well together. I chose her because she didn't roll her eyes & make snide remarks about new grads. She is like a mom. When you have problems, you run to her.	I learned by doing [things] with my mentor. Leaning all the things is hard.	I was scared being on my own. Once you are done with mentoring, there is no official follow up [from admin].	I mentored unit clerks when I was working before graduation.
Scully	I would not have been able to continue without a mentor. It's dangerous to you, patients & the employer. It's all shocking.	She was very empathic. She was same as me, a minority. She was another mom. I felt connected. She remembered what is like to be a new grad.	I learned the background, & knowledge to feel confident. I learned skills, fitting in, & confidence for personal growth.	I started taking patients. on my own. If I question something, I will ask my mentor to take second look at patient.	

Thematic Analysis
Stumbling

Data	Themes
Adriana (study participant) It was rough, scary, a major shock. It was not what I expected as a student. It was overwhelming. It's not what I went to school for. I'm in the wrong Profession. Felt like I'm not fitting in. Significant in a negative way. I felt thrown to the wolves. I am still a student.	Stressful & Unexpected Overwhelming, shock, scary. Wrong profession. I am still a student. Thrown to wolves.
Alicia (pilot study participant) I was all thumbs. It was very intimidating experience. It was a huge transition. In nursing school everything looked pretty on paper. It is so far fetched and is not what it's made out to be. You develop a backbone out of fear & intimidation. You have bad assignments, too many patients and no guidance.	Fear, stress, the unexpected. Patient ratio is too heavy.
Alexis (study participant) It's a make or break time. I learned to cope. Being a new nurse is scary. The exposure is a shock, mind blowing. You need a mentor to ease you into practice. You have to adjust to change. It happens quickly.	Make or break time. Scary. Shock, mind blowing. Need a mentor to ease you into practice. Rapid changes, adjusting
Amy (study participant) It's like you are belly flopped into the pool. It's a big old shock. I was in complete shock. Oh my God, what will I have to do tomorrow? You want to say, wait a minute, we touched on that but not all of it. Without a mentor I probably would quit nursing. Your license in on the line. You are putting yourself at risk to lose it quickly. You don't know what you are doing at first. You need someone to help you out. I couldn't sleep for thinking about the kind of patient I would get tomorrow & wondering what to do.	Shock, Quit nursing License at risk Don't know what to do. Need someone to help. Fear & anticipation
Angie (study participant) It was not easy but not difficult. I worked 7.5 years at the hospital before I graduated [from nursing]. I felt comfortable asking questions & knew where to go with a problem. You don't know everything & it's important to ask questions.	Insider knowledge Still learning as new graduate

Thematic Analysis
Stumbling

Data	Themes
Cari (study participant)	
We learn a lot in books but it's not the same until you are there. What you learn in school is not the same. You get out and have sick people that crash on you any time. You want to know more than the book says.	Books versus practice Not prepared for very sick people.
Christine (study participant)	
This is very challenging. It's the lack of practical skills. Some days are so stressful. I go out on the porch and yell really loud, then come back in and eat. I yell across the lake. It is very dark to jump into the water without help.	Challenging Stressful. Lack skills to work without help.
Felicia (pilot study participant)	
Lots of things you are not exposed to in school & need help with. What they teach you is totally different from what goes on in the real world. I freaked out sometimes and felt uncomfortable as a new graduate. I disappear and come back when I am ready. It was emotionally rough. Its scary dealing with peoples' lives.	Entering the real world Withdrawing & regrouping. Stress Scary Emotionally challenging Need help
Kevin (study participant)	
[I have fared] better than what I've seen other new grads experience. The doctors asked how the patient is doing and I thought what does he mean. They ask what I think. That's scary. It's fear. You want to do well and when I've had bad days wondered if I would come back. But I do.	Fear Lack of confidence Bad days Keep trying Interacting with team
Michelle (study participant)	
I was so worried that I was not doing everything I should be doing or doing things as well as I should. I don't know that I would have been able to continue in the profession [without help]. I am such a perfectionist. It's necessary to have reinforcement early on. You just don't know what you don't know yet if you don't have a mentor. You practice blind.	Fear, stress Couldn't stay in profession without help Don't know what you don't know yet.

Thematic Analysis
Stumbling

Data	Themes
Sandra (study participant)	
I used to think clinicals were scary. Now they are a breeze. You go to work, feel your heart pounding because you have very important responsibilities. It doesn't matter how many Good skills & knowledge you have. It's a matter of putting it together. In the beginning you are not really able to do it. New grads should get all the nurturing and receive a lot of support from management. Some times you have to stand your ground & say no [I'm not ready to do that].	Fear, stress, Don't know how to put it together. Need nurturing & support
Scully (study participant)	
It was so stressful. At first you think you are never going to know enough. I would not have been able to continue in the profession without a mentor. It would have scared me to death. It is dangerous to you, patients & employer. It's all shocking	Stress shock Couldn't continue in pro - fession with a mentor. Risks to everyone.
Sasha (study participant)	
Learning all the things was hard. Nursing had been in my blood for so long. That was 10 years of observation [as a N.A.]. I can't imagine being thrown in there. It's scary.	Previous experience as N.A. helped entry.

Appendix H

Definition of Terms

Bracketing:	Suspending personal beliefs about a particular phenomenon to conduct a non-biased study (Cohen, 2000).
Culturally Diverse:	Indicates an individual from one of the formally recognized ethnic groups (IOM, 2003).
Essence:	The inner nature of a phenomena (van Manen, 1990).
Human Science:	The study of meaning (van Manen, 1990).
Intentionality:	Humans being are present in the world and are mindful Self-interpreting beings (van Manen, 1990).
Intuiting:	Clear seeing of phenomena as they appear in our awareness, as we understand them (van Manen, 1990).
Lived Experience:	The meaning of a person's experience in his or her consciousness (Van Manen, 1990).
Lifeworld	The lived experience of being in the world (van Manen, (1990).
Phenomena:	Objects and events as they appear to consciousness (Munhall, 2001).
Phenomenology:	Descriptive study of lived experiences, the way we understand them (van Manen, 1990).
Reality:	Reality is created by the person's perception (Munhall & Oiler, 1999).
Subjectivity:	Being in the world shapes experiences (van Manen, 1990).
Transition:	The progress from one way of being to another. The acceptance and management of change (Densmore, 2000).
Truth:	A model of reality (Merleau-Ponty, 1968).