Internationally Educated Nurses' Emotional, Behavioural, and Cognitive Responses to Workplace Integration in High-Income Countries' Healthcare Environments: A Scoping Review

by

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Submitted in partial fulfillment of the requirements
for the degree of Master of Science

at

Dalhousie University
Halifax, Nova Scotia
July 2025

Dalhousie University is located in Mi'kma'ki, the
ancestral and unceded territory of the Mi'kmaq.
We are all Treaty people.

DEDICATION PAGE

To my family,

whose unwavering love, encouragement, and sacrifice made this journey possible!

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Abstract

Nursing shortages are a growing global concern, with workforce migration flows predominantly from low- and middle-income countries to high-income countries. Following the recruitment of internationally educated nurses (IENs), workplace integration becomes a crucial phase that although necessary, can provoke negative and/or positive responses, affecting both individual well-being and healthcare system outcomes. Improving positive integration experiences, enhancing workforce retention, and preserving healthcare delivery requires a thorough understanding of these responses. Nevertheless, existing evidence on IENs integration has not been systematically mapped. The purpose of this scoping review was to identify and chart current evidence on emotional, behavioural, and cognitive responses of IENs from low- and middle-income countries during workplace integration in high-income countries' healthcare environments. This review utilized the JBI scoping review methodology. A comprehensive search was conducted across MEDLINE, CINAHL, Embase, PsycINFO, Cochrane CENTRAL, JBI Evidence Synthesis, ProQuest Dissertations and Theses Global, and grey literature. Inclusion criteria were applied by two independent reviewers to identify and select appropriate sources. A total of 13,178 records were retrieved through the search. Of these, 37 sources were included, comprising of 30 qualitative studies, four quantitative studies, two mixed-methods studies, and one literature review. Results revealed three distinct domains of responses: emotional (ranging from initial optimism to distress, frustration, and isolation), cognitive (including reality shock, perceptions of professional devaluation, and inequality), and behavioural (encompassing avoidance, overcompensation, and adaptation strategies). Integration followed a temporal pattern progressing from initial optimism through crisis phases to either successful adaptation or departure from the healthcare system.

Keywords: behavioural responses; cognitive responses; emotional responses; internationally educated nurses; workplace integration

List of Abbreviations and Symbols Used

AHPRA - Australian Health Practitioner Regulation Agency

CINAHL - Cumulative Index to Nursing and Allied Health Literature

FTE - Full-Time Equivalent

HICs - High-Income Countries

IENs - Internationally Educated Nurses

LMICs - Low- and Middle-Income Countries

NHS - National Health Service

OECD - Organisation for Economic Co-operation and Development

PCC - Population, Concept, Context

PRISMA-ScR - Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews

RN - Registered Nurse

UK - United Kingdom

US - United States of America

Acknowledgments

I would like to express my sincere gratitude to all those who supported me throughout the completion of this Master's thesis.

First and foremost, I extend my deepest appreciation to my supervisors, Dr. Audrey Steenbeek and Dr. Kelly Lackie, for their invaluable guidance, expertise, and unwavering support not only throughout this thesis project but during the entire two years of my Master's program. Their insights and constructive feedback were instrumental in shaping this work and my development as a researcher.

I am grateful to my thesis committee members, Dr. Marilyn MacDonald and Dr. Melissa Rothfus, for their thoughtful contributions, critical feedback, and expertise that enriched this research.

Special thanks to Mona Rafie for graciously accepting my invitation to serve as the second reviewer for this project.

My sincere appreciation goes to the School of Nursing at Dalhousie University for providing an environment conducive to learning and research excellence.

Finally, I would like to thank my family and friends for their patience and encouragement throughout this journey. Their unwavering support has been a constant source of strength and motivation.

Chapter 1: Introduction

Global Nursing Shortage

The sustainability of global healthcare systems fundamentally depends on an adequate nursing workforce, as nurses constitute the largest group of healthcare professionals (Haddad et al., 2023). Registered Nurses (RNs) play a fundamental role in healthcare delivery worldwide, leveraging their comprehensive educational preparation, clinical expertise, and specialized training to deliver evidence-based care to patients across diverse clinical environments. However, an unprecedented global nursing shortage threatens this foundation, with profound implications for healthcare access, quality, and patient safety worldwide (Juraschek et al., 2019). Nursing shortages can manifest at various levels and durations, from temporary local staffing gaps to persistent regional challenges, particularly affecting rural and underserved communities (Auerbach et al., 2017). While these localized challenges may naturally resolve, nursing shortages at the national level present far more severe implications, impacting healthcare access, care quality, patient safety, and medical costs across entire countries (Auerbach et al., 2017). In the wake of the COVID-19 pandemic, the shortage has risen exponentially in both high-income countries (HICs) and low- and middle-income countries (LMICs) (Burnett, 2024). Before the COVID-19 pandemic, the global nursing shortage was estimated to be 5.9 million nurses (Buchan et al., 2022). More recently, projections suggest that by 2030, an additional 13 million nurses may be needed globally to meet healthcare demands (Buchan et al., 2022). In 2023, Statistics Canada revealed a significant rise in nursing vacancies, with positions for registered nurses and registered psychiatric nurses increasing by 20% (n = 5,475) compared to the previous year, marking the largest numerical increase across all occupational categories in the labour market. According to the European Labour Authority Report on Labour Shortages and Surpluses

(2023), nursing has emerged as a critical workforce deficit, with more than 50% of healthcare administrators reporting the shortage as high magnitude (i.e., severe shortage). In Europe, the nursing shortage ranking has escalated significantly, moving from sixth position in 2019 to the second most understaffed profession in 2022.

Essentially, nursing shortages occur when the demand for nursing workforce exceeds the available supply. This gap becomes more severe when the supply of nurses cannot keep pace with the demand, whether through the integration of new graduates and/or international recruitment, leading to an increasing number of unfilled positions (Peters, 2023). Furthermore, high patient-to-nurse ratios prevent the delivery of comprehensive, evidence-based care, as nurses cannot adequately address all patient needs. This represents a system-level challenge rather than an individual performance issue.

International Recruitment Trends

In response to these workforce challenges, HICs have increasingly turned to international recruitment as a strategy to bolster their nursing workforce, an approach that is less feasible for many LMICs due to poor working conditions, limited opportunities, and economic strains (Catton, 2024). Low- and middle-income countries often lack the resources to offer competitive salaries and benefits to attract IENs and struggle to retain their own nursing workforce (Kurup et al., 2022; Lauxen et al., 2019; OECD, 2023). The scale of RN international recruitment is substantial and growing in HICs; according to Statistics Canada, the proportion of IENs in the Canadian nursing workforce rose from 8% in 2017 to 12% in 2022, representing a 50% increase in just five years (Frank et al., 2023). The United Kingdom has witnessed an even more dramatic shift compared to previous years, with over 40% of new registrants with the Nursing and Midwifery Council in 2022-2023 being internationally educated (Buchan et al., 2023). This

represents the highest proportion of international registrants in two decades, reflecting the United Kingdom (UK)'s increased reliance on overseas recruitment to meet its nursing workforce needs. Similarly, the Australian Health Practitioner Regulation Agency (AHPRA) reported an 87% increase in new applications from IENs and midwives in early 2022-23 compared to the previous year, indicating a rapid acceleration in international recruitment efforts. In the United States of America (US), the trend is equally pronounced, with approximately 500,000 immigrant nurses active in 2022, constituting about one-sixth of the country's 3.2 million registered nurses (Pillai et al., 2024). The substantial demand for nursing professionals in HICs is predominantly fulfilled by LMICs, with India, Nigeria, and the Philippines serving as primary sources. In Canada, nurses are primarily recruited from India and the Philippines (Crea-Arsenio et al., 2023; Harun & Walton-Roberts, 2022). Globally, the US is ranked first in the employment of IENs, with 141,000 Filipino nurses representing 28% of its immigrant nursing workforce; India follows in second place, contributing 32,000 registered nurses (6.4%); and Nigeria ranks third, with 24,000 registered nurses (4.8%) (Parungao, 2024; Zhang, 2017).

Workplace Integration

While IEN recruitment can address workforce shortages, it also introduces complex challenges when it comes to workplace integration. Integration is a multifaceted process involving the interaction between an individual and their environment, where novel or unfamiliar experiences (e.g., immigration, linguistic and cultural adaption, and socioeconomic adjustments) and professional role activities collide (Whittemore, 2005). Workplace integration involves uniting individuals from varied backgrounds, experiences, and abilities to create an inclusive and harmonious work environment. It seeks to foster a sense of belonging, uphold equal opportunities, and cultivate mutual respect amongst employees, regardless of their differences

(Rapid Interactive Disability Management, n.d.). Workplace integration requires sustained organizational commitment and involves mutual processes that benefit both individuals and institutions. These processes enable full participation across various dimensions, from professional development to cultural engagement, ultimately supporting positive outcomes in professional performance, social connections, cultural expression, and workplace involvement (Ramji, 2016). Schmidt and Müller (2021) proposed that workplace integration can be conceptualized along two primary dimensions: system integration and social integration. System integration, also referred to as structural incorporation, encompasses the external and internal labor market processes, including policies, the evaluation of qualifications and credentials, job opportunities, and fair wages (Lockwood, 1964; Schmidt & Müller, 2021). Social integration, on the other hand, pertains to the practices, mechanisms, and outcomes of interpersonal and group interactions, encompassing aspects such as language, personal experiences, and emotional factors (Schmidt & Müller, 2021). Numerous factors can influence an IEN's workplace integration, like pre-departure preparation (Leone et al., 2020), communication and language dynamics (Miyata, 2023), cultural aspects (Joseph et al., 2021), variations in role expectations and clinical practices (Korzeniewska & Erdal, 2019), social interactions (Kamau et al., 2022), and organizational support structures (Rodriguez-Arrastia et al., 2020). When IENs from LMICs transition into healthcare systems in HICs, they often face multiple factors that influence how they adapt. Research on integration and adjustment processes suggests that individual struggles and self-regulation manifest through three interrelated responses: emotional (e.g., mood-related responses), cognitive (e.g., self-doubt), and behavioural (e.g., social withdrawal) (Geng et al., 2023; Khoddam, 2024). These responses can affect their retention (Roth et al., 2021), individuals

well-being (National Academy of Medicine, 2019) and ultimately the quality of patient care (Flaubert et al., 2021).

Problem Statement

While previous reviews have documented the challenges and barriers faced by IENs during integration into new healthcare environments (Abuliezi et al., 2020; Rajpoot et al., 2024; Likupe, 2006), less attention has been paid to comprehensively chart the emotional, behavioural, and cognitive responses during workplace integration. Current evidence suggests that integration experiences can manifest in various responses that affect both individual well-being and professional performance (National Academy of Medicine, 2019). However, despite the critical importance of this knowledge, current evidence remains fragmented across multiple studies without comprehensive synthesis. The impact of these responses extends beyond individual well-being; they can influence patient care quality and safety, potentially affecting the substantial investments made by governments and healthcare organizations in international recruitment and training (Glauser, 2018; Søvold et al., 2021). A systemic understanding of these responses is crucial, as they can significantly influence IENs' integration outcomes, professional satisfaction, and ultimately, their retention in the healthcare workforce. A scoping review of existing evidence is essential for understanding the full spectrum of IENs' emotional, behavioural, and cognitive responses to integration, identifying research gaps and areas for future research to inform the development of evidence-based strategies to support their successful integration. This knowledge can inform healthcare organizations, policymakers, and educators in creating more effective integration programs and supportive environments for IENs.

Research Objectives

After a preliminary search of PROSPERO, MEDLINE, the Cochrane database, and JBI Evidence Synthesis, no existing or in-progress scoping/systematic reviews were identified that examined the responses of IENs from LMICs working in HICs healthcare settings during workplace integration. This scoping review aims to systematically map and chart the available evidence regarding emotional, behavioural, and cognitive responses of IENs from LMICs during workplace integration in HICs healthcare environments and illustrate the potential factors contributing to these responses.

Chapter 2: Background

IENs Migration Context

Migration Patterns from LMICs to HICs

The global migration of healthcare professionals, particularly nurses, represents one of the most significant workforce movements in modern healthcare systems. The First World War led to drastic changes in migration and migration policies around the world (Schrover, 2014). The phenomenon of nurse migration gained prominence in the post-World War II era, when many HICs experienced severe nursing shortages due to rapid healthcare expansion and demographic changes (University of Pennsylvania, n.d.). Historically, international nurse migration often occurred either between HICs (North-North migration) or between LMICs (South-South migration). For instance, North-North migration includes Canadian nurses working in the US or Australian nurses moving to New Zealand, while South-South migration can be seen in Kenyan or Filipino nurses working in Indonesia (Kingma, 2008). However, over the past several decades, this pattern of migration has evolved substantially. Recent trends highlight increased nursing workforce migration from LMICs to HICs, often shaped by complex economic and social factors that continue to influence contemporary migration dynamics. In 2000, more than double the number of new nursing graduates in Ghana migrated abroad for employment in industrialized countries (Zachary, 2001, as cited in Kingma, 2008). Around 70% of the 7,000 nurses who graduate annually in the Philippines migrate, leaving many vacant positions in both public and private hospitals across the country (Skeldon, 1999). Similarly, between 1999 and 2000, over 60% (n =114) of RNs at a major hospital in Malawi left to work overseas (Martineau et al., 2002). In 2003, a hospital in Swaziland reported that 30% of its 125 nurses relocated for work abroad (Kober & Van Damme, 2006), and from 1999 to 2001, Zimbabwe saw 32% of its

RNs migrate to the UK for employment (Chikanda, 2005). Current nurse migration patterns reveal well-established corridors between major source countries and destination countries. Some countries are particularly notable as major exporters of nursing staff in the global nursing market. For example, the Philippines is the world's largest exporter of nurses and continues to be the leading source country, having institutionalized nurse migration through specialized education programs and bilateral agreements. For decades, the country has consistently provided nurses to Canada, the US, the UK, and wealthy Gulf Cooperation Council (GCC) countries. A case study by Lorenzo et al. (2007) revealed that the Philippines accounted for 25% of all nurses involved in international migration, with nearly 80% of Philippine nurses relocating to the US.

While the Philippines remains a dominant force in nurse "export," other countries are also contributing significant numbers of IENs. In recent years, India has emerged as a rising global player in the migration of nurses. In 2015/16, India had the second highest number of nurse exports after the Philippines (OECD, 2020), with around 88,000 of its nurses migrating to seven OECD countries, specifically, Canada, Denmark, Finland, Ireland, Portugal, the UK, and the US (WHO, 2006). African countries, especially those in Sub-Saharan Africa (SSA), also serve as exporters of nurses, including Nigeria, South Africa, and Kenya. Amongst all healthcare professionals in Nigeria, a notable trend was observed amongst nurses. Between 2002 and 2021, a total of 60,729 Nigerian nurses migrated to the UK, with a steady increase from 1,393 nurses in 2002 to 5,543 in 2021(OECD, 2022 as cited in Yakubu et al., 2023). Migration patterns significantly affect both the source and destination countries' healthcare systems. For LMICs, the continuous outflow of nursing professionals often leads to critical workforce shortages, particularly in rural and underserved areas, resulting in heavier workloads, reduced job satisfaction, low morale, high absenteeism, and a decline in the quality of care delivery (Adesuyi

et al., 2024; Isfahani et al., 2024). The migration of scientists and other educated professionals from an LMIC to a HIC for work (known as brain drain) can compromise healthcare delivery capacity in source countries as it might lead to losses in the qualified nursing workforce and increase the workload for the remaining nurses in the migrant-sending country (Ulupinar et al., 2024). Conversely, destination countries benefit from an experienced workforce that helps address their immediate healthcare needs, though this often requires significant consideration regarding cultural adaptation and workplace integration (Health Canada, 2023).

Demand Patterns in HICs

Over recent decades, HICs have experienced distinct patterns in healthcare workforce demand, particularly for nurses. Data demonstrate significant nursing vacancies in UK hospitals. As of June 2023, there were more than 46,000 nursing vacancies nationwide, highlighting an increasingly critical issue for the country's healthcare system (Queen Margaret University, 2023). Another analysis in 2021/22 highlighted a healthcare workforce supply-demand gap of approximately 103,000 across the UK. With a projected demand increase of 9%, this shortfall is expected to reach 156,000 full-time equivalents (FTE) by 2030/31 (Shembavnekar et al., 2022). This statistic is especially striking given that the UK was a pioneer in recruiting nurses internationally. In fact, the British government established one of the first overseas nurse recruitment agencies—a practice rooted in its colonial history, when it actively recruited workers from its territories and former colonies (Solano & Rafferty, 2006). In Canada, between 1993 and 1998, all provinces except Newfoundland saw a decrease in the number of registered nurses per 100,000 population, with 7.5 registered nurses for every 1000 people (Spurgeon, 2000). Through sustained efforts and the introduction of multiple new policies and government initiatives since that time, by 2020 Canada increased its nurse-to-population ratio to 10 nurses per 1,000 people

(OECD, 2022, as cited in Canadian Federation of Nurses Unions, 2022). However, it was estimated that Canada would face a nursing shortage exceeding 100,000 nurses nationwide by 2030 (Baumann & Crea-Arsenio, 2023).

A workforce analysis published in April 2022, found that the total supply of RNs in the US declined by over 100,000 between 2020 and 2021, marking the most significant decrease recorded in the past four decades (Auerbach et al., 2022). Federal projections estimate a shortage of 63,720 full-time RNs by 2030 (National Center for Health Workforce Analysis, 2022). Exacerbating the problem, certain nursing specialties experience particularly acute shortages in HICs. According to the Bureau of Labor Statistics (2025), the Advanced Practice Registered Nurse (APRN) workforce, which includes nurse practitioners, nurse anesthetists, and nurse midwives, is projected to grow by 38% between 2022 and 2032, significantly outpacing the average growth rate of all occupations in the US. High-income countries also face significant constraints in their domestic nursing education capacity. Despite growing demand, many countries struggle to expand nursing programs due to faculty shortages, limited clinical placement opportunities, and resource constraints. For instance, US nursing schools turned away over 80,000 qualified applicants in recent years due to capacity limitations (The American Association of Colleges of Nursing, 2023).

While the nursing shortages in the UK, Canada, and the US highlight the severity of this issue, these challenges are not confined to these countries alone. Many other HICs also face significant difficulties in meeting the growing demand for nurses. Considering Nordic countries, Finland will require over 31,000 additional practical nurses by 2040 to address the demands of an aging population and the healthcare sector will also need nearly 14,000 more RNs, with many of them employed in specialized care (Helsinki Times, 2025). Denmark estimates a shortage of

15,000 healthcare staff across all healthcare professions by 2035, and in Norway, a shortage of 13000 RNs is expected by 2030 (The European Observatory on Health Systems and Policies, 2019). Despite having the highest nurse-to-population ratio in the European Union, with 13.9 nurses per 1,000 inhabitants (Reiff 2020), Germany continues to face challenges in meeting the growing demand for qualified nurses. A study by Prognos (2012) projected a shortage of 520,000 full-time nurses in Germany by 2030. Between 2017 and 2022, Australia's nursing workforce grew by 36,573 nurses; however, an aging population and the rising prevalence of chronic diseases continue to drive demand, with baseline projections indicating a shortfall of 70,707 full-time equivalent (FTE) nurses by 2035 (Australian government, 2024). Saudi Arabia's demand for nurses is expected to double by 2030, driven by an annual population growth rate of 2.52%. To meet this demand, approximately 150,000 nurses will need to be hired by 2030 (Mariano et al., 2022). Without relying on international recruitment, at least 10,000 new nurses would need to graduate and enter the workforce in Saudi Arabia each year (Mariano et al., 2022). Factors such as an aging population, increasing chronic disease burden, and expanding healthcare access are expected to accelerate demand growth. For instance, Japan is another HIC facing rising nursing demand, with projections indicating that by 2030, the proportion of people aged 75 or older will continue to increase significantly. While the country currently has approximately 2.15 million nursing care workers across all levels of nursing practice, a shortage of around 570,000 is expected by 2040 (the Straits Times 2024). These nursing shortages reflect both numerical deficits and uneven distribution across regions and specialties, leading HICs to increasingly rely on recruiting IENs to address their workforce gaps.

Push and Pull Factors for IENs Migration

The migration of IENs is driven by complex interacting factors that both push nurses from their home countries and pull them toward HICs. From a push-factor perspective, economic conditions represent a primary motivation for nurse migration, as low wages in many LMICs often fail to provide an adequate living standard. As stated by Alibudbud (2022), entry-level nurses in Philippine public hospitals earn approximately 33,575 PHP per month (around 578 USD, based on an exchange rate of 58 PHP to one USD as of February 2025). However, many are employed on short-term contracts, reducing their earnings to 22,000 PHP (about 378 USD) without benefits. The situation in private hospitals can be even more challenging, with salaries as low as 8,000 PHP (approximately 137 USD). As reported by PayScale (2025), Indian RNs earn an average of ₹315,882 annually (around 3560 USD, based on an exchange rate of ₹87 to 1 USD as of February 2025). Beyond their base salaries, nurses in LMICs face economic instability due to minimal benefits, unpredictable pay schedules, and increasing living costs driven by inflation (Alibudbud, 2023). These financial challenges heighten the risk of burnout and job dissatisfaction, leading many to pursue employment opportunities in HICs where conditions are more favorable.

Poor working conditions represent another critical push factor driving migration decisions. These conditions encompass both physical infrastructure deficiencies, such as inadequate lighting and malfunctioning medical equipment, as well as organizational challenges including poor workplace culture (Prasad, 2022). For instance, an estimated 40–70% of medical devices and equipment in LMICs are either broken, unused, or unfit for use, with limited financial support available for necessary improvements (Diaconu et al., 2017). Taiwo (2024) explains that limited healthcare resources and challenging working conditions in Nigeria

contribute to high rates of burnout amongst Nigerian professional workers like RNs, serving as a key driver of the "Japa" phenomenon, a local urban term for emigrating in search of better employment opportunities abroad (Okunade & Awosusi, 2023).

Limited career advancement opportunities are another contributing push factor in LMICs. A comprehensive study on Filipino nurses identified that limited professional development opportunities was one of the key factors influencing their decision to migrate (Castro-Palaganas et al., 2017). In Nigeria, Ngozi et al. (2023) highlighted the adverse impact of limited career advancement opportunities on the nursing professional environment. Limited career advancement opportunities create professional dissatisfaction, motivating nurses to pursue positions in countries offering structured professional development pathways (Akinyemi et al., 2022). Beyond encouraging individual nurses to seek opportunities abroad, these push factors contribute to a cyclic deterioration of healthcare systems in LMICs. As more nurses leave, healthcare delivery capacity decreases, working conditions worsen for the remaining staff, and the pressure to migrate intensifies, creating a continuous cycle of workforce depletion in LMICs.

From a different perspective, powerful pull factors in HICs attract IENs through strategic recruitment initiatives and favorable conditions like salary differences. High-income countries possess greater economic stability, enabling them to offer attractive financial incentives that appeal to IENs. In general, economic stability, professional advancement opportunities, and higher living standards are considered additional pull factors attracting nurses to HICs. A quantitative study by Kadel and Bhandari (2018) conducted on 99 nurses found that the most significant pull factors attracting nurses to migrate to HICs included higher pay (86.9%), a better work environment (81.8%), improved education opportunities (77.8%), and greater career growth prospects (87.9%). For instance, Saudi Arabia, as one of the leading destinations for

IENs, offers migrant healthcare workers numerous benefits, including approximately 60 days of paid vacation and holidays, complimentary annual flights to their home countries, housing or a housing allowance, a travel allowance, and in some cases, family contracts covering children under 18 years old (Almansour et al., 2023). Additionally, IENs migrate to new countries to seek diverse experiences and challenges, acquire a new language, reunite with their families, enhance their professional autonomy, collaborate with healthcare teams, enjoy flexible work schedules, or attain religious freedom (Moyce et al., 2015; Salami, 2016). Canada in particular, offers attractive incentives by emphasizing work-life balance and professional development (Pivotal Solutions, 2024). The Canadian healthcare system offers comprehensive benefits including student loan forgiveness, extensive health coverage, premium pension plans, and 24/7/365 employee assistance programs providing professional counseling services for personal and workplace challenges (Government of Canada, 2022).

Each HIC offers unique combinations of professional, personal, and social benefits that appeal to migrating nurses. For instance, optimal nurse-to-patient ratios are a critical factor in enhancing patient care quality and reducing nurses' workload. Australian healthcare organizations, in particular, have implemented mandatory nurse-to-patient ratios, such as one nurse to four patients (1:4) for morning shifts in some regions, ensuring safer practice environments (McHugh et al., 2021). The complex interaction between push and pull factors drives nurse migration from LMICs to HICs, with significant implications for global healthcare delivery. While push factors create pressures for nurses to leave their home countries, HICs' strategic recruitment initiatives and comprehensive benefits packages create compelling reasons to migrate.

Theoretical Perspectives on Integration

Since the 1970s, researchers have thoroughly examined integration from different perspectives and developed various theoretical models of social, cultural, and organizational adjustment, offering structured frameworks for understanding the multifaceted process of integration. Following theoretical frameworks provide comprehensive understanding of integration within a new environment. Workplace integration still involves the same fundamental challenges such as cultural adjustment, professional identity development, and organizational adaptation that these theories address. Each framework contributes unique insights into different aspects of the integration experience and provides structured approaches to understand how responses develop over time, interact with each other, and are influenced by both individual and organizational factors.

Feldman's Model of Organizational Socialization

Organizational socialization is the process through which outsiders evolve into active and successful insiders (Feldman, 1976). Feldman's Model of Organizational Socialization conceptualizes organizational socialization as a developmental journey through three distinct phases which illustrate an individual's transition from being an outsider to becoming an integrated organizational member. The first stage is *Anticipatory Socialization*, which occurs before the individual formally enters the organization. This process, often referred to as the pre-arrival stage, involves transmitting, receiving, and evaluating information about the new work environment. Two essential factors of Realism (how accurately individuals perceive organizational realities) and Congruence (the mutual fit between organizational resources and individual capabilities and needs) influence progress during this stage. As newcomers step into the organization, they enter the *Accommodation phase*, often described as the *encounter stage*.

This is where expectations meet reality. In this stage, they engage in four essential activities that shape their integration. They develop task competencies, forge relationships with colleagues, clarify their organizational roles, and continuously evaluate their progress. There are some process variables that indicate progress through this stage like *initiation to the group* (the degree to which employees feel accepted and trusted by colleagues) and *role definition* (the extent to which employees have fully clarified their organizational roles). In the final phase, *Role Management,* the challenge shifts from learning and integrating to balancing and resolving conflicts. In this stage, the individual must now mediate work-life conflicts and inter-group conflicts. Successful progression through this stage is marked by the individual's ability to resolve outside life conflicts and resolution of conflicting demands. Following successful progression through these three stages, four key outcomes of general satisfaction, mutual influence, internal work motivation, and job involvement will be established.

Berry's Acculturation Model

Defined by American Sociological Association (2018), *acculturation* refers to "processes by which groups or individuals adjust the social and cultural values, ideas, beliefs, and behavioural patterns of their culture of origin to those of a different culture" (para. 1). In other words, it is the process of social and psychological adjustment that takes place when two different cultures meet and it can affect immigrants, refugees, or anyone who spends a prolonged period living in a foreign country. Berry (1992) proposed a model of acculturation that categorizes individual adaptation strategies along two dimensions of retention or rejection of an individual's native culture and adoption or rejection of the host culture. Berry proposed that people experiencing acculturation behave in one of four ways: *Assimilation, Separation*, *Integration,* and *Marginalization*. Individuals may adapt to the host or dominant culture and

leave the original culture behind (i.e., *assimilation),* and may avoid interactions with the new in favor of preserving their culture of origin (i.e., *separation*). They may experience biculturalism and integrate with the new culture whilst still maintaining the original culture (i.e., *integration*) or may leave the original culture behind but struggle to integrate into the new culture and reject both their culture of origin and the dominant host culture (i.e., *marginalization).* Although acculturation strategies can be different between private and public areas of life, it does however highlight the importance of cultural maintenance and participation in shaping adaptation outcomes in a new environment.

U-curve Theory of Cross-Cultural Adjustment

The concept of culture shock is described as the physical, psychological, and behavioural reactions that often occur when individuals are attempting to live, work, or study in unfamiliar cultural contexts (Oberg, 1960). U-curve Theory of Cross-Cultural Adjustment by Lysgaard (1955) depicts moving from an initial *honeymoon* period through culture shock before ultimately reaching recovery and adaptation. This framework evolved alongside the concept of culture shock, providing a structured pattern to illustrate the entire adjustment process. According to the U-curve Theory of Cross-Cultural Adjustment, in the *honeymoon stage,* individuals experience feelings of excitement, curiosity, and optimism in the new life in the host culture. This is followed by the *crisis stage* (i.e., culture shock phase**)**, where the initial enthusiasm gives way to frustration and anxiety, due to challenges like language barriers experienced in new and unfamiliar contexts. Over time, individuals enter the *recovery phase*, during which they gradually adapt to the new environment, develop coping strategies, and achieve greater emotional stability. Eventually, the individual can successfully establish a balance between their

original cultural identity and the host culture and achieve a sense of comfort, functionality, and integration (Lysgaard, 1955).

The continued relevance of this theory, same as those developed decades ago, lies in their focus on fundamental human psychological processes that remain consistent across time periods during integration. U-curve model provides a valuable framework for understanding the temporal nature of emotional responses during cross-cultural transitions and offers insights into when individuals may experience different phases of adjustment and how emotional states may evolve throughout the adaptation process. While some research has documented variations from the U-curve pattern, this framework has remained one of the most prominent and widely referenced theories in cross-cultural adaptation literature over the past seven decades (Lam, 2025).

Social Identity Theory

One of the critical dimensions of adjustment is related to how individuals navigate their identity during transition into the new environments. For instance, the complex interplay between previous and new professional identity significantly influences integration outcomes yet is not fully captured by many models. Social Identity Theory (SIT) (Tajfel & Turner,1979; Tajfel, 1978) seeks to explain the cognitive processes and social conditions underlying intergroup behaviours, especially those related to prejudice, bias, and discrimination. The theory illuminates three key psychological processes that shape identity development during integration. First, through *social categorization*, individuals classify themselves and others into meaningful groups to understand the environment (i.e., distinguishing between locally educated nurses and IENs). They may categorize the various social groups based on attributes like race, gender, or religion. *Social identification* occurs next when individuals invest in group membership and categorizes themselves as members of a particular group and adopts the characteristics of that group like

norms, values, and behaviours. After categorizing and identifying with a group, *social comparison* involves evaluating one's group relative to others which can lead to in-group favoritism and competing identities. This group connection can influence not only self-perception but also foster belonging, create purpose, build self-worth, and shape identity.

Pilette's Four-Phase Transition Model

Pilette's model (1989) outlines four generic phases of adjustment that characterize international nurses' first-year experiences as they adapt to new healthcare environments, reflecting shifts in their individual responses. *Acquaintance* is the first phase, which often spans the first three months after arrival, when an individual first encounters a new workplace and associated realities. At this stage, IENs focus primarily on basic survival and orientation needs with experiences often oscillating between excitement about new opportunities and anxiety about meeting expectations. As IENs progress to the *indignation* phase, challenges will be more tangible, and initial optimism is often replaced with frustration as the gap between expectations and reality becomes apparent. This stage is characterized by cultural, professional, and psychological dissonance. For instance, individuals may experience disappointment with their roles which can, in turn, form into professional identity conflicts. The third phase, *conflict resolution* (typically in 6-9 months), involves IENs developing strategies to address the challenges identified in the indignation phase. During this period, nurses may develop new behaviours and shift their attitudes toward the new healthcare environment, ultimately working to resolve conflicts. Next, IENs enter into the *integration* phase, reflecting successful adaptation to the new healthcare environment where the IEN demonstrates both competence and confidence in their roles. Consequently, they contribute meaningfully to their organizations and develop a new sense of *unit community life* and achieve a sense of psychological relief. Pilette's model

(1989) also highlights that even experienced practitioners undergo significant professional identity reconstruction when transitioning between healthcare systems, particularly when moving to unique and unfamiliar contexts where practice patterns, technology utilization, and professional autonomy may differ substantially (e.g., moving from LMICs to HICs).

Multidimensional Integration

Integration is a complex process that extends far beyond simple adjustment. Various dimensions of integration collectively shape an individual's emotional, behavioural, and cognitive responses in new environments. Understanding these fundamental components is essential for comprehending the experience of a population within an unfamiliar environment, as failures in coordination are often rooted in poor integration.

Workplace Integration

The strategic recruitment of educated migrants has emerged as a key solution to labour market gaps, particularly in skill-dependent Western economies. Successful integration of migrant workers within unfamiliar organizations is key to optimizing fitness and efficiency. Integration is defined as a 'two-way process' (Frideres & Biles, 2012) in which the host society establishes norms, while migrants undergo personal and cultural changes as they adapt to the community (Garrido et al., 2012). Orientation and transition programs have been identified as inseparable parts of the workplace integration process as they accelerate and facilitate professional adaptation (Rush et al., 2013). As nurses educated abroad transition from LMICs to work in HICs, several key components emerge. These include professional role adaptation (e.g., adjusting to the scope of practice differences) (Gajda, 2019), procedural competence (e.g., workplace-specific protocols) (Ramji et al., 2019), institutional knowledge acquisition (e.g.,

workplace values and expectations) (Gajda, 2019), and resource navigation (e.g., support systems) (Mautz et al., 2001). These elements play key roles in successful workplace integration.

The integration dynamics involves reciprocal adaptation, where migrants and host community members alike experience significant adjustments. The process of adapting to a new cultural environment can be demanding, as they may face prejudice (emotional bias), discrimination (behavioural bias), or stereotypes (cognitive bias) from the local group (Fiske, 2025). On the other hand, local colleagues might perceive migrants as outsiders who threaten their cultural identity or economic stability (Ha & Jang, 2014). If left unresolved, this can exacerbate tensions between groups and complicate the integration process. To facilitate the integration of culturally and linguistically diverse nurses, it is necessary for the organization to implement inclusive policies that respect cultural identity and foster opportunities for meaningful interaction between immigrants and native residents (Kamau et al., 2022; Ramji et al., 2019). The effectiveness of such integration efforts, however, depends on multiple migrant-specific variables. Research indicates that variables such as professional experience, educational qualifications, previous labor market participation, marital status, country of origin, and length of time since immigration can all significantly influence integration outcomes (Kamau et al., 2022).

Social Integration

Social integration refers to the extent of an individual's connection to, or attachment with, their social environment across various levels, including community engagement, personal networks of social relationships, and intimate interpersonal links (Ader, 2007). At the interpersonal level, social integration for IENs involves developing meaningful collegial relationships with nursing peers, physicians, and other health professionals. Such relationships provide emotional and social support, and explicit knowledge (e.g., information that is

previously documented). They also serve as crucial sources for accessing tacit knowledge (e.g., information acquired through personal experience) regarding workplace norms, informal practices, and unwritten expectations often missing from formal orientation (Westmaas, 2022). Gayan (2024) highlights that strong interpersonal connections within the workplace are associated with reduced stress and enhanced professional confidence. According to Wani (2024), social networks can provide access to career advancement opportunities, and improving clinical practice, and professional advocacy. Effective social integration can also lead to social cohesion which reflects trust and reciprocity amongst network members and a sense of belonging (Berkman & Glass, 2000; Da Costa et al., 2020)

However, research shows that individuals may encounter barriers to social integration (Walsh & Jago, 2025). For instance, communication is one of the most important components of social integration process. Although most IENs require language proficiency as a prerequisite for registration and employment, mastering profession-specific terminology, understanding colloquial expressions, interpreting non-verbal communication cues and culturally influenced communication styles remain noticeable challenges (Sahadevan & Sumangala, 2021; Xu et al., 2012). Failure to address these concerns can result in isolation (Graham et al., 2007) and can significantly impede social integration, contributing to feelings of alienation that ultimately can undermine professional identity and job satisfaction (Walsh & Jago, 2025). Conversely, successful social integration and workplace relationships help safeguard against health decline by fostering mutual support and respect, while also enhancing overall well-being and job satisfaction (Government of Canada, 2024).

Cultural Integration

Over the past few decades, Western nations have prioritized cultural identity and diversity in political discussions. In the early 1960s, concerns about the erosion of immigrant cultural identities resulted in the development of policies to promote multiculturalism and pluralism (Algan et al., 2012). Canada exemplified this shift, becoming one of the first nations to institutionalize multiculturalism through official policies aimed at preserving cultural heritage while fostering social cohesion (Raska, 2020). These multicultural policies were designed to facilitate cultural integration while ensuring immigrants had equal access to rights and resources. Canada is known for multiculturalism, with its immigrant population demonstrating higher rates of naturalization, political participation, and civic engagement compared to other Western nations (Kymlicka, 2012), and Canadians generally hold more favorable attitudes toward immigrants than other Western countries (Kymlicka, 2012).

Despite these progressive policies, individual immigrants still face significant integration challenges. Foreign-sounding names, distinctive ethnic appearances, or unique identities can also lead to separation from the broader workplace community. Immigrants from minority backgrounds, whether skilled professionals or asylum seekers, consistently face challenges when adapting to Western cultural norms and societal expectations. Cultural integration weaves together diverse cultural backgrounds, influencing both native and immigrant communities, and gradually reshapes distinct behavioural norms into shared values and common aspirations (Wang et al., 2020; Wang & Giovanis, 2023). The process of cultural integration is often accompanied by varying degrees of acceptance, rejection, or reaction and frequently gives rise to what researchers refer to as *cultural dissonance* (Rothe et al., 2010; Patterson, 2018). This phenomenon emerges when individuals experience conflicts between their own cultural values

and the expectations of the host environment. In the workplace context, cultural integration (e.g., culturally responsive orientation programs) can result in effective and mutually beneficial outcomes for both migrants and host communities, while failure to adapt culturally, especially when accompanied by fear of otherness, can become a source of psychological tension that can undermine individual well-being and negatively impact professional confidence, work satisfaction, and retention (Wang & Giovanis, 2023; Kamau et al., 2022). Workplace integration involves a range of enablers and barriers that shape expatriates' transition experiences at both individual and systemic levels. Understanding these factors is key, as unresolved challenges can lead to broader consequences for organizations and society.

Integration Barriers and Enablers

Existing literature has identified multiple factors operating at both individual and system levels that either facilitate or hinder IENs' workplace integration experiences (Kamau et al., 2022; Zhong et al., 2023). Understanding these barriers and enablers provides essential context for examining how IENs respond to workplace integration and the factors that influence their emotional, cognitive, and behavioural responses.

Individual-Level Factors

Language and Communication. Communication is a cornerstone in safe healthcare delivery and is recognized as one of the most significant challenges faced by immigrants (Zhong et al., 2023). Meeting English language requirements alone are insufficient for effective communication within the healthcare environment. In a new context, individuals must also learn various components of communication, such as colloquial expressions and regional accents, particularly in high-pressure situations requiring rapid information exchange like hospitals. Also,

different cultural norms regarding eye contact, physical proximity, and emotional expression can vary significantly (Taylan & Weber, 2022). Without prior training, healthcare professionals may misinterpret these norms, leading to misunderstandings with local patients and staff, which in turn, can erode trust, hinder effective communication, and ultimately compromise the quality of patient care (Roth et al., 2023). It has also been found that ineffective communication can lead to negative cognitive responses in immigrants, leading to a sense of reduced self-worth within the host community (Kishi et al., 2014). If left unaddressed, communication barriers can increase workload by requiring additional time for repetitive clarification efforts and extensive documentation of interactions and heighten the risk of anxiety and insecurity for both healthcare providers and recipients (Ramji & Etowa, 2018; Roth et al., 2023; Zhong et al., 2023). Providing language program opportunities can enhance communication. Belay (2019) conducted a qualitative investigation into the lived experiences of IENs following their participation in a 13-week accent modification program. The study revealed that participants perceived improved communication abilities regardless of age, gender, country of origin, and length of stay in the US.

Willingness to Learn and Adapt. Commitment to engage in continuous learning and adaptation is a crucial factor in successful workplace integration (Iheduru-Anderson & Wahi, 2018). This willingness to embrace new cultural norms and professional practices significantly contributes to a smoother transition process. IENs who actively participate in additional training, seek constructive feedback, and identify their strengths and areas for improvement are better equipped to navigate complex workplace challenges. This adaptability demonstrates resilience in the face of professional obstacles (Philip et al., 2018) while simultaneously fostering a sense of

competence and value within the new healthcare environment (Iheduru-Anderson & Wahi, 2018).

Cultural Differences. In an unfamiliar context, expatriates are expected to navigate acculturation, a process that impacts their cultural attitudes, beliefs, and practices while requiring cultural, behavioural, and psychological adjustments as they interact with the new culture (Samnani et al., 2013). Cultural differences significantly contribute to the challenges and barriers affecting the experiences of IENs in a host country (Allen, 2018). Limited understanding of the local population's mindsets and cultural values serves as a key barrier to effective communication and interaction with patients and colleagues from diverse backgrounds (Roth et al., 2023). Hofstede (1980) identified several cultural dimensions that impact how individuals' function in workplace settings: power distance (the expectation and acceptance of unequal power distribution), individualism-collectivism (the degree to which people define themselves as individuals or members of groups), and uncertainty avoidance (tolerance for ambiguity). In healthcare settings, these differences can create value conflicts and ethical tensions and can trigger psychological impacts such as anxiety and depression among IENs (Zanjani et al., 2018). While research on metacognitive cultural awareness (i.e., a component of cultural intelligence (CQ), although not extensively applied to IENs specifically, offers promising insights for workplace integration. Metacognitive CQ refers to an individual's ability to consciously reflect on their own cultural knowledge, recognize differences between cultural backgrounds, and adapt behaviour to navigate cross-cultural interactions effectively (Earley & Ang, 2003; Lorenz et al., 2017). At the individual level, navigating these cultural differences requires significant cognitive and emotional adaptation as IENs reconcile their internalized cultural frameworks with new cultural expectations.

Professional Identity and Competence. Adams et al. (2006) defined professional identity as "the attitudes, values, knowledge, beliefs, and skills that are shared with others within a professional group and relate to the professional role being undertaken by the individual" (p. 5). For IENs integrating into new workspaces in HICs, professional identity manifests as their self-perception within the unfamiliar healthcare environment, influenced by their role and clinical experiences in their home countries (Philippa et al., 2021). Concurrently, professional competence encompasses their ability to meet local healthcare standards and perform clinical practices according to the host country's expectations (Wit et al., 2023). For many IENs, the transition to HICs involves a profound emotional challenge as their established professional identity is questioned or devalued due to differences in healthcare systems or unrecognized credentials. A qualitative study by Lillekroken and Nortvedt (2024) found that IENs pursuing licensure in Norway experienced frustration and a diminished sense of self-worth when their extensive prior experience was overlooked. This finding aligns with the social identity theory, which posits that exclusion from a valued professional group undermines one's self-concept (Tajfel & Turner, 1979). However, IENs who successfully navigate these challenges report a restored sense of professional identity and competence, which enhances their confidence and workplace integration. For instance, Cubelo et al. (2024) found that IENs in Canada who completed bridging programs felt more professionally validated when their skills were recognized, which facilitated their behavioural alignment with local expectations. The relationship between identity and competence is further complicated by deskilling, where IENs are relegated to lower-level roles. A systematic review by Salami et al. (2018) found that deskilling creates cognitive dissonance for IENs, as their professional self-perception conflicts with their reduced status in the new healthcare environment. Deskilling can erode motivation, yet

resilient IENs with a strong intrinsic sense of professional identity can proactively seek opportunities to demonstrate competence, such as through additional training or mentorship. Feldman's Model of Organizational Socialization (1976), emphasizes that achieving role clarity and task mastery reinforces professional identity and supports integration. This aligns with Pilette's Four-Phase Transition Model, which suggests that successful progression through the integration phase occurs as IENs rebuild their competence and confidence in the new healthcare context (Pilette, 1989). Thus, while threats to professional identity and competence pose significant barriers, they also serve as enablers when IENs leverage individual initiative and systemic support to reaffirm their expertise.

System-Level Factors

Organizational Leadership. Effective leadership fosters an inclusive environment where minorities feel valued. A qualitative study conducted in Sweden by Eriksson et al. (2018) found that supportive managers helped IENs regain confidence during challenging stages. Within the clinical aspect of workplace integration, clear and concise guidance from managers enhances IENs' ability to perform tasks accordingly. Kamau et al. (2022) reported that UK hospitals with proactive leadership saw IENs quickly adapt to clinical protocols. Moreover, managers who clarify roles and expectations aid IENs in understanding host systems. Newton et al. (2012) observed that IENs benefited from managerial guidance in navigating unfamiliar healthcare structures, aligning with Feldman's Model of Organizational Socialization, which emphasizes role clarity as a socialization outcome (Feldman, 1976; Newton et al., 2012). In Canada, supportive leadership reduces emotional strain, and subsequently, IENs felt more professionally affirmed when managers advocated for them (Newton et al., 2012). Conversely, unsupportive leadership exacerbates challenges. Pressley et al. (2022) noted that IENs in the US experienced

higher turnover when managers failed to address their integration needs. In another study conducted in Australia, Pung and Goh (2017) showed that leaders who model cultural sensitivity, improved IENs' behavioural inclusion in healthcare teams and adaptation to their new environments. This dual role of leadership as a barrier or enabler underscores its systemic influence on workplace integration.

Racism. Racism, defined as negative beliefs (stereotypes), attitudes (prejudice), and behaviours (discrimination) based on race, ethnicity, or perceived foreignness (Gee et al., 2019; Paradies et al., 2015), is a pervasive system-level barrier affecting immigrant integration. In the United States, immigrants face interpersonal racism through xenophobic coworker remarks (i.e., prejudice against people from other countries), resulting in emotional distress and isolation (Williams et al., 2019). This can also result in reduced workplace participation and productivity (Salari et al., 2024), hinder integration, and lead to poor health outcomes (Szaflarski & Bauldry, 2019). At the institutional level, discrimination against ethnic and religious minorities contributes to the underutilization of an immigrant's skills (Raihan et al., 2023). Smith et al. (2021) explained that racism emerges through cultural stereotypes. They found that UK immigrants experienced emotional strain from being labeled as outsiders. Furthermore, societal attitudes hinder integration, as a study on the health of immigrant workers in Spain revealed that immigrants experienced confusion while adjusting to cultural norms due to public hostility (Agudelo-Suárez et al., 2011). Creating an inclusive organization that addresses all aspects of fairness, equity, acceptance, and belonging proves crucial in facilitating the workplace integration of IENs beyond mere survival. For instance, many organizations implement racism training programs in different formats to advance diversity, equity, and inclusion (DEI) and antiracism in the workforce (Wang et al., 2023). These challenges, aligned with Berry's

Acculturation Framework (1992), highlight how host rejection impedes adaptation, significantly hindering immigrants' integration.

Structured Programs and Mentorship. Structured programs and mentorship are critical system-level enablers that support integration. A systematic review by Viken et al. (2018) noted that adequate orientation programs can reduce anxiety and stress for IENs experiencing transition. Although the term *mentorship* is often used interchangeably with supervisor, preceptor, or facilitator, Hawkins and Fontenot (2010) described mentorship as a supportive relationship built on trust, in which a more experienced individual (the mentor) guides and serves as a role model for the mentee (i.e., someone with less experience). Well-designed mentorship and orientation programs can foster an understanding of enduring elements of practice within an organization, influencing the personal development and career growth of participants (Burgess et al., 2018). A recent scoping review on the impact of orientation programs for new nurses in hospitals revealed that programs with well-designed components and optimal duration enhanced nurses' competence, knowledge, confidence, satisfaction, and professional development, while also yielding positive organizational outcomes (Ernawaty et al., 2024). Several countries, like Canada and the UK, have implemented specifically designed bridging programs to support the transition of IENs into practice. In Canada, these programs are offered in various formats (e.g., hybrid, simulation-based) and include diverse components such as nursing knowledge, protocols, and language skills (Covell et al., 2017). In a mixed-methods systematic review, Cubelo et al. (2024) demonstrated that structured bridging programs can significantly reduce frustration and disappointment, thereby facilitating the transition process for IENs. Although IENs possess prior nursing experience, there remains a need to enhance holistic and patient-centered care, as

insufficient knowledge in these areas can hinder effective care delivery and jeopardize patient safety.

Supportive Workplace Environment. Fostering a welcoming and encouraging workplace atmosphere is a crucial step in facilitating successful IEN integration (Kishi et al., 2014). Establishing a learning culture and a better working climate is essential for promoting professionalism and desirable outcomes (Boswell et al., 2017; Luthans et al., 2008). Akay and Ahmadi (2022) noted that immigrant employees, regardless of their profession, can face various stressors, and managers are responsible for creating and maintaining a sound, equitable, and inclusive working environment. A supportive workplace environment can promote mental wellness, increase employee engagement, enhance productivity, and increase retention (Ahakwa et al., 2021; Yusliza et al., 2021; Zhenjing et al., 2022). When the team invests time in supporting IENs in the workplace and addressing their challenges, it has a favorable impact on the overall integration process (Roth et al., 2023). Gomez and Bernet (2019), noted that diverse healthcare teams that are supported by inclusive environments, improve patient outcomes and satisfaction, particularly in culturally diverse communities. This is relevant for IENs, whose diverse backgrounds can enrich patient care when supported appropriately.

Response Domains

The focus on emotional, cognitive, and behavioural response domains was informed by existing research on integration and adjustment processes. According to the evidence, when individuals integrate into new environments, they exhibit various responses that can be organized into three domains of affective reactions, cognitive processing changes, and observable behavioural modifications (Geng et al., 2023; Khera & Rangasamy, 2021; Khoddam, 2024). In other words, when IENs integrate into new workplace environments, they can exhibit emotional

responses (feelings and affective reactions), cognitive responses (thoughts and mental processes), and behavioural responses (observable actions and strategies). These three response domains provide a structured yet comprehensive approach to understanding the multifaceted nature of IENs' workplace integration experiences.

Emotional Responses

Irrespective of an individual's emotional intelligence or available emotional support, emotional regulation typically occurs when confronting new experiences. Emotional responses, the result of emotional regulation, are defined as multicomponent responses that manifest over a relatively short span of time and occur in response to a stimulus, event or situations (King, 2020). Emotions can be classified into various dimensions, such as valence, which distinguishes them as positive or negative. For instance, during early stages of integration into new environment, individuals can show both positive and negative emotions (e.g., excitement, fear) (Crocker, 2015; King, 2020).

Immigration and relocation to a new environment often triggers complex emotional and psychological responses (Hausman & Reed, 1991). Internationally educated nurses report an initial sense of excitement, with positive anticipation largely influenced by the promise of better remuneration, professional recognition, career advancement opportunities, and improved living conditions (Dywili et al., 2011; Eriksson et al., 2023). However, these positive feelings are usually followed by anxiety and disharmony due to unfamiliar cultural and workplace settings (Balante et al., 2021). Each workplace environment has its own hierarchical structures and characteristics which can be compounded by implicit biases and discriminatory practices (Wingfield & Chavez, 2020), leading to unfavorable emotional responses. These responses can also manifest as physiological symptoms ranging from stress-related conditions (Cherry, 2023)

to fatigue secondary to discrimination (Seeger, 2024; Theorell-Haglöw et al., 2006). Collectively, IENs' emotional responses reflect a spectrum from optimism to vulnerability.

Cognitive Responses

Cognitive responses refer to the internal processes and self-directed dialogue that are triggered when an individual encounters a specific stimulus. In psychology, cognitive response refers to the mental processes through which individuals interpret, analyze, memorize and retrieve information, which ultimately shapes their attitudes and influences their behaviour (Khera & Rangasamy, 2021). Cognitive responses occur during cognitive processes (e.g., integration) and they can involve various aspects of perception, memory, reasoning, judgment, and problem-solving (Cherry, 2024; Dhakal & Bobrin, 2023). Cherry (2025) asserts that when two individuals with differing cultural backgrounds and values interact in a new environment, they are likely to experience cognitive dissonance. Cognitive dissonance is the mental discomfort that results from holding two conflicting beliefs, values, or attitudes. These experiences can result in different cognitive responses like rationalizing, being ashamed, embarrassed or experiencing guilt and regret.

For instance, IENs may need to reconcile differences between their prior training and the standards of HICs healthcare systems, requiring them to reframe their understanding of clinical practices or patient care. This cognitive reorientation involves assimilating new information and adapting to current structures while retaining their existing knowledge (Covell et al., 2017). Throughout the integration process, individuals may exhibit various cognitive responses, such as questioning their competence, experiencing self-doubt about their capabilities, and developing uncertainty regarding their professional identity (Serafin et al., 2022). These responses can result in reduced self-esteem, negatively impact their well-being, and lead to inappropriate decision-

making within the healthcare environment, ultimately affecting the quality of care provided (Serafin et al., 2022; Witkin, 1982).

Behavioural Responses

Actions and change in the activity that are performed by a person as a conscious response to external or internal stimuli are called behavioural responses (Pal, 2022). According to Smollan (2006), behavioural responses to change are shaped by a combination of individual factors (i.e., emotional intelligence, prior change experiences), the attributes of change managers (leadership competence), and organizational elements (culture and context). While several individual and system-level factors can influence IENs, behavioural responses are usually the result of underlying cognitive and emotional reactions (Smollan, 2006). Several scholars in the fields of organizational psychology and management have emphasized that an employee who is optimistic about the new workplace (cognitive) and experiences positive exhilaration from coworkers (emotional) is more likely to show willingness to engage in assigned tasks and may even attempt to exceed performance expectations (Antonacopoulou & Gabriel, 2001; French, 2001; Smollan, 2006). A similar phenomenon can manifest as negative behavioural responses when expectations are unmet, and conflicts emerge. New employees may exhibit various counterproductive behaviours, including strikes, work slowdowns, task avoidance (Skarlicki et al., 1999; Li et al., 2017), or even voluntary turnover through job abandonment or intent to quit (Li et al., 2017; Turnley & Feldman, 1999). Therefore, behavioural responses (positive, negative, neutral or mixed) carry implications for patient care, as adaptability can enhance collaboration, while disengagement may compromise team efficacy.

Rationale and Significance of the Scoping Review

The global nursing shortage has intensified the reliance on IENs to sustain healthcare systems in destination HICs. In such circumstances, patient safety and the quality of care can be significantly affected, especially when migrants are involved as healthcare providers. Effective teamwork relies on open communication, mutual respect, and a shared sense of purpose. However, when subgroups (e.g., IENs) form within the workplace, these dynamics can be disrupted, potentially leading to conflicts.

Studies have identified the many challenges and barriers encountered by IENs throughout their integration journey (Alostaz et al., 2024; Ghazal et al., 2019). Foreign educated nurses typically face a range of difficulties during pre-migration, licensing, and workplace integration stages. These include communication and language barriers (Lum et al., 2014), racism and discrimination (Baptiste, 2015), costly and time-consuming credential assessments (Alostaz et al., 2024), differing scopes of practice, and unfamiliarity with new healthcare systems (Ghazal et al., 2019). To address these issues many organizations and HICs have implemented various solutions such as bridging programs and supportive working conditions to assist IENs, enhance operational efficiency, and ensure patient safety (Cubelo et al., 2024c; Viken et al., 2018). Previous reviews have focused on different aspects of the IEN experience. Abuliezi et al. (2020) examined the experiences and challenges of nurses working in Japan under the country's Economic Partnership Agreement (EPA). Rajpoot et al. (2024) conducted a systematic review of the general IEN population, emphasizing challenges and push-pull factors in host countries. Likupe (2006) explored the experiences of African nurses and the challenges they face in the UK's National Health Service.

In contrast, this scoping review adopts a unique perspective by focusing specifically on workplace integration and the responses IENs exhibit when facing challenges. The population of interest consists of IENs from LMICs, as their experiences differ from those of IENs moving between HICs, and because most IENs globally originate from LMICs. Importantly, this review does not cover pre-departure or licensing challenges but rather centers on how IENs respond to integration challenges within the workplace. The responses will be categorized into three main domains: emotional, cognitive, and behavioural, mapping them to previously identified barriers and challenges.

Whether the responses are positive or negative, this review is essential for understanding how IENs respond to workplace integration challenges. For one, it helps identify existing knowledge gaps and highlights areas for future research. Additionally, it provides a valuable foundation for policymakers and stakeholders to consider the full spectrum of responses and make informed decisions when designing future interventions, grounded in current evidence.

Chapter 3: Method

Methodology: Scoping Review

A scoping review was selected as the most appropriate method, as it offers a systemic approach to explore the breadth of existing literature, while mapping and analyzing the existing evidence to provide a comprehensive overview of emerging or poorly understood issues, identifying what is known about a phenomenon, knowledge gaps and informing future research initiatives (Peters et al., 2024; Tricco et al., 2018). This scoping review examined studies on IENs' integration to identify the key characteristics or factors related to the concept (Munn et al., 2018). The review was conducted following the JBI methodology for scoping reviews (Peters et al., 2024). Following the methodological guidelines outlined within the JBI Manual for Evidence Synthesis (Peters et al., 2024) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al. 2018), a scoping review protocol was developed for this research.

The main criteria for the scoping review include: (1) identifying the research question(s), (2) identifying the relevant research/search strategy, (3) evidence screening and selection, (4) data extraction, and (5) analysis and presentation of results.

Research Questions

The research questions were developed to help explore the complex nature of workplace integration responses and illustrate what is known about this phenomenon, while maintaining a focused examination of specific response types and their triggers. One primary question (i) and two sub questions (ii, iii) guided this scoping review, and include: (i) What is known about how IENs, from low- and middle-income countries, respond emotionally, cognitively and

behaviourally to workplace integration in high-income countries' healthcare environments? (ii) What are the factors that precipitate emotional, cognitive, and behavioural responses amongst internationally educated nurses during their integration? (iii) What are the current gaps in the literature regarding the responses of internationally educated nurses to workplace integration in healthcare environments within high-income countries?

Identifying Relevant Studies and Search Strategy

The principal investigator worked closely with a health science librarian to develop the search strategy. The search strategy aimed to find both published and unpublished primary studies including grey literature. The recommended three-phase search strategy was implemented to identify available and relevant evidence (Peters et al., 2024). The initial phase involved a limited search conducted in MEDLINE (Ovid) and CINAHL (EBSCO) to identify studies relevant to the topic with the help of the health science librarian. The finalized MEDLINE (Ovid) search strategy was developed through preliminary searches, analysis of relevant article text words and index terms, and multi-stage calibration. In the second phase, a finalized MEDLINE (Ovid) search strategy was translated into each included database using the appropriate syntax and index terms for that database to search for relevant articles. Systematic searches were conducted across multiple electronic databases, including MEDLINE (Ovid), CINAHL (EBSCOhost), Embase (Elsevier), PsycINFO (EBSCOhost), Cochrane CENTRAL, and JBI Evidence Synthesis database (Ovid). Unpublished evidence (gray literature) was explored in ProQuest Dissertations & Theses Global (ProQuest) and the first ten pages of Google search.

To guide evidence retrieval, key search terms were developed through an iterative process. The search was not limited by language or date. A complete list of the final search strategy using these terms, along with Boolean operators and database-specific syntax for

included electronic databases, is presented in detail (see Appendix A). In the third phase, the reference lists of the final included articles were reviewed, and citation tracking was used to identify relevant studies; however, no additional studies were identified for full-text review.

Evidence Screening and Selection

After the database searches, all identified studies were uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia) and duplicates were removed prior to screening. To ensure rigorous screening, a second reviewer with relevant background was invited to participate in the screening process. The principal investigator developed the inclusion and exclusion criteria and conducted two briefing meetings with the second reviewer to establish a mutual understanding of the protocol and other criteria. Inclusion criteria were selected in alignment with the review questions. The inclusion and exclusion criteria were structured according to the Population, Concept, and Context (PCC) framework for scoping reviews. Details of criteria are presented in Table 1.

Table 1

Inclusion and Exclusion Criteria

Elements	Inclusion Criteria	Exclusion Criteria
Population characteristics	• Internationally Educated Nurses (IENs) who completed their professional education in low- and middle-income countries (LMICs) and are currently working in high-income countries (HICs). • Working as Registered Nurse • Studies involving various internationally educated health professionals (e.g., nurses, physicians, and dentists) if IENs comprise 50% or more of the study population. • All relevant studies, regardless of participants' age, gender, ethnicity, race, specific country of origin within LMICs, level of education, or years of experience	• Studies focusing solely on local or domestic nurses within HICs • Nursing students (Domestic or International) • IENs moving between same country classifications • IENs from HICs • Other internationally educated health professionals (e.g., physician) • IENs that do not work as RN • Studies that do not include IENs • Studies that do not specify the country of origin of the IENs
Concept	• Any emotional responses regarding workplace integration experiences	• Emotional responses rooted in pre-existing conditions (e.g., Covid-19) or

Elements	Inclusion Criteria	Exclusion Criteria
	• Any cognitive responses regarding workplace integration experiences • Any behavioural responses regarding the workplace integration experiences • Any ameliorating and exacerbating factors related to each response	personal life events (e.g., being a refugee) • Cognitive responses rooted in pre-existing conditions or personal life events • Behavioural responses rooted in pre-existing conditions or personal life events • Any responses unrelated to workplace integration
Context	• Healthcare settings in HICs • Private or Public sector • HICs according to World bank classifications: American Samoa / Andorra / Antigua and Barbuda / Aruba / Australia / Austria / Bahamas, The / Bahrain / Barbados / Belgium / Bermuda / British Virgin Islands / Brunei Darussalam / Bulgaria / Canada / Cayman Islands / Channel Islands / Chile / Croatia / Curaçao / Cyprus / Czechia / Denmark / Estonia / Faroe	• Studies conducted in healthcare setting of the low- or middle-income countries • Academic settings like universities • IENs working in LMICs • Studies where the setting or country context cannot be clearly determined

Elements	Inclusion Criteria	Exclusion Criteria
	Islands / Finland / France / French Polynesia / Germany / Gibraltar / Greece / Greenland / Guam / Guyana / Hong Kong SAR, China / Hungary / Iceland / Ireland / Isle of Man / Israel / Italy / Japan / Korea, Rep. / Kuwait / Latvia / Liechtenstein / Lithuania / Luxembourg / Macao SAR, China / Malta / Monaco / Nauru / Netherlands / New Caledonia / New Zealand / Northern Mariana Islands / Norway / Oman / Palau / Panama / Poland / Portugal / Puerto Rico / Qatar / Romania / Russian Federation / San Marino / Saudi Arabia / Seychelles / Singapore / Sint Maarten (Dutch part) / Slovak Republic / Slovenia / Spain / St. Kitts and Nevis / St. Martin (French part) / Sweden / Switzerland / Taiwan, China / Trinidad and Tobago / Turks and Caicos Islands / United Arab	

Elements	Inclusion Criteria	Exclusion Criteria
	Emirates / United Kingdom / United States / Uruguay / Virgin Islands (U.S.)	
Evidence Characteristic	• In any language • No limitation for date of publication • Peered-reviewed studies, evidence syntheses, unpublished evidence, grey literature	• Due to the inclusion of both primary studies and evidence syntheses, primary sources were excluded if they were already fully incorporated in an included evidence synthesis, unless they presented unique data not otherwise reported in that synthesis.

Two independent reviewers screened titles and abstracts against predetermined inclusion criteria. Prior to screening, pilot screening of 20 randomly selected records was conducted by both reviewers independently. During the title and abstract screening phase, reviewers independently identified additional duplicate studies that were not automatically detected by Covidence. During the full text screening stage, records were screened by two reviewers independently and were excluded if they did not meet inclusion criteria. During full-text screening phase, if articles were inaccessible through university library resources, the corresponding author was contacted directly via email (with a maximum of two contact attempts made) to request access to their complete manuscripts. To ensure methodological rigor and minimize bias throughout the entire screening process, the screening process was blinded; reviewers were unable to view each other's screening results until they had independently

completed their reviews. Disagreements were resolved through discussion at each stage of the screening process.

Data Extraction

Data extraction was conducted using a standardized tool adopted from the JBI template and tailored specifically to capture information relevant to the review objectives. Data extraction was independently conducted by the principal investigator (PM) with additional quality assurance through random sample checks performed by a second reviewer (MR), to maintain consistency and rigor throughout the data charting process. The tool was piloted on a subset of included sources to ensure clarity, feasibility, and robustness of the data charting process. The extraction tool captured detailed information about study characteristics such as author(s), study location, target population, design, key findings related to responses and triggers, and recommendations for practice and research (if applicable). We modified the data extraction tool during the iterative data charting process, as recommended by the JBI Manual for Evidence Synthesis (Peters et al., 2024), which acknowledges that refinements may be necessary during data extraction. First, we added a row to record the *title of each article*. This addition was made to enhance transparency and improve clarity, especially in cases where the same authors had published multiple distinct studies in the same year. Including the title ensured more precise referencing and easier tracking of the included sources. Second, we modified the original "Measurements" section in the data extraction tool. Initially, this section was designed to capture both *what* was measured (key variables) and *how* it was measured (assessment metrics). However, consistent with the primary aim of a scoping review, our study objectives focused on mapping the current evidence reported in the literature rather than evaluating measurement

quality or methodology; therefore, we refined this section to focus exclusively on what each study measured. Definitions for each descriptor have been provided in Table 2.

Table 2

Descriptor Definitions Used in the Data Extraction Tool

Descriptor	Definition
Title	Full title of evidence
Author(s)	Full names of researchers who conducted/published the study
Year	Publication date of the research (month if available)
Type of evidence	Category of research output (e.g., peer-reviewed article, report, thesis)
Country	Geographic location where study was conducted (If multiple countries or specific cities/regions, list all)
Healthcare setting	Specific medical environment (e.g., hospital, clinic, long-term care)
Aims/purpose	Primary objectives
Study design and Methodology	Research approach and methods used
Data collection	Techniques used to gather information
Population and sample size	Participant characteristics (e.g., origin) and number
Study Focus	WHAT the study measured
Related key findings	Major outcomes relevant to research question

Following JBI guidelines for scoping reviews (Peters et al., 2022; JBI Manual for Evidence Synthesis, 2024), this review did not include critical appraisal of individual sources.

This approach aligns with the primary aim of scoping reviews to map and describe available literature rather than evaluating methodological quality of individual studies. Any conflict between the two independent reviewers was resolved through discussions during charting until a decision on inclusion or exclusion was reached.

Data Analysis

A systemic approach was employed to identify patterns and key findings emerging from literature related to IENs' responses. First, all extracted data from included sources were reviewed comprehensively by the primary reviewer (PM) to gain familiarity with the breadth and depth of available evidence. The analysis involved iterative examination of key findings related to emotional, cognitive, and behavioural responses, organizing them according to the three research questions. Response patterns were identified through systematic categorization of findings within each domain, with particular attention to the temporal progression of responses and their triggering factors. Common response types were grouped based on similarity of reported experiences across different studies. Factors influencing IEN responses were systematically categorized as either ameliorating or exacerbating based on their reported effects on integration outcomes. To ensure analytical consistency, the extracted data from more than 50% of the included sources was independently reviewed by the second reviewer to validate emerging patterns and themes.

Following PRISMA-ScR reporting guidelines, findings are presented through a combination of narrative description and visual representations (tables, and figures). The specific results of this analysis are presented in the subsequent results chapter.

Chapter 4: Results

This chapter presents the findings from the scoping review, organized to address each research question systematically. The results reveal complex patterns in how IENs from LMICs respond to workplace integration challenges, the factors influencing these responses, and significant gaps in current literature.

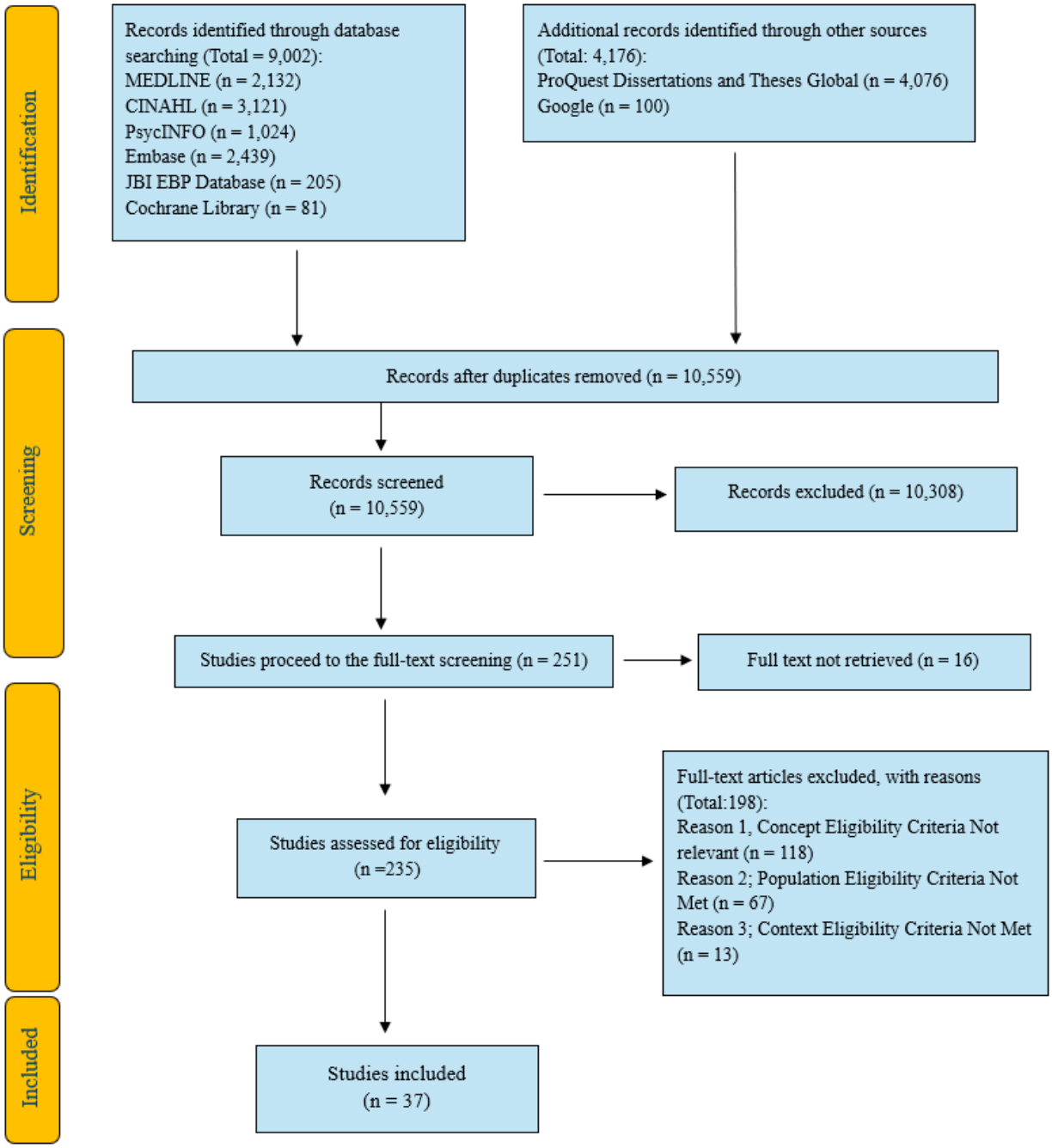
Search Results

The systematic search conducted in December 2024 identified 13,178 potentially relevant sources of literature. After removing 2,619 duplicates, 10,559 records underwent title and abstract review. Of these, 10,308 records were removed, leaving 251 records for full-text screening. Sixteen studies were not retrieved as the full text was not available, leaving 235 records for full text screening. Full-text screening was conducted based on predetermined inclusion and exclusion criteria structured according to the PCC framework. As a result, 198 records were excluded with documented reasons. The complete list of excluded records and corresponding reasons for exclusion are categorized and presented (See Appendix B). The most common reasons for exclusion were that studies focused on nursing students instead of registered nurses. Additionally, many records were excluded because they examined other internationally educated health professionals such as physicians, or involved IENs from HICs rather than from LMICs, and studies where IENs comprised less than 50% of the study population. Concept-related exclusions occurred when records focused solely on challenges or problems without addressing emotional, cognitive, or behavioural responses related to workplace integration. Records that examined responses influenced by pre-existing conditions, such as COVID-19, or personal life events were also excluded. Context eligibility criteria were not met when studies were conducted in healthcare settings within LMICs rather than HICs, or when they took place in

academic settings such as universities rather than clinical practice environments. After full text screening, 37 sources met all eligibility criteria and proceeded to data extraction. The PRISMA flow diagram (Figure 1) illustrates the systematic screening process, detailing the number of records identified, screened, and included in each stage.

Figure 1

PRISMA-ScR Study Selection Flow Diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

Characteristics of Included Sources

Publication Characteristics

The 37 included sources were developed between 2005 and 2024. Of these, seven (18.9%) were from 2005–2009, nine (24.3%) from 2010–2014, nine (24.3%) from 2015–2019, and twelve (32.4%) from 2020–2024. The included sources comprised 26 published primary research articles, nine unpublished doctoral dissertations, one unpublished master's thesis (2.7%), and one literature review (2.7%). Among the 36 primary research sources (excluding the literature review), qualitative methodologies dominated the research approach (*n*=30, 83.3%), including phenomenology (*n*=14, 38.9%), qualitative descriptive approaches (*n*=5, 13.9%), grounded theory (*n*=5, 13.9%), ethnography (*n*=2, 5.6%), case studies (*n*=2, 5.6%), sources with unspecified qualitative methodologies (*n*=1, 2.8%), and narrative inquiry (*n*=1, 2.8%). The remaining primary research sources employed cross-sectional and survey designs (*n*=4, 11.1%) and mixed methods (*n*=2, 5.6%). Geographically, the included sources were conducted across multiple HICs, with the United Kingdom (*n*=14, 37.8%) and the United States (*n*=13, 35.1%) as the most represented, followed by Australia (*n*=5, 13.5%), Saudi Arabia (*n*=2, 5.4%), Canada (*n*=2, 5.4%), and Japan (*n*=1, 2.7%).

Participant Characteristics

The 36 primary research sources included diverse IEN samples, with Filipino nurses being the most frequently studied population, present in 22 sources (61.1%), followed by nurses from African countries in 18 sources (50.0%), Indian nurses in eight sources (22.2%), nurses from East/Southeast Asia in nine sources (25.0%), and nurses from the Middle East in three sources (8.3%). Biological sex was reported across sources, with 25 studies (69.4%) reporting

mostly female samples, four studies (11.1%) noting balanced biological sex representation, and seven studies (19.4%) not reporting biological sex distribution.

Findings Related to Research Questions

The findings below address the three research questions guiding this review. First, the emotional, cognitive, and behavioural responses demonstrated by IENs during workplace integration are mapped and described. Second, the key factors that precipitate and influence these responses are identified and analyzed. Finally, current gaps in the literature regarding IENs' workplace integration experiences are highlighted. Complete source characteristics and extracted findings for all 37 included sources are presented in Appendix C.

Emotional Domain

Initial Emotional Responses. During early integration, IENs commonly experienced initial optimism and excitement about their new work environments, with nurses expressing enthusiasm for professional integration and reporting an increased sense of opportunity in their workplace transitions (Alonso-Garbayo, 2007; Alshayeg, 2023). This positive enthusiasm often stemmed from specific expectations, including desires for better socio-economic positions and professional development opportunities compared to their home countries (Dahl et al., 2021; Geun et al., 2016). The initial optimism was, however, frequently replaced by emotional distress when IENs encountered workplace realities different from their expectations, triggering feelings of shock and disillusionment that subsequently led to uncertainty and fear (Adhikari & Melia, 2015; Alexis, 2013; Alvaro, 2007; Hughes, 2008; Lin, 2013; Jose, 2010, 2011; Murphy, 2008). Anxiety, fear, and nervousness emerged as common emotional responses across various workplace contexts, including fears about making mistakes, anxiety when facing unfamiliar

medical equipment, and heightened nervousness during interactions with physicians and management (Delos Reyes, 2019; Dildar, 2015; Iheduru-Anderson, 2018; Likupe, 2013; Lin, 2013; Murphy, 2008; Obrey, 2013).

Feelings of isolation and loneliness were consistently reported (Alvaro, 2007; Clark, 2020; Dildar, 2015; Joseph et al., 2021; Pettey, 2016; Reyes, 2019). Internationally educated nurses described experiencing exclusion from team interactions and feeling like outsiders due to an inability to develop a sense of belonging (Alexis, 2013; Alvaro, 2007; Clark, 2020; Dildar, 2015; Joseph et al., 2021; Pettey, 2016; Reyes, 2019; Uwabuike, 2021).

Emotional Responses to Workplace and Professional Changes. Internationally educated nurses experienced a range of emotional responses with respect to professional devaluation and challenges to their professional identity. A phenomenological study of internationally recruited neonatal nurses in the UK revealed feelings of "being back to square one and back to zero" (Alexis & Shillingford, 2011, p. 4) when their prior experience was unrecognized, despite having substantial professional experience in their home countries (Hughes, 2008). Professional devaluation led to feelings of inadequacy and psychological stress. Frustration and disappointment emerged when IENs realized their career aspirations could not be fulfilled or when they encountered work realities different from their expectations (Adhikari & Melia, 2015; Alonso-Garbayo, 2007; Dildar, 2015; Iheduru-Anderson & Wahi, 2018).

Humiliation and emotional distress resulted from experiences of racist bullying by managers and colleagues, as well as unfair performance reviews (Allan et al., 2009; Alexis & Shillingford, 2011; Alexis & Vydelingum, 2005). Anger was reported in response to racism, particularly when nurses felt their abilities were undermined or when they experienced salary inequities (Estacio & Saidy-Khan, 2014; Iheduru-Anderson & Wahi, 2018; Van Rooyen et al.,

2010). Experiences of unfair treatment, including discriminatory managerial decisions, broken promises regarding career development, discriminatory scheduling, and favoritism toward local nurses, not only generated anger but also led IENs to develop feelings of distrust toward their supervisors and healthcare organizations (Delos Reyes, 2019; Likupe, 2013; Uwabuike, 2021).

Emotional Responses Following Initial Adjustment. As IENs gradually adapted to their new environments, their emotional responses shifted toward more positive experiences. Pride and validation were felt when they received appreciation from patients (Alexis, 2013) and satisfaction when overcoming initial challenges (Jose, 2010). For example, a quantitative study with 1,215 IENs in Canada found that building good relationships with coworkers ($ß = 0.043$, $p < .005$) and developing nursing knowledge and skills ($ß = 0.178$, $p < .003$) significantly fostered feelings of acceptance and belonging (Covell & Sands, 2020).

Joy and satisfaction emerged as positive emotional responses when IENs successfully navigated complex work environments and achieved professional milestones. Sources documented feelings of accomplishment when IENs developed autonomous practice roles, demonstrated confident clinical decision-making, and gained recognition for their clinical competence (Jose, 2010; Lin, 2013). These positive emotions were particularly evident when IENs felt their professional expertise was valued and when they could contribute meaningfully to patient care outcomes.

Behavioural Domain

Avoidance and Withdrawal Behaviours. Internationally educated nurses commonly adopted avoidance and withdrawal strategies when facing workplace challenges. Social withdrawal emerged as a predominant response to discrimination and exclusion, with IENs from Philippines avoiding interactions with local nurses in workplace environments (Allan et al.,

2009; Alexis, 2013; Delos Reyes, 2019). Across multiple settings, IENs from the Philippines and African countries working across the UK and Australia refrained from confrontation and tolerated racial microaggressions to maintain employment stability and, became less communicative than expected (Alexis, 2013; Clark, 2020; Crawford et al., 2017; Estacio & Saidy-Khan, 2014; Hughes, 2008).

These withdrawal patterns extended to workplace participation, where IENs from African countries adopted silence, withdrawal, and reduced participation in workplace activities (e.g., team meetings) when experiencing unfair treatment from peers and leadership (Iheduru-Anderson et al., 2021).

Communication avoidance manifested in various forms including not speaking up when reprimanded by colleagues (Crawford et al., 2017), not initiating conversations with colleagues (Delos Reyes, 2019), not answering unit phone calls, and distancing themselves from local colleagues during lunch to minimize speaking English (Johnson, 2018; Liou & Cheng, 2011). In some cases, avoidance extended to patient care, with African nurses avoiding attending to patients with racist tendencies due to fear of false accusations during patient care assignments (Likupe, 2013).

Overcompensation and Demonstrating Competence. Internationally educated nurses are commonly engaged in overcompensation behaviours to prove their professional competency and address feelings of inadequacy during workplace integration. (Alexis & Shillingford, 2011; Connor, 2016; Estacio & Saidy-Khan, 2014). These behaviours included working beyond scheduled shifts and taking on additional overtime hours during early employment periods, pursuing additional qualifications and education beyond licensure requirements such as specialty certifications, taking accent modification classes and watching television programs to adapt to

local communication styles, and actively seeking mentoring and educational opportunities to overcome adaptation barriers (Alexis, 2013; (Pettey, 2016; Iheduru-Anderson, 2020).

These overcompensation strategies appeared to serve dual purposes: coping with feelings of inadequacy during early months of employment while simultaneously proving professional competency to colleagues and supervisors and attaining professional recognition and collegial respect (Iheduru-Anderson, 2020; Iheduru-Anderson & Wahi, 2018; Johnson, 2018; Likupe, 2013).

Coping Behaviours and Support Networks. Developing and utilizing support networks were identified as key behavioural coping mechanisms during workplace integration. Internationally educated nurses predominantly sought support from colleagues of the same nationality or ethnic group rather than local nurses, creating networks with other IENs and encouraging family members to provide additional support with responsibilities such as childcare (Alexis, 2013; Alexis & Shillingford, 2011; Alexis & Vydelingum, 2005; Connor, 2016; Uwabuike, 2021).

Beyond social support networks, IENs employed diverse individual coping strategies including engaging in physical activities, socializing, prayer, and increased communication with family via email and phone calls (Al-Nusair & Alnjadat, 2022). Spiritual and religious practices served as important emotional coping strategies when experiencing workplace stress (Connor, 2016; Uwabuike, 2021; Van Rooyen et al., 2010).

Cultural identity management emerged as another coping mechanism, with IENs developing strategies such as switching off or compartmentalizing their cultural identity, adopting different behaviours at work while maintaining their cultural norms at home (Johnson,

2018; Zhou, 2014). Professional help-seeking, including therapy, was utilized to manage workplace stress and emotional distress from discrimination (Iheduru-Anderson et al., 2021).

Adaptation and Learning Strategies. In later stages of integration, IENs developed diverse active adaptation and learning strategies across professional, communicative, and cultural domains. Professional adaptations included learning to be more assertive, adopting proactive approaches to patient advocacy, and developing observational learning strategies such as *copy-cat* and *shadowing* techniques to acquire new practices (Lin, 2013; Murphy, 2008).

Communication adaptations involved conscious efforts to learn and adapt to different communication styles, engaging with local media to better understand local culture and improve social integration at work, and developing documentation strategies such as carrying notebooks to record patient information and work-related notes to ensure accurate communication when encountering verbal communication difficulties (Delos Reyes, 2019; Jose, 2010; Joseph et al., 2021).

Cultural adaptation behaviours emerged as another important dimension, with IENs finding creative ways to maintain cultural and religious practices within local restrictions, such as holding discreet religious gatherings using code words to comply with local religious regulations (Van Rooyen et al., 2010). These adaptation strategies demonstrated IENs' initiative in developing creative solutions to navigate workplace integration barriers.

Career Navigation and Mobility. Internationally educated nurses employed distinct strategies to navigate career barriers and workplace challenges. Career positioning strategies included accepting entry-level positions despite holding advanced clinical specializations due to credential recognition obstacles and institutional biases (Adhikari & Melia, 2015; Alexis &

Vydelingum, 2005). Career advancement challenges prompted various behavioural responses, including discontinuing pursuit of promotions after facing discriminatory rejection, declining advancement opportunities requiring advanced language proficiency, and deliberately avoiding managerial and faculty applications due to anticipated accent-based discrimination (Alexis & Vydelingum, 2009; Iheduru-Anderson, 2020; Nagaya et al., 2024).

Geographic mobility emerged as a significant strategic response, with IENs strategically relocating to regions with established cultural communities for enhanced support and acceptance (Dildar, 2015). When workplace conditions became untenable, IENs demonstrated decisive mobility responses including resigning from positions with toxic environments, departing due to racist bullying, and planning migration to other countries with healthier workplace environments where they believed they would be more accepted (Allan et al., 2009; Alonso-Garbayo, 2007; Iheduru-Anderson et al., 2021; Pressley et al., 2024).

Cognitive Domain

Workplace Reality. When IENs recognized discrepancies between their pre-migration expectations and actual workplace conditions, various cognitive responses emerged. Internationally educated nurses commonly acknowledged that their initial expectations about nursing practice were inaccurate after experiencing the actual work environment (Adhikari & Melia, 2015). Similarly, individuals with extensive experience expected a smooth workplace transition but faced major cultural and system related barriers, such as unfamiliar documentation systems, and workplace discrimination (Alexis & Vydelingum, 2005; Alexis, 2013; Hughes, 2008).

These reality-expectation gaps were further compounded by perceived significant professional differences, role ambiguity, and unclear expectations including different scopes of nursing practice during initial work experiences (Alexis, 2013; Jose, 2010). Recognition of workplace realities triggered cognitive reframing strategies, with IENs shifting perspectives to emphasize job satisfaction despite challenges or recalibrating expectations to focus on financial stability rather than career growth (Alonso-Garbayo, 2007; Pettey, 2016).

Professional Devaluation. Internationally educated nurses experienced significant shifts in professional self-perception and career progression when their qualifications and expertise were not recognized or utilized appropriately. Professional identity shifts occurred when IENs were assigned to basic care tasks rather than positions matching their expertise, with many transitioning from specialized nurse identities to general care provider roles despite holding qualifications in specialized areas. The misalignment between qualifications and job placement, including predominant placement in nursing homes rather than specialized units, led to feelings of professional devaluation and gradual deskilling of specialized abilities, resulting in diminished professional confidence (Adhikari & Melia, 2015; Alexis & Shillingford, 2011; Alvaro, 2007; Iheduru-Anderson, 2020). Professional stagnation (i.e., limited career advancement opportunities despite holding advanced qualifications), emerged as a form of professional devaluation (Iheduru-Anderson, 2020; Zhou, 2014). This included perceptions of inequitable career progression, with some IEN groups experiencing fewer advancement opportunities compared to others (Alexis & Shillingford, 2011; Alexis & Vydelingum, 2009; Iheduru-Anderson, 2020; Zhou, 2014).

Perception of Inequality. Internationally educated nurses perceived inequality within the workplace, recognizing differential treatment based on race and nationality across multiple

healthcare settings. (Alexis & Vydelingum, 2009; Alexis, 2013; Nagaya et al., 2024). These perceptions encompassed several dimensions of workplace inequality. Career advancement inequality was evident, with IENs recognizing discriminatory practices despite expecting procedural fairness, and observing that advancement systems favored certain nationalities over others, such as Filipino and Indian nurses over African nurses, or Western nurses over others in some contexts (Al-Nusair & Alnjadat, 2022; Alexis, 2013; Alexis & Vydelingum, 2005; Alexis & Vydelingum, 2009; Nagaya et al., 2024).

Performance requirement disparities were also recognized, with IENs believing they needed to demonstrate superior qualifications and exert double the effort to secure positions equivalent to local nurses, particularly amongst visible minority IENs who understood that their racial status impeded workplace integration (Covell & Sands, 2020; Dywilli et al., 2021; Iheduru-Anderson et al., 2021; Likupe, 2013). Cultural positioning awareness emerged as IENs recognized being situated as *the other* when experiencing differences in communication, values, and expectations (Zhou, 2014).

These perceptions of inequality led to cognitive recognition of survival requirements within inequitable systems. In particular, some acknowledged that maintaining employment necessitated enduring discrimination while continuously demonstrating competence and hiding their true feelings (i.e., emotional concealment) for workplace survival (Alexis & Vydelingum, 2005; Iheduru-Anderson et al., 2021).

Adaptive Cognitive Strategies. Internationally educated nurses developed various cognitive strategies to make meaning of their experiences and maintain psychological well-being. Reframing strategies were prominent, with IENs reframing challenges as opportunities for growth, maintaining hope as a strategy to overcome obstacles, and developing beliefs that

enduring hardships would lead to long-term benefits (Connor, 2016; Murphy, 2008; Van Rooyen et al., 2010; Zhou, 2014). These cognitive approaches included recognizing the need to build strength during adaptation, viewing hardships as contributing to growth and maturity, and perceiving the workplace as both challenging and an opportunity for growth (Alshayeg, 2023; Jose, 2010; Van Rooyen et al., 2010; Zhong et al., 2023; Zhou, 2014).

Rationalization emerged as another adaptive strategy, with IENs attributing unfavorable treatment from clients to external factors such as mental health status, accepting hierarchical structures that conflicted with their cultural beliefs, and attributing integration difficulties to systemic factors rather than personal deficiencies (Joseph et al., 2021; Uwabuike, 2021). Over time, as they adapted to workplace environments, many IENs developed resilience through these various cognitive coping mechanisms (Iheduru-Anderson & Wahi, 2018; Pettey, 2016; Zhou, 2014).

Ameliorating and Exacerbating Factors Influencing IENs' Responses

This section addresses the second research question by charting the key factors that either ameliorate or exacerbate IENs' emotional, behavioural, and cognitive responses during workplace integration, with some factors serving as protective elements while others intensified integration challenges.

Racism and Discrimination. Racism and discrimination emerged as the most prominent exacerbating factor intensifying negative responses across all domains (Allan et al., 2009; Alexis & Vydelingum, 2005; Alexis & Shillingford, 2011; Alexis, 2013; Al-Nusair & Alnjadat, 2022; Alshayeg, 2023; Clark, 2020; Covell & Sands, 2020; Delos Reyes, 2019; Dildar, 2015; Dywili et al., 2021; Estacio & Saidy-Khan, 2014; Iheduru-Anderson & Wahi, 2018; Joseph et al., 2021;

Likupe, 2006; Pettey, 2016; Uwabuike, 2021). Various forms of discrimination, ranging from subtle microaggressions to overt racist bullying, has been noted as contributing towards emotional breakdown and creating confusion and distress (Allan et al., 2009; Estacio & Saidy-Khan, 2014).

Visible minority status particularly intensified experiences of racism and discrimination, with accent-based and skin color-based discrimination leading colleagues to underestimate IENs' intellectual capabilities and subsequently, treat them unequally (Alexis & Vydelingum, 2009; Covell & Sands, 2020; Dywili et al., 2021; Iheduru-Anderson, 2020).

Professional Recognition and Deskilling. Workplaces that did not recognize IENs' prior qualifications and experience exacerbated multiple negative responses across all domains, including cognitive responses such as professional identity confusion, emotional responses such as frustration, and various behavioural adaptations (Alexis & Shillingford, 2011; Alexis & Vydelingum, 2005; Likupe, 2013). Lack of recognition at the workplace was also seen to intensify negative responses and integration difficulties across all response domains (Adhikari & Melia, 2013; Alvaro, 2007; Alexis & Shillingford, 2011; Alexis, 2013; Covell & Sands, 2020; Hughes, 2008; Likupe, 2006; Likupe, 2013; Murphy, 2008; Pressley et al., 2024). For instance, institutional placement in basic care units, such as long-term care units, regardless of previous specialized experience in critical care, led to deskilling and subsequently, cognitive and emotional dissonance (Adhikari & Melia, 2013; Dildar, 2015).

Conversely, appropriate professional recognition functioned as an ameliorating factor that facilitated positive emotional responses and professional identity development. When institutions acknowledged prior qualifications through formal validation processes and provided positions

matching expertise levels, IENs developed professional confidence (Al-Nusair & Alnjadat, 2022) and established clear professional goals (Jose, 2010).

Communication and Language. Despite meeting minimum language requirements for licensure, IENs experienced significant difficulties with dialect variations, medical terminology, and accent-related issues (Nagaya et al., 2024). Insufficient language proficiency and communication challenges served as a trigger for negative experiences. (Alexis, 2013; Alshayeg, 2023; Delos Reyes, 2019; Johnson, 2018; Liou & Cheng, 2011; Murphy, 2008; Nagaya et al., 2024; Obrey, 2013; Pettey, 2016; Zhou, 2014). In particular, African nurses were repeatedly asked to repeat themselves due to their accents (Iheduru-Anderson, 2020). Also, patient and colleague assumptions about communication competence that was based on accents functioned as additional exacerbating factors to negative responses, particularly when patients refused care from IENs due to perceived language barriers (Liou & Cheng, 2011; Nagaya et al., 2024)

However, organizational accommodation of communication differences improved integration experiences. Institutional policies encouraging slower speech, avoiding assignment of language-intensive tasks, providing interpreter services and providing educational programs like accent modification courses created supportive conditions that reduced communication-related stress and facilitated positive workplace interactions (Alshayeg, 2023; Iheduru-Anderson, 2020; Liou & Cheng, 2011; Pressley et al., 2024).

Cultural Distance. Initially, IENs do not often expect to face significant challenges from cultural diversity in the workplace environment, but as they enter the workplace, they realize that cultural differences are more difficult to cope with than anticipated (Jose, 2010). Cultural differences in nursing practice, professional values, and workplace norms created significant adaptation challenges that evoked adverse responses amongst IENs across multiple healthcare

settings (Alonso-Garbayo, 2007; Alexis, 2013; Alshayeg, 2023; Crawford et al., 2017; Delos Reyes, 2019; Dywili et al., 2021; Johnson, 2018; Jose, 2010; Zhou, 2014; Zhong et al., 2023). For instance, communication style differences emerged as particularly challenging, with IENs identifying Western communication patterns as distinctly direct and initially confrontational, while recognizing organizational interactions as more transparent than professional norms in their countries of origin (Crawford et al., 2017; Zhong et al., 2023). Joseph et al. (2021) reported that Indian nurses in Australian healthcare settings frequently questioned their migration decisions and contemplated returning to India after fully comprehending the extent of cultural differences in their new environment. Additionally, religious and cultural restrictions in certain contexts also caused negative experiences, with IENs showing adverse responses when required to adhere to local dress codes and cultural practices that conflicted with their personal beliefs (Van Rooyen et al., 2010).

On the other hand, having a greater cultural orientation served as an ameliorating factor that resulted in positive responses. For example, in a study of 195 IENs in the US by Cheng and Liou (2011), cultural orientation was positively correlated with organizational commitment (R^2 = 5.8%, B = 0.59, t = 3.34, p = 0.001) and perceptions of the practice environment (R^2 = 3.9%, B = 1.34, t = 2.69, p = 0.01), but negatively correlated with intention to leave (R^2 = 6.1%, B = −0.47, t = −3.53, p = 0.001). In other words, IENs with greater cultural awareness were more committed to their organizations, had better perceptions of the work environment, and were less likely to intend to leave their jobs.

Organizational Support. Inadequate orientation programs exacerbated transition difficulties, while comprehensive programs with timely implementation, well-designed content, and qualified mentors facilitated workplace integration (Alexis & Shillingford, 2011; Cheng &

Liou, 2011). Institutions that failed to address workplace discrimination, exhibited unfair treatment toward IENs, imposed restrictive contractual terms, maintained inequitable compensation structures, or displayed bias in advancement decisions intensified IENs' emotional distress (Alexis & Vydelingum, 2005; Alexis & Vydelingum, 2009; Likupe, 2013; Pressley et al., 2024; Van Rooyen et al., 2010). The effectiveness of anti-discrimination policies influenced response patterns. For example, when discrimination complaints were dismissed, IENs exhibited withdrawal behaviours such as absenteeism or bypassing organizational channels in favor of external support resources (Allan et al., 2009; Clark, 2020).

Conversely, diversity initiatives, workplace diversity policies including the presence of co-national nurses, and supportive organizational environments and colleagues enhanced integration behaviours and significantly reduced emotional distress among IENs (Clark, 2020; Dywili et al., 2021; Hughes, 2008). The relationship between organizational support and improved outcomes was well supported. For example, Clark (2020) demonstrated a statistically significant relationship in which higher levels of employer and colleague support were associated with reduced emotional distress ($\beta = -0.22$, $p < 0.05$) among Filipino nurses in the US.

Gaps in the Literature Regarding IENs' Responses

This section addresses the third research question by identifying gaps in the current evidence based on the analysis of the data extracted.

Limited Research on Positive Integration Experiences. Analysis of the extracted data revealed that the majority of studies focused predominantly on challenges and barriers, with only limited evidence documenting positive integration experiences or responses. While some studies documented positive emotions like pride and satisfaction (Alexis, 2013; Jose, 2010) and a sense

of fulfillment when applying critical thinking skills to patient care (Zhong et al., 2023), a more comprehensive examination of positive response patterns and successful adaptation strategies remains underrepresented in the literature.

Limited Comparative Analysis Across IEN Groups. The data extraction revealed minimal comparative research examining different IEN populations within the same healthcare contexts. Only one study (Alexis & Vydelingum, 2009) directly compared experiences between African and Asian nurses, noting that African nurses felt more marginalized than Asian nurses. Similarly, despite nursing being a predominantly female profession, comparative analysis between male and female IENs' workplace integration experiences was notably absent from the literature with only one study out of 37 primary studies having more male participants. The absence of comparative analyses across different countries of origin, receiving HICs, cultural backgrounds, gender, and previous nursing experience levels represents a significant gap in understanding how these demographic and professional factors influence integration responses.

Chapter 5: Discussion

The purpose of this scoping review was to systematically map the available evidence on how IENs from LMICs respond to workplace integration in HICs healthcare environments. Specifically, this review aimed to map existing evidence on the emotional, cognitive, and behavioural responses demonstrated by IENs during integration, identify what is known about the precipitating factors that influence these responses, and determine current gaps in the literature regarding IENs' workplace integration experiences.

The analysis of 37 sources, spanning nearly two decades (2005-2024) demonstrates the complex, multidimensional nature of workplace integration and illustrates that IENs' responses to workplace integration are not isolated reactions but interconnected processes that influence one another throughout the integration process. Rather than emotional, behavioural, and cognitive responses functioning as separate domains, they interact in dynamic ways that shape IENs' overall integration experiences. Interconnectedness of these response domains has been documented in other adaptation contexts. For instance, research on university students shows that emotional regulation (emotional domain) influences cognitive processes (e.g., attention, memory) and behavioural outcomes (e.g., academic performance) through mediators like self-efficacy and motivation (Hasanov et al., 2021). However, this interconnected pattern has not been explicitly documented for IEN workplace integration. The evidence from this review demonstrates that cognitive elements (e.g., recognition of workplace inequalities) triggers emotional distress (Alexis & Vydelingum, 2005; Uwabuike, 2021), which subsequently manifests in behavioural responses such as withdrawal (Iheduru-Anderson, 2020; Johnson, 2018).Also, IENs’ responses are also shaped not only by personal characteristics and coping strategies but also by broader system related structures and workplace culture.

The evidence reveals that IENs exhibit diverse response patterns across emotional, cognitive, and behavioural domains during workplace integration, with literature documenting both successful integration experiences and ongoing challenges that may lead to departure from positions. These response patterns and their theoretical alignment are discussed in detail in the following section.

Responses Patterns and Theoretical Alignment

The findings reveal a complex pattern of responses that evolve throughout the integration process, indicating that IENs begin with initial optimism and positive expectations (Alonso-Garbayo, 2007; Alshayeg, 2023), particularly driven by expectations of better socio-economic positions and professional development opportunities, which often transition into periods of emotional, cognitive, and behavioural distress as workplace realities emerge (Adhikari & Melia, 2015; Alexis, 2013; Hughes, 2008). This distress phase ultimately leads to divergent pathways, with some IENs achieving successful adaptation and professional integration (Jose, 2010), while others experience persistent difficulties that contribute to intentions to leave or actual departure from their positions (Alexis, 2013; Clark, 2020).

The progression from initial optimism through distress aligns with Lysgaard's (1955) U-curve theory of cross-cultural adjustment, suggesting that IENs' workplace integration follows similar psychological processes as other cross-cultural transitions. The emotional responses documented in this review, such as anxiety, fear, isolation, and loneliness (Connor, 2016; Dildar, 2015; Delos Reyes, 2019), correspond to what Lysgaard described as the crisis stage of cultural adjustment. This pattern extends beyond healthcare settings. For example, Demes and Geeraert (2015) examined stress trajectories among 2,500 international exchange students in over 50 countries and found similar crisis-stage stress and homesickness during the 6-12 month period.

Their findings parallel with the emotional distress documented among IENs in this review. Importantly, both populations showed similar outcomes when experiencing persistent stress. Demes and Geeraert observed that higher stress levels correlated with early program termination, which mirrors the departure patterns among IENs experiencing ongoing integration difficulties. However, one key difference emerged: the exchange student study found no consistent honeymoon phase across participants. This suggests that while the crisis stage appears universally across professional cross-cultural transitions, the initial optimism phase documented in IEN integration may be specific to healthcare migration contexts.

This pattern also supports Pilette's (1989) transition model, particularly the indignation phase, where initial optimism is replaced with frustration as the gap between expectations and reality becomes apparent (Al-Nusair & Alnjadat, 2022; Alexis & Shillingford, 2011). This review found that IENs from culturally and linguistically diverse backgrounds may experience prolonged periods of adaptation when they encounter significant cultural and linguistic differences in their new workplace environments (Kawi & Xu, 2009). Previous literature suggests this challenge can be further intensified when nurses are expected to demonstrate cultural competency and provide culturally appropriate care within diverse healthcare environments (Kokorelias et al., 2025).

A similar pattern has been noted within the behavioural domain, when IENs respond through withdrawal and avoidance strategies (Alexis, 2013; Johnson, 2018), overcompensation efforts (Iheduru-Anderson, 2020; Pettey, 2016), or eventual departure from hostile environments (Allan et al., 2009; Pressley et al., 2024) in response to encountering exclusion, discrimination, language barriers, and cultural dissonance (Alexis, 2013; Li et al., 2017; Liou & Cheng, 2011; Johnson, 2018) that they may experience during crisis stages. For instance, overrepresentation of

some behavioural responses like overcompensation indicates that current integration approaches may inadvertently recreate power imbalances where IENs must prove their worth within established systems rather than contributing their expertise to system enhancement (Iheduru-Anderson, 2020; Petty, 2016). The pattern remains the same within the cognitive domain, with IENs showing various negative responses when recognizing discrepancies between expectations and reality (Alexis, 2013; Adhikari & Melia, 2015). This pattern of cognitive challenges during workplace integration is not unique to nurses, as similar findings have been documented among other culturally and linguistically diverse healthcare practitioners. Research on internationally educated physicians has shown that they also experience cognitive and self-perceptual adjustment challenges including increased self-doubt and decreased self-efficacy due to workplace discrimination (Harris et al., 2024), suggesting that cognitive responses to integration barriers may be universal across internationally educated healthcare professions rather than being a nurse-specific phenomena.

However, despite these response patterns, IENs eventually learn to develop professional and personal adaptation strategies (Alshayeg, 2023; Jose, 2010; Lin, 2013) that align with conflict resolution phase of Pilette's model (1989), and the recovery stage of Lysgaard's (1955) U-curve theory of cross-cultural adjustment. In these phases, newcomers engage in task mastery and skill development, such as cognitive survival strategies (Connor, 2016; Murphy, 2008), to integrate into their new environment. The evidence reveals that progression to effective adaptation strategies typically occurs months after the starting point, when initial support systems have ended and IENs are left to navigate emotional distress, cognitive dissonance, and behavioural adaptations independently. This temporal pattern indicates that the most critical period for intervention occurs not during initial optimism, but when IENs are experiencing peak

emotional distress and cognitive dissonance. This suggests that support systems are most needed during this later crisis and recovery period rather than front-loaded during early integration phases.

External Factors Influencing Integration

Although not directly related to workplace dynamics, there are family related and socioeconomic factors that can also accelerate IENs' negative responses to workplace integration. Physical separation from family creates conditions that intensify emotional responses (Connor, 2016.). The literature documented how family separation added more negative feelings of guilt when IENs were unable to be physically present with family members (Van Rooyen et al., 2010). This pattern appears common among internationally educated healthcare professionals, with similar family separation challenges documented among internationally educated physicians who also reported emotional distress when unable to fulfill family obligations (Harris et al., 2024)

Additionally, financial stressors can further complicate integration experiences. The evidence revealed a dual financial burden where IENs face higher-than-expected living costs while simultaneously maintaining family remittance obligations (Alonso-Garbayo, 2007; Johnson, 2018). This financial stress compounds the emotional challenges of family separation, creating additional psychological pressure during an already vulnerable integration period.

Broader Healthcare Context

With global projections suggesting that by 2030, an additional 13 million nurses may be needed to meet healthcare demands (Buchan et al., 2022), HICs have increasingly turned to international recruitment as a primary strategy to address these workforce deficits. However, the

patterns of negative integration experiences in this review suggest that current integration strategies like front-loaded orientation programs and one-dimensional approaches that focus solely on IEN adaptation may be counterproductive. From an economic perspective, these patterns represent substantial financial waste for healthcare systems already under strain. Healthcare organizations invest significant resources in IENs recruitment, with estimates ranging from $10,000 to $50,000 per recruited nurse when including recruitment fees, relocation costs, and initial training and orientation program (Pittman et al., 2007; Singer, 2021). When IENs experience poor integration, they may be unable to effectively implement their skills in the healthcare environment, creating a revolving door effect where substantial investments in recruitment and training are lost, particularly when IENs decide to leave due to poor integration experiences. This is especially problematic given the scale of ongoing international recruitment, with countries like the US recruiting thousands of new IENs to maintain their current workforce of approximately 500,000 IENs (Pillai et al., 2024), meaning that even a small percentage of integration failures represent substantial financial losses when multiplied across the healthcare system.

Apart from all identified factors, workplace inequalities within the healthcare context emerged as an underestimated but critical trigger for cascading negative responses across all three domains (Alexis, 2013; Nagaya et al., 2024). The manifestations of these inequalities, such as differential treatment, unequal access to opportunities, exclusion practices by managers and colleagues, and broken promises regarding benefits, demonstrate how systemic barriers operate through multiple pathways to undermine integration success. This pattern of workplace inequalities directly contradicts the pull factors that originally motivated IENs to migrate to HICs. Internationally educated nurses are attracted by promises of fair wages, better work

environments, and equal opportunities (Kadel & Bhandari, 2018), yet the documented inequalities suggest a fundamental disconnect between what is explicitly promised during recruitment and what IENs actually encounter in their workplace experiences. When IENs encounter differential treatment despite possessing equivalent or superior qualifications to their domestically educated colleagues, it creates cognitive dissonance regarding their professional identity that is a key component for successful integration (Covell et al., 2016). The hidden nature of these inequalities makes them particularly insidious, as they may not be immediately apparent during recruitment or initial orientation phases but emerge gradually during workplace integration. This aligns with Pilette's (1989) Four-Phase Transition Model, where the indignation phase occurs as the gap between expectations and reality becomes apparent (Johnson, 2018).

Policy Implications and Considerations

Healthcare administrators may need to fundamentally reconceptualize integration as a mutual adaptation process (Ramji et al., 2019) that requires organizational and individual adjustment. Although integration is a two-way process, nursing literature has traditionally presented a predominantly one-dimensional perspective by focusing primarily on the adjustments that IENs must make to adapt to the host country (Raghuram, 2007; Roth et al., 2025). The scoping review findings reveal that racism and discrimination emerged as the most reported exacerbating factor across all response domains. Despite decades of diversity initiatives and cultural competency training, IENs continue to report experiences of marginalization that directly contradict healthcare's ethical foundations, suggesting that current approaches may be insufficient to address deeper structural inequities. To create more inclusive environments, the findings suggest that healthcare organizations may benefit from strategies including mutual cultural competence training for domestic staff, orientation programs addressing both clinical

protocols and workplace culture, inclusive leadership development, and policy reviews that involve minority voices to ensure safe, respectful workplaces for all employees (Health Canada, 2021; Lennox, 2018).

The evidence mapped in this review highlights several practice-related themes that warrant consideration. Across multiple studies, the importance of structured mentorship programs with qualified mentors emerged as a recurring factor (Alexis & Shillingford, 2011), while communication challenges consistently pointed toward the potential value of language support programs that extend beyond basic proficiency to include medical terminology and communication norms (Crawford et al., 2017). Career-related barriers frequently identified across studies suggest that clear pathways for expertise recognition and career advancement may be fundamental to integration success (Alexis & Vydelingum, 2005), and the systemic nature of challenges identified indicates that systemic changes that protect IEN welfare while maximizing their contributions to healthcare delivery could address underlying structural issues. While evidence from this review suggests these areas show promise, the literature lacks rigorous evaluation studies examining their long-term effectiveness.

Evidence indicates that integration experiences may vary across individuals, suggesting that tailored approaches could be more supportive than standardized and universal programs. For instance, some evidence views maintaining one's cultural identity as a protective factor that supports well-being during integration (Connor, 2016; Van Rooyen et al., 2010), while others argued that adapting to the new culture leads to more successful integration outcomes (Crawford et al., 2017; Lin, 2013). Another example of these contradictory approaches emerged in career advancement, where some IENs actively avoided promotional opportunities while others simultaneously complained about lack of advancement access (Iheduru-Anderson, 2020; Nagaya

et al., 2024; Zhou, 2014). These opposing responses across different integration domains demonstrate that IENs have diverse individual needs and coping preferences, suggesting that standardized orientation programs may be insufficient and that tailored support approaches may be necessary to address the diverse nature of IEN integration experiences.

Another critical finding from this review is the interconnected nature of these response domains. The evidence demonstrates that cognitive recognition of workplace inequalities triggers emotional distress, which subsequently manifests in behavioural adaptations. This interconnectedness suggests that interventions targeting only one domain may be insufficient for comprehensive integration support.

The recurring pattern of professional deskilling across diverse contexts which often leads to cognitive dissonance and emotional distress (Alexis & Shillingford, 2011; Adhikari & Melia, 2015), indicates that deskilling is not a coincidental outcome, but a systemic issue embedded within current international recruitment practices. This represents not simply an individual struggle, but a broader structural failure that undermines the effective use of global nursing talent. The patterns identified in this review suggest that this may require targeted policy reforms (e.g., IENs' prior expertise recognized based on demonstrated clinical competencies rather than country of origin). The broader literature suggests that organizational policies focusing on competency-based assessment and skills optimization can effectively reduce professional deskilling during workplace integration (Senivongse, 2023) to ensure that IENs are employed in roles that align with their qualifications and expertise, thereby optimizing human capital investment.

Implications for Future Research

This scoping review highlights several critical research priorities. Future studies should track integration experience changes over time. They should examine the timing and duration of integration phases to determine optimal intervention points, investigate factors that predict divergent outcomes between successful adaptation and departure, and identify early warning indicators that could prevent integration failure. Comparative research across different IEN groups and organizational contexts should focus on understanding why similar workplace challenges produce different responses among various populations, examining whether certain demographic or professional characteristics correlate with specific coping strategies, and determining which organizational factors consistently predict positive versus negative integration outcomes. For example, as male nurses represent an increasingly prominent segment of the nursing workforce (Egan, 2024), future research should investigate whether male IENs encounter workplace integration challenges and demonstrate different responses than female IENs. There is also a need to develop and evaluate targeted interventions to address common reported exacerbating factors like communication barriers, discrimination, and racism.

Given that only a small number of sources documented positive integration experiences (Alexis, 2013; Jose, 2010; Lin, 2013), future research should prioritize identifying protective factors and successful adaptation strategies that promote positive emotional, cognitive, and behavioural responses among IENs. This gap in positive integration research represents a critical limitation, as most evidence focused predominantly on challenges and barriers, potentially skewing understanding toward deficit-based perspectives rather than strength-based approaches.

Limitations of the Scoping Review

The focus on IENs from LMICs working in HICs means that findings may not be transferable to other migration contexts, such as nurse migration between HICs (e.g., Canada to US) or between LMICs. Although nursing is a predominantly female-dominated profession (Masibo et al., 2024), the overrepresentation of women in the included studies may limit insights into the experiences of male and gender-diverse IENs, whose perspectives are often overlooked in the literature. This imbalanced representation may particularly affect understanding of workplace dynamics and integration experiences that could differ across different genders.

Conclusion

This scoping review systematically identified and charted the current evidence on emotional, cognitive, and behavioural responses of IENs from LMICs during workplace integration in HICs healthcare environments. The analysis of 37 sources of evidence from 2005 and 2024 revealed that IENs experience predictable response patterns across all three domains. Responses typically initiated with positive emotional responses and expectations that frequently transition into emotional distress, especially when facing workplace realities that differ from expectations. Fear, anxiety, isolation, and frustration were commonly reported, particularly when IENs faced various form of discrimination and racism, professional devaluation and unsupportive workplace environment. These emotional experiences were closely linked to cognitive shifts, including altered self-perception regarding capabilities, professional identity, and starting to rationalization, and adaptive reframing. From behavioural perspective, IENs showed various forms of withdrawal and avoidance strategies and overcompensation efforts to prove competence. This review also highlights various factors that ameliorate or exacerbate IENs' responses during workplace integration. Most commonly exacerbating factors include:

various forms of racism and discrimination, lack of professional qualification recognition, communication and language barriers, cultural differences, and unsupportive workplace environments. In contrast, ameliorating factors encompass structured mentorship and orientation programs, inclusive organizational policies, supportive workplace cultures, and professional recognition. Besides challenges and negative responses, evidence also shows that IENs eventually demonstrated remarkable resilience and developed adaptive strategies that enable professional growth and positive integration outcomes that lead to positive responses like happiness and improved confidence.

Regarding implications, there is a need to design and extend the support for IENs beyond initial orientation and toward long-term integration strategies like prolonged mentorship program, cultural safety initiatives, and mechanisms for validating international expertise. Educators and regulators are encouraged to refine bridging programs to address not only clinical and communication competencies but also emotional resilience, cultural adjustment, and workplace reality. The evidence also demonstrates that unresolved negative response in one domain can lead to negative effects in other domains. Therefore, incorporating initiatives and programs that address all three domains can be more favorable. Additionally, decision makers and managers are encouraged to make sure recruitment is based on equitable employment frameworks that prevent deskilling and facilitate advancement based on demonstrated competence rather than country of origin. Furthermore, research efforts should shift toward positive integration experiences, evaluating the effectiveness of interventions and exploring the integration experience across diverse populations, including underrepresented groups such as male IENs.

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Appendices

Appendix A

Search Strategies for Electronic Databases

Table A1

MEDLINE (Ovid)

#	Query	Results on 15 December
	Population: Internationally educated Nurses	
1	"Foreign Professional Personnel"/ or "Nurses, International"/	2499
2	(IEN or IENs).mp.	274
3	((international* or foreign* or immigrant* or migrant* or overseas*) adj2 (nurs* or educat* or train* or qualif* or certif* or licens* or graduat* or registered nurs* or RN or RNs)).tw,kf.	9845
4	or/1-3	11812
	Concept: Emotional, cognitive and behavioural response during workplace integration	
5	exp Emotions/ or exp "Adaptation, Psychological"/	558266
6	((emotion* or feeling* or mood* or psychological* or mental*) adj3 (respon* or experience* or express* or react* or state* or adjust* or adapt* or pattern* or chang*)).tw,kf.	170059
7	(emotion* or anxiet* or stress* or confiden* or worr* or fear* or frustrat* or satisf* or belong* or isolat* or comfort* or distress* or secur* or overwhelm* or empower* or morale).tw,kf.	4939150
8	exp cognition/	213527
9	((cogniti* or thought* or perception* or understand*) adj3 (respon* or process* or function* or experience* or adapt* or adjust* or pattern* or chang* or aware* or state* or alter*)).tw,kf.	380411
10	exp Behavior/ NOT exp Behavior, Animal/	1870285

11	(behavio?r* adj3 (respon* or experience* or pattern* or adapt* or adjust* or chang* or interact* or perform* or function* or react* or express*)).tw,kf.	246916
12	((profession* or practice* or work*) adj3 (perform* or function* or adapt* or interact* or competenc*)).tw,kf.	100321
13	((integrat* or transition* or adapt* or adjust* or acculturat* or settle* or orientation* or onboard* or bridging* or coping*) adj3 (process* or practice* or experience* or phase* or stage* or period* or program* or behavio?r*)).tw,kf.	212749
14	((work* or professional* or occupation* or career* or job* personal* or interpersonal*) adj3 (integrat* or adapt* or adjust* or transition* or acculturat* or settle* or camaraderie*)).tw,kf.	26807
15	or/5-14	7080173
	Context: Healthcare environment in high-income countries	
16	exp Health Facilities/ or exp Health Services/	3080594
17	(hospital* or clinic* or ward* or unit* or "healthcare environment*" or "health care environment*" or "clinical environment*" or "practice environment*" or "workplace environment*" or "healthcare setting*" or "health care setting*" or "clinical setting*" or "practice setting*" or "acute care" or "primary care" or "secondary care" or "intensive care unit*" or ICU or ED or ER or "emergency department*" or emergency room* or long term care* or "nursing home*" or "community health*" or host countr* or destination countr* or work environment* or workplace setting* or workforce*).tw,kf.	8081260
18	exp Developed Countries/	21706
19	(((high-income or "high income" or developed or advanced or industrialized) adj2 (countr* or nation* or econom*)) or "global north").tw,kf.	89780
20	or/16-19	9834359
21	4 and 15 and 20	2132

Table A2

CINAHL (EBSCOhost)

#	Query	Results on 15 December
	Population: Internationally educated Nurses	
1	MH "Foreign Professional Personnel"/ OR MH "Foreign Nurses"	3,204
2	TI(IEN OR IENs) OR AB (IEN OR IENs) OR MW (IEN OR IENs)	107
3	TI ((international* OR foreign* OR immigrant* OR migrant* OR overseas*) N1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs)) OR AB ((international* OR foreign* OR immigrant* OR migrant* OR overseas*) N1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs)) OR MW ((international* OR foreign* OR immigrant* OR migrant* OR overseas*) N1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs))	12,617
4	S1 OR S2 OR S3	12,646
	Concept: Emotional, cognitive and behavioural response during workplace integration	
5	MH "Emotions+" OR MH "Adaptation, Psychological+" OR MH "Psychological Well-Being"	264,049
6	TI ((emotion* OR feeling* OR mood* OR psychological*) N2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*)) OR AB ((emotion* OR feeling* OR mood* OR psychological*) N2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*)) OR MW ((emotion* OR feeling* OR mood* OR psychological*) N2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*))	77,984
7	TI (emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower*) OR AB (emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower*) OR MW (emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower*)	1,424,682
8	(MH "Cognition+")	86,010

9	TI ((cogniti* OR thought* OR perception* OR understand*) N2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state*)) OR AB ((cogniti* OR thought* OR perception* OR understand*) N2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state*)) OR MW ((cogniti* OR thought* OR perception* OR understand*) N2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state*))	101,366
10	(MH "Behavior+") NOT (MH "Behavior, Animal")	1,213,553
11	TI (behavio#r* N2 (respon* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*)) OR AB (behavio#r* N2 (respon* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*)) OR MW (behavio#r* N2 (respon* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*))	65,268
12	TI ((profession* OR practice* OR work*) N2 (perform* OR function* OR adapt* OR interact* OR competenc*)) OR AB ((profession* OR practice* OR work*) N2 (perform* OR function* OR adapt* OR interact* OR competenc*)) OR MW ((profession* OR practice* OR work*) N2 (perform* OR function* OR adapt* OR interact* OR competenc*))	54,601
13	TI ((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) N2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio#r*)) OR AB ((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) N2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio#r*)) OR MW ((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) N2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio#r*))	57,605
14	TI ((work* OR professional* OR occupation* OR career* OR job*) N2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle* OR personal* OR interpersonal*)) OR AB ((work* OR professional* OR occupation* OR career* OR job* OR personal* OR interpersonal*) N2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle*)) OR MW ((work* OR professional* OR occupation* OR career* OR job* OR personal* OR interpersonal*) N2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle*))	17,988
15	(S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14)	2,394,287
	Context: Healthcare environment in high income countries	
16	(MH "Health Facilities+") OR (MH "Health Services+") OR (MH "Long Term Care")	1,604,982

17	TI (hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR ("intensive care unit*" OR ICU) OR ("emergency department*" OR ED) OR ("emergency room*" OR ER) OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*) OR AB (hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR ("intensive care unit*" OR ICU) OR ("emergency department*" OR ED) OR ("emergency room*" OR ER) OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*) OR MW (hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR ("intensive care unit*" OR ICU) OR ("emergency department*" OR ED) OR ("emergency room*" OR ER) OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*)	3,176,346
18	MH "Developed Countries"	4,515
19	TI (((high-income OR “high income” OR developed OR advanced OR industrialized) N1 (countr* OR nation* OR econom*)) OR "global north") OR AB ((high-income OR “high income” OR developed OR advanced OR industrialized) N1 (countr* OR nation* OR econom*)) OR "global north") OR MW ((high-income OR “high income” OR developed OR advanced OR industrialized) N1 (countr* OR nation* OR econom*))	20,456
20	S16 OR S17 OR S18 OR S19	3,812,590
21	S4 AND S15 AND S20	3,121

Table A3

PsycInfo (EBSCOhost)

#	Query	Results on 15 December
	Population: Internationally educated Nurses	
1	DE "Migrant Workers" OR DE "Foreign Workers"	929
2	TI (IEN OR IENs) OR AB (IEN OR IENs) OR KW (IEN OR IENs)	48
3	TI ((international* OR foreign* OR immigrant* OR migrant* OR overseas*) N1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs)) OR AB ((international* OR foreign* OR immigrant* OR migrant* OR overseas*) N1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs)) OR KW ((international* OR foreign* OR immigrant* OR migrant* OR overseas*) N1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs))	5,947
4	S1 OR S2 OR S3	6,856
	Concept: Emotional, cognitive and behavioural response during workplace integration	
5	DE "Emotions" OR DE "Emotional Content" OR DE "Emotional Intelligence" OR DE "Emotional Processing" OR DE "Emotional Regulation" OR DE "Emotional Responses" OR DE "Emotional States" OR DE "Emotional Style" OR DE "Expressed Emotion" OR DE "Emotional Adjustment" OR DE "Emotional Control" OR DE "Emotional Health" OR DE "Emotional Well Being"	188,388
6	TI ((emotion* OR feeling* OR mood* OR psychological*) N2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*)) OR AB ((emotion* OR feeling* OR mood* OR psychological*) N2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*)) OR KW ((emotion* OR feeling* OR mood* OR psychological*) N2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*))	167,707
7	TI (emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower*) OR AB (emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower*) OR KW (emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower*)	1,398,046
8	DE "Cognitions" OR DE "Conspiracy Beliefs" OR DE "Expectations" OR DE "Intrusive Thoughts" OR DE "Irrational Beliefs" OR DE "Thought Suppression" OR DE "Role Expectations" OR DE "Self-Fulfilling Prophecies"	40,010
9	TI ((cogniti* OR thought* OR perception* OR understand*) N2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state*)) OR AB ((cogniti* OR thought* OR perception* OR understand*) N2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state*)) OR KW ((cogniti* OR thought* OR perception* OR	261,400

	understand*) N2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state*))	
10	DE "Behavior" OR DE "Achievement" OR DE "Adaptive Behavior" OR DE "Adjunctive Behavior" OR DE "Adjustment" OR DE "Adolescent Behavior" OR DE "Antisocial Behavior" OR DE "Approach Avoidance" OR DE "Approach Behavior" OR DE "Attachment Behavior" OR DE "Avoidance" OR DE "Behavior Change" OR DE "Behavior Problems" OR DE "Choice Behavior" OR DE "Commitment" OR DE "Compulsions" OR DE "Consequence" OR DE "Consumer Behavior" OR DE "Coping Behavior" OR DE "Cues" OR DE "Daily Activities" OR DE "Drinking Behavior" OR DE "Drug Usage" OR DE "Eating Behavior" OR DE "Endurance" OR DE "Exploratory Behavior" OR DE "Habits" OR DE "Health Behavior" OR DE "Hoarding Behavior" OR DE "Illness Behavior" OR DE "Individual Differences" OR DE "Instinctive Behavior" OR DE "Lifestyle" OR DE "Motivation" OR DE "Obscenity" OR DE "Performance" OR DE "Planned Behavior" OR DE "Predisposition" OR DE "Productivity" OR DE "Psychological Reactance" OR DE "Reasoned Action" OR DE "Resistance" OR DE "Responses" OR DE "Sedentary Behavior" OR DE "Self-Defeating Behavior" OR DE "Social Behavior" OR DE "Stereotyped Behavior" NOT DE "Animal Behavior"	695,971
11	TI (behavio#r* N2 (respon* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*)) OR AB (behavio#r* N2 (respon* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*)) OR KW (behavio#r* N2 (respon* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*))	189,904
12	TI ((profession* OR practice* OR work*) N2 (perform* OR function* OR adapt* OR interact* OR competenc*)) OR AB ((profession* OR practice* OR work*) N2 (perform* OR function* OR adapt* OR interact* OR competenc*)) OR KW ((profession* OR practice* OR work*) N2 (perform* OR function* OR adapt* OR interact* OR competenc*))	57,664
13	TI ((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) N2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio#r*)) OR AB ((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) N2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio#r*)) OR KW ((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) N2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio#r*))	117,101
14	TI ((work* OR professional* OR occupation* OR career* OR job*) N2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle* OR personal* OR interpersonal*)) OR AB ((work* OR professional* OR occupation* OR career* OR job* OR personal* OR interpersonal*) N2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle*)) OR KW ((work* OR professional* OR occupation* OR career* OR job* OR personal* OR interpersonal*) N2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle*))	36,102
15	(S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14)	2,263,081
	Context: Healthcare environment in high-income countries	

16	DE "Hospital Environment" OR DE "Treatment Facilities" OR DE "Clinics" OR DE "Community Mental Health Centers" OR DE "Facility Admission" OR DE "Facility Discharge" OR DE "Hospitals" OR DE "Nursing Homes" OR DE "Rehabilitation Centers" OR DE "Therapeutic Camps"	55,217
17	TI (hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR ("intensive care unit*" OR ICU) OR ("emergency department*" OR ED) OR ("emergency room*" OR ER) OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*) OR AB (hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR ("intensive care unit*" OR ICU) OR ("emergency department*" OR ED) OR ("emergency room*" OR ER) OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*) OR KW (hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR ("intensive care unit*" OR ICU) OR ("emergency department*" OR ED) OR ("emergency room*" OR ER) OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*)	1,231,255
18	DE "Developed Countries"	2,503
19	TI (((high-income OR high income OR developed OR advanced OR industrialized) N1 (countr* OR nation* OR econom*)) OR "global north") OR AB ((high-income OR developed OR advanced OR industrialized) N1 (countr* OR nation* OR econom*)) OR "global north") OR KW ((high-income OR developed OR advanced OR industrialized) N1 (countr* OR nation* OR econom*)) OR "global north")	13,478
20	S16 OR S17 OR S18 OR S19	1,241,125
21	S4 AND S15 AND S20	1,024

Table A4

EMBASE (ELSIVER)

#	Query	Results on 15 December
	Population: Internationally educated Nurses	
1	'foreign nurse'/exp	360
2	ien:ti,ab,kw OR iens:ti,ab,kw	372
3	((international* OR foreign* OR immigrant* OR migrant* OR overseas*) NEAR/1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR 'registered nurs*' OR rn OR rns)):ti,ab,kw	7443
4	#1 OR #2 OR #3	7865
	Concept: Emotional, cognitive and behavioural response during workplace integration	
5	'emotion'/exp OR 'psychological adjustment'/exp	875364
6	((emotion* OR feeling* OR mood* OR psychological* OR mental*) NEAR/2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*)):ti,ab,kw	187987
7	emotion*:ti,ab,kw OR anxiet*:ti,ab,kw OR stress*:ti,ab,kw OR confiden*:ti,ab,kw OR worr*:ti,ab,kw OR fear*:ti,ab,kw OR frustrat*:ti,ab,kw OR satisf*:ti,ab,kw OR belong*:ti,ab,kw OR isolat*:ti,ab,kw OR comfort*:ti,ab,kw OR distress*:ti,ab,kw OR secur*:ti,ab,kw OR overwhelm*:ti,ab,kw OR empower*:ti,ab,kw OR morale:ti,ab,kw	6217392
8	'cognition'/exp	3327661
9	((cogniti* OR thought* OR perception* OR understand*) NEAR/2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state* OR alter*)):ti,ab,kw	341752
10	'behavior'/exp NOT 'animal behavior'/exp	5377825
11	(behavio?r* NEAR/2 (respon* OR experience* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*)):ti,ab,kw	57076
12	((profession* OR practice* OR work*) NEAR/2 (perform* OR function* OR adapt* OR interact* OR competenc*)):ti,ab,kw	76991
13	((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) NEAR/2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavio?r*)):ti,ab,kw	152651
14	((work* OR professional* OR occupation* OR career* OR job* OR personal* OR interpersonal*) NEAR/2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle* OR camaraderie*)):ti,ab,kw	24456
15	#5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14	11724553
	Context: Healthcare environment in high-income countries	
16	'health care facility'/exp OR 'health service'/exp	8657543
17	hospital*:ti,ab,kw OR clinic*:ti,ab,kw OR ward*:ti,ab,kw OR unit*:ti,ab,kw OR 'healthcare environment*':ti,ab,kw OR 'health care environment*':ti,ab,kw OR 'clinical	11445052

	environment*':ti,ab,kw OR 'practice environment*':ti,ab,kw OR 'workplace environment*':ti,ab,kw OR 'healthcare setting*':ti,ab,kw OR 'health care setting*':ti,ab,kw OR 'clinical setting*':ti,ab,kw OR 'practice setting*':ti,ab,kw OR 'acute care':ti,ab,kw OR 'primary care':ti,ab,kw OR 'secondary care':ti,ab,kw OR 'intensive care unit*':ti,ab,kw OR icu:ti,ab,kw OR 'emergency department*':ti,ab,kw OR ed:ti,ab,kw OR 'emergency room*':ti,ab,kw OR er:ti,ab,kw OR 'long term care*':ti,ab,kw OR 'nursing home*':ti,ab,kw OR 'community health*':ti,ab,kw OR 'host countr*':ti,ab,kw OR 'destination countr*':ti,ab,kw OR 'work environment*':ti,ab,kw OR 'workplace setting*':ti,ab,kw OR workforce*:ti,ab,kw	
18	'high income country'/exp OR 'developed country'/exp	48147
19	((('high income' OR 'high-income' OR developed OR advanced OR industrialized) NEAR/1 (countr* OR nation* OR econom*)):ti,ab,kw) OR 'global north':ti,ab,kw	83081
20	#16 OR #17 OR #18 OR #19	15698583
21	#4 AND #15 AND #20	2439

Table A5

Cochrane Library

#	Query	Results on 15 December
	Population: Internationally educated Nurses	
1	MeSH descriptor: [Nurses, International] explode all trees	1
2	MeSH descriptor: [Foreign Professional Personnel] this term only	1
3	(IEN or IENs):ti,ab,kw	51
4	(international* or foreign* or immigrant* or migrant* or overseas*) NEAR/1 (nurs* or educat* or train* or qualif* or certif* or licens* or graduat* or "registered nurse" or RN or RNs):ti,ab,kw	182
5	#1 or #2 or #3 or #4	233
	Concept: Emotional, cognitive and behavioural response during workplace integration	
6	MeSH descriptor: [Emotions] explode all trees	41320
7	MeSH descriptor: [Adaptation, Psychological] explode all trees	7046
8	(emotion* or feeling* or mood* or psychological* or mental*) NEAR/2 (respon* or experience* or express* or react* or state* or adjust* or adapt* or pattern* or chang*):ti,ab,kw	32580
9	(emotion* or anxiet* or stress* or confiden* or worr* or fear* or frustrat* or satisf* or belong* or isolat* or comfort* or distress* or secur* or overwhelm* or empower* or morale):ti,ab,kw	437445
10	MeSH descriptor: [Cognition] explode all trees	16746
11	(cogniti* or thought* or perception* or understand*) NEAR/2 (respon* or process* or function* or experience* or adapt* or adjust* or pattern* or chang* or aware* or state* or alter*):ti,ab,kw	37758
12	MeSH descriptor: [Behavior] explode all trees	132936
13	MeSH descriptor: [Behavior, Animal] explode all trees	4943
14	(behavior* or behaviour* NEAR/2 (respon* or experience* or pattern* or adapt* or adjust* or chang* or interact* or perform* or function* or react* or express*)):ti,ab,kw	147486
15	(profession* or practice* or work*) NEAR/2 (perform* or function* or adapt* or interact* or competenc*):ti,ab,kw	7514
16	(integrat* or transition* or adapt* or adjust* or acculturat* or settle* or orientation* or onboard* or bridging* or coping*) NEAR/2 (process* or practice* or experience* or phase* or stage* or period* or program* or behavior* or behaviour*):ti,ab,kw	14112
17	(work* or professional* or occupation* or career* or job* or personal* or interpersonal*) NEAR/2 (integrat* or adapt* or adjust* or transition* or acculturat* or settle*):ti,ab,kw	1641
18	#6 or #7 or #8 or #9 or #10 or #11 or #12 NOT #13 or #14 or #15 or #16 or #17	609943
	Context: Healthcare environment in high-income countries	
18	MeSH descriptor: [Health Facilities] explode all trees	23627
19	MeSH descriptor: [Health Services] explode all trees	142999
20	(hospital* or clinic* or ward* or unit* or (healthcare NEXT environment*) or (health NEXT care NEXT environment*) or (clinical NEXT environment*) or (practice NEXT	1304292

	environment*) or (workplace NEXT environment*) or (healthcare NEXT setting*) or (health NEXT care NEXT setting*) or (clinical NEXT setting*) or (practice NEXT setting*) or (acute NEXT care) or (primary NEXT care) or (secondary NEXT care) or (intensive NEXT care NEXT unit*) or ICU or (emergency NEXT department*) or ED or (emergency NEXT room*) or ER or (long NEXT term NEXT care*) or (nursing NEXT home*) or (community NEXT health*) or (host NEXT countr*) or (destination NEXT countr*) or (work NEXT environment*) or (workplace NEXT setting*) or workforce*):ti,ab,kw	
21	MeSH descriptor: [Developed Countries] explode all trees	94
22	((("high income" or "high-income" or developed or advanced or industrialized) NEAR/1 (countr* or nation* or econom*)) or "global north"):ti,ab,kw	3015
23	#19 or #20 or #21 or #22 or #23	1340678
22	#5 AND #18 AND #24	81

Table A6

JBI (Ovid)

#	Query	Results on 15 December
	Population: Internationally educated Nurses	
1	(IEN or IENs).mp.	2
2	((international* or foreign* or immigrant* or migrant* or overseas*) adj2 (nurs* or educat* or train* or qualif* or certif* or licens* or graduat* or registered nurs* or RN or RNs)).tw,ab,hw	218
3	or/1-2	220
	Concept: Emotional, cognitive and behavioural response during workplace integration	
4	((emotion* or feeling* or mood* or psychological* or mental*) adj3 (respon* or experience* or express* or react* or state* or adjust* or adapt* or pattern* or chang*)).tw,ab,hw	964
5	(emotion* or anxiet* or stress* or confiden* or worr* or fear* or frustrat* or satisf* or belong* or isolat* or comfort* or distress* or secur* or overwhelm* or empower* or morale).tw,ab,hw	4895
6	((cogniti* or thought* or perception* or understand*) adj3 (respon* or process* or function* or experience* or adapt* or adjust* or pattern* or chang* or aware* or state* or alter*)).tw,ab,hw	1283
7	(behavio?r* adj3 (respon* or experience* or pattern* or adapt* or adjust* or chang* or interact* or perform* or function* or react* or express*)).tw,ab,hw	802
8	((profession* or practice* or work*) adj3 (perform* or function* or adapt* or interact* or competenc*)).tw,ab,hw	454
9	((integrat* or transition* or adapt* or adjust* or acculturat* or settle* or orientation* or onboard* or bridging* or coping*) adj3 (process* or practice* or experience* or phase* or stage* or period* or program* or behave?r*)).tw,ab,hw	627
10	((work* or professional* or occupation* or career* or job* or personal* or interpersonal*) adj3 (integrat* or adapt* or adjust* or transition* or acculturat* or settle* or camaraderie*)).tw,ab,hw	147
11	or/4-10	5223
	Context: Healthcare environment in high-income countries	
12	(hospital* or clinic* or ward* or unit* or "healthcare environment*" or "health care environment*" or "clinical environment*" or "practice environment*" or "workplace environment*" or "healthcare setting*" or "health care setting*" or "clinical setting*" or "practice setting*" or "acute care" or "primary care" or "secondary care" or "intensive care unit*" or ICU or ED or ER or "emergency department*" or "emergency room*" or "long term care*" or "nursing home*" or "community health*" or "host countr*" or "destination countr*" or "work environment*" or "workplace setting*" or workforce*).tw,ab,hw	7542
13	(((high-income or "high income" or developed or advanced or industrialized) adj2 (countr* or nation* or econom*)) or "global north").tw,ab,hw	514
14	or/12-13	7547
22	3 and 11 and 14	205

Table A7

ProQuest Dissertations & Theses Global

#	Query	Results on 20 December
	Population: Internationally educated Nurses	
S1	noft(IEN OR IENs) OR noft((international* OR foreign* OR immigrant* OR migrant* OR overseas*) NEAR/1 (nurs* OR educat* OR train* OR qualif* OR certif* OR licens* OR graduat* OR "registered nurs*" OR RN OR RNs))	15400
	Concept: Emotional, cognitive and behavioural response during workplace integration	
S2	noft((emotion* OR feeling* OR mood* OR psychological* OR mental*) NEAR/2 (respon* OR experience* OR express* OR react* OR state* OR adjust* OR adapt* OR pattern* OR chang*)) OR noft(emotion* OR anxiet* OR stress* OR confiden* OR worr* OR fear* OR frustrat* OR satisf* OR belong* OR isolat* OR comfort* OR distress* OR secur* OR overwhelm* OR empower* OR morale) OR noft((cogniti* OR thought* OR perception* OR understand*) NEAR/2 (respon* OR process* OR function* OR experience* OR adapt* OR adjust* OR pattern* OR chang* OR aware* OR state* OR alter*)) OR noft(behavior* OR behaviour* NEAR/2 (respon* OR experience* OR pattern* OR adapt* OR adjust* OR chang* OR interact* OR perform* OR function* OR react* OR express*)) OR noft((profession* OR practice* OR work*) NEAR/2 (perform* OR function* OR adapt* OR interact* OR competenc*)) OR noft((integrat* OR transition* OR adapt* OR adjust* OR acculturat* OR settle* OR orientation* OR onboard* OR bridging* OR coping*) NEAR/2 (process* OR practice* OR experience* OR phase* OR stage* OR period* OR program* OR behavior* OR behaviour*)) OR noft((work* OR professional* OR occupation* OR career* OR job* OR personal* OR interpersonal*) NEAR/2 (integrat* OR adapt* OR adjust* OR transition* OR acculturat* OR settle* OR camaraderie*))	1719577
	Context: Healthcare environment in high-income countries	
S3	noft(hospital* OR clinic* OR ward* OR unit* OR "healthcare environment*" OR "health care environment*" OR "clinical environment*" OR "practice environment*" OR "workplace environment*" OR "healthcare setting*" OR "health care setting*" OR "clinical setting*" OR "practice setting*" OR "acute care" OR "primary care" OR "secondary care" OR "intensive care unit*" OR ICU OR "emergency department*" OR "emergency room*" OR "long term care*" OR "nursing home*" OR "community health*" OR "host countr*" OR "destination countr*" OR "work environment*" OR "workplace setting*" OR workforce*) OR noft((high-income OR "high income" OR developed OR advanced OR industrialized) NEAR/1 (countr* OR nation* OR econom*) OR "global north")	4512185
S4	([S1] AND [S2] AND [S3])	4076

Table A8

Google Search

#	Query	Results on 23 December
1	("internationally educated nurses" OR "foreign nurses" OR "migrant nurses" OR "overseas nurses" OR IEN OR IENs) AND ("emotional response" "cognitive response" OR "behavioural response" OR emotion OR feeling OR mood OR psychological OR mental OR anxiety OR stress OR confidence OR worry OR fear OR frustration OR satisfaction OR belonging OR isolation OR comfort OR distress OR secure OR overwhelmed OR empowered OR morale OR cognition OR thought OR perception OR understanding OR behavior OR behaviour Or coping OR "professional performance" OR "workplace integration" OR "professional integration" OR "transition experience" OR adaptation OR acculturation OR adjustment OR orientation OR onboarding OR "coping process") AND ("healthcare environment" OR "healthcare workplace" OR "healthcare setting" OR hospital OR clinic OR "clinical environment" OR "practice setting" OR "developed countries" OR "high income countries" OR "host country" OR "destination country") -site:ovid.com -site:ebscohost.com -site:elsevier.com -site:proquest.com -site:cochranelibrary.com -site:pubmed.gov -site:medline.com -site:scholar.google.com -site:ncbi.nlm.nih.gov -site:sciencedirect.com -site:researchgate.net -site:sagepub.com	first 10 pages
	Total	100

Appendix B

Sources Excluded Following Full-text Review

Table B

Table of Excluded Studies

Population Eligibility Criteria Not Met (*n*=67): IENS not from LMICs/Proportion of IENs Undetermined- IENs < 50% of whole population	
First author/ year of publication	Title of evidence
Shiju, 2024	Barriers and Enablers of Successful Workplace Integration of Internationally Educated Nurses (IENs) in a Host Country: A Qualitative Evidence Synthesis.
Thomas, 2024	Factors influencing the transition of foreign educated nurses to the US healthcare setting: A systematic review.
Austin, 2024	Enhancing Integration of Internationally Educated Health Professionals in the Healthcare Workforce: Implications for Regulators.
Lanada, 2024	The experiences of internationally educated nurses who joined the nursing workforce in England.
AlAchkar, 2023	Integrating Immigrant Health Professionals into the U.S. Healthcare Workforce: Barriers and Solutions.
Miyata, 2023	Challenges and career consequences of internationally educated nurses: Empirical research qualitative.
Kurup, 2023	Transition of internationally qualified nurses in Australia: Meta-synthesis of qualitative studies.
Zanjani, 2018	Challenges and experiences of overseas qualified nurses adjusting to new roles and health care systems: A narrative review of the literature.
O'Callaghan, 2018	Exploring the experiences of internationally and locally qualified nurses working in a culturally diverse environment.
Pendleton, 2017	The experiences of black and minority ethnic nurses working in the UK.
Brunton, 2020	Home and away: A national mixed-methods questionnaire survey of host and migrant Registered Nurses in New Zealand.
Ramji, 2018	Unpacking "two-way" workplace integration of internationally educated nurses.
ChunTie, 2019	Playing the game: A grounded theory of the integration of international nurses.
Wesołowska, 2019	Psychosocial work environment and cross-cultural competence among native and foreign-born registered nurses.
Eriksson, 2018	Internationally educated nurses' descriptions of their access to structural empowerment while working in another country's health care context.
Schilgen, 2019	Work-related barriers and resources of migrant and autochthonous homecare nurses in Germany: A qualitative comparative study.

Buttigieg, 2018	The integration of immigrant nurses at the workplace in Malta: a case study.
Kamau, 2022	Culturally and linguistically diverse registered nurses' experiences of integration into nursing workforce - A qualitative descriptive study.
Chok, 2017	The factors impacting personal and professional experiences of migrant nurses in Australia: An integrative review.
ChunTie, 2018	The Experiences of Internationally Qualified Registered Nurses Working in the Australian Healthcare System: An Integrative Literature Review.
Dongxia Xiao, 2014	Factors affecting the integration of immigrant nurses into the nursing workforce: A double hermeneutic study.
Bhandari, 2015	Job satisfaction of overseas-qualified nurses working in Australian hospitals.
Geun, 2016	Turnover and Associated Factors in Asian Foreign-Educated Nurses.
Ho, 2015	A meta-ethnography of the acculturation and socialization experiences of migrant care workers.
Wheeler, 2014	The experience of discrimination by US and Internationally educated nurses in hospital practice in the USA: a qualitative study.
Alosaimi, 2016	The Challenges of Cultural Competency Among Expatriate Nurses Working in Kingdom of Saudi Arabia.
Tregunno, 2009	International nurse migration: U-turn for safe workplace transition.
Hayne, 2009	Filipino nurses in the United States: recruitment, retention, occupational stress, and job satisfaction.
Nichols, 2010	The experiences of internationally recruited nurses in the UK (1995-2007): an integrative review.
Brunero, 2008	Expectations and experiences of recently recruited overseas qualified nurses in Australia.
Wolcott, 2013	Integration of Internationally Educated Nurses Into the U.S. Workforce.
Cummins, 2009	Migrant nurses' perceptions and attitudes of integration into the perioperative setting.
Konno, 2006	Support for overseas qualified nurses in adjusting to Australian nursing practice: a systematic review.
Beaton, 2010	Overseas recruitment: experiences of nurses immigrating to Newfoundland and Labrador, 1949-2004.
Magnusdottir, 2005	Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse.
Jackson, 1996	The multicultural workplace: comfort, safety and migrant nurses.
deVeer, 2004	Experiences of foreign European nurses in The Netherlands.
Cooke, 1998	Overseas nurses' experiences of working in clinical settings in England, and the experiences of their hosts: a phenomenological study.
Dumalagan, 2016	Foreign-educated nurses' transition in the United States workforce.
Mitchell, 2009	Job satisfaction and burnout among foreign-trained nurses in Saudi Arabia: a mixed-method study.
Omiyi, 2024	Exploring the Motivations, Challenges, and Integration of Internationally Educated Healthcare Workers in the UK: A Scoping Review.

Alostaz, 2024	Sociodemographic Characteristics of Internationally Educated Nurses Associated With Successful Outcomes in Canada: Quantitative Analysis.
Al-Btoush, 2024	Challenges affecting migrant healthcare workers while adjusting to new healthcare environments: a scoping review.
Moser, 2024	From margins to mainstream: Incorporating internationally educated health professionals' skills into primary care.
Ung, 2024	Global migration and factors influencing retention of Asian internationally educated nurses: a systematic review.
Zwergel, 2024	Academically educated nurses from third countries: Professional self-concept versus working life in Germany. A qualitative study using the example of migrant nurses from the Philippines.
Pressley, 2023	Internationally recruited nurses and their initial integration into the healthcare workforce: A mixed methods study.
Schilgen, 2020	The Extent of Psychosocial Distress among Immigrant and Non-Immigrant Homecare Nurses-A Comparative Cross-Sectional Survey.
Moyce, 2016	Migration Experiences of Foreign Educated Nurses: A Systematic Review of Literature.
Bidwell, 2014	Security and skills: the two key issues in health worker migration.
Higginbottom, 2011	The transitioning experiences of internationally educated nurses into a Canadian health care system: A focused ethnography.
Xu, 2008	Adaptation and transformation through (un)learning: lived experiences of immigrant Chinese nurses in US healthcare environment.
Villamin, 2024	Retention and turnover among migrant nurses: A scoping review
Neiterman, 2015	Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada
Takeno, 2010	Facilitating the transition of Asian nurses to work in Australia
Boateng, 2015	Exploring the Career Pathways, Professional Integration and Lived Experiences of Regulated Nurses in Ontario, Canada
Hearnden, 2007	Nursing across cultures: The communicative needs of internationally educated nurses working with older adults
Kernis, 2020	Understanding the Reentry Experiences of Immigrant Nurses in the U.S. A Qualitative Case Study
Njie-Mokonya, 2014	Exploring the Integration Experiences of Internationally Educated Nurses (IENs) within the Canadian Health Care System
OngeriMachage, 2015	Understanding the Lived Experiences of the Foreign Trained Nurses Working in New Castle County, Delaware
Saquib, 2019	Association of cumulative job dissatisfaction with depression, anxiety and stress among expatriate nurses in Saudi Arabia.
Abuliezi, 2021	The experiences of foreign-educated nurses in Japan: a systematic review.
Ham, 2019	Social Processes Affecting the Workforce Integration of First-Generation Immigrant Health Care Professionals in Aging Citizens in the Netherlands.

O'Brien, 2012	Understanding the recruitment and retention of overseas nurses: realist case study research in National Health Service Hospitals in the UK.
Rosenkoetter, 2017	Internationally Educated Nurses in Transition in the United States: Challenges and Mediators.
Xu, 2007	Strangers in Strange Lands A Meta synthesis of Lived Experiences of Immigrant Asian Nurses Working in Western Countries
Baptiste, 2015	Workplace Discrimination: An Additional Stressor for Internationally Educated Nurses.
Concept Criteria Not Met (*n*=118): Pre-Existing Conditions or Unrelated factors/ Not Workplace Integration-Related/ Not Mentioned Emotional or Behavioural or Cognitive Responses	
First author/ year of publication	Title of evidence
Mani, 2024	Bridging cultural gaps in end-of-life care: the experiences of international charge nurses in Saudi Arabia.
Lillekroken, 2024	Hope, passion and perseverance: experiences of internationally educated nurses pursuing nursing authorisation in Norway a qualitative study.
Porter, 2024	Transition to Professional Practice in the United States: Exploring the Experiences of Internationally Educated Nurses.
Shoki, 2024	Factors Related to Job Continuance of Nurses Who Migrated to Japan: A Cross-Sectional Study.
Bayuo, 2023	A meta-synthesis of the transitioning experiences and career progression of migrant African nurses.
Njie-Mokonya, 2024	Examining Workplace Practices Used to Facilitate Successful Integration of Internationally Educated Nurses Into Acute Care Settings: A Scoping Review.
Kurup, 2024	The perspectives of internationally qualified nurses regarding their specialty skill transition to Australia: A cross sectional survey.
Phiri, 2022	International recruitment of mental health nurses to the national health service: a challenge for the UK.
Presley, 2023	Empowerment of Foreign Nurses to Develop Self-efficacy in Culturally Competent Care Delivery.
Hua, 2023	Job Satisfaction, Intention to Leave, and Related Factors among Foreign-Educated Nurses in Japan: A Cross-Sectional Study.
Hadziabdic, 2021	Experiences of nurses educated outside the European Union of a Swedish bridging program and the program's role in their integration into the nursing profession: a qualitative interview study.
Shatnawi, 2023	Researching the job satisfaction of migrant critical care nurses in Saudi Arabia.
Randall, 2023	Supporting self-determination among internationally educated nurses: a discussion.
Cubelo, 2023	Linguistic racism towards internationally educated nurses in Finland: Critical reflective analysis.

yılmaz, 2023	Professional Experiences of Immigrant Turkish Nurses in Berlin, Germany: A Descriptive Phenomenological Qualitative Study.
Högstedt, 2024	Self-rated professional competence and well-being at work after obtaining a Swedish nursing license: A longitudinal mixed-methods study of internationally and domestically educated nurses.
Almansour, 2022	Home and expatriate nurses' perceptions of job satisfaction: Qualitative findings.
Jenkins, 2016	“We Are the International Nurses”: An Exploration of Internationally Qualified Nurses’ Experiences of Transitioning to New Zealand and Working in Aged Care
Zanjani, 2021	Overseas qualified nurses' sociocultural adaptation into the Australian healthcare system: A cross-sectional study.
Ohr, 2016	The transition of overseas qualified nurses and midwives into the Australian healthcare workforce.
Belita, 2021	Reducing Barriers and Achieving Success in Registration Examination Among Internationally Educated Nurses: A Participatory Action Research Project.
Ghazal, 2020	Transition-to-U.S. Practice Experiences of Internationally Educated Nurses: An Integrative Review.
Angus, 2021	Experience of internationally qualified nurses providing palliative care in a New Zealand aged residential care facility.
Baluyot, 2018	Using Action Research As The Basis For Transforming A Workplace Culture So That Integration Of Overseas Registered Nurses To The Nursing Home Clinical Setting Be More Adaptive, Inclusive And Mutually Supportive: How To Integrate Overseas Registered Nurses
Deegan, 2010	Expert to novice: experiences of professional adaptation reported by non-English speaking nurses in Australia.
Gao, 2020	International Operating Room Nurses' Challenges in Providing Person-Centered Care During Organ Procurement Surgery.
Nortvedt, 2020	A courageous journey: Experiences of migrant Philippine nurses in Norway.
Efendi, 2020	The lived experience of Indonesian nurses in Kuwait: A phenomenological study.
Brunton, 2019	Internationally qualified nurse communication-A qualitative cross country study.
Zaghloul, 2019	Mental Health Status of Expatriate Nurses in Northcentral Saudi Arabia.
Philip, 2019	Overseas Qualified Nurses' (OQNs) perspectives and experiences of intraprofessional and nurse-patient communication through a Community of Practice lens.
Okougha, 2010	Experience of overseas nurses: the potential for misunderstanding.
Daniel, 2001	Professional issues. Expectations and experiences of newly recruited Filipino nurses.
Parrone, 2008	Charting the 7 c's of cultural change affecting foreign nurses: competency, communication, consistency, cooperation, customs, conformity and courage.
Philip, 2019	Overseas qualified nurses' communication with other nurses and health professionals: An observational study.
Covell, 2017	Internationally educated nurses in Canada: predictors of workforce integration.

Crick, 2019	'This Building Looks Like a Mansion but Feels Like a Prison': Personal and Professional Practice Perspectives on Recruiting and Retaining Internationally Educated Nurses.
Covell, 2018	Internationally educated nurses in Canada: perceived benefits of bridging programme participation.
Brunton, 2018	Dis/Integrating cultural difference in practice and communication: A qualitative study of host and migrant Registered Nurse perspectives from New Zealand.
Allen, 2018	Experiences of internationally educated nurses holding management positions in the United States: Descriptive phenomenological study.
Cook, 2018	The importance of moral emotions for effective collaboration in culturally diverse healthcare teams.
Pung, 2017	Job satisfaction demands of immigration among international nursing staff working in the long-term care setting: A cross-sectional study.
Pung, 2017	Challenges faced by international nurses when migrating: an integrative literature review.
Stievano, 2017	Indian nurses in Italy: a qualitative study of their professional and social integration.
Stubbs, 2017	Recruitment of nurses from India and their experiences of an Overseas Nurses Program.
Goh, 2016	Acculturation, quality of life and work environment of international nurses in a multi-cultural society: A cross-sectional, correlational study.
Lum, 2016	Internationally educated nurses' reflections on nursing communication in Canada.
Jenkins, 2015	A missing piece of the workforce puzzle. The experiences of internationally qualified nurses in New Zealand: a literature review.
Al-Hamdan, 2015	Experiencing transformation: the case of Jordanian nurse immigrating to the UK.
Connor, 2014	Occupational stress and adaptation of immigrant nurses from the Philippines.
Ho, 2015	Investigating Internationally Educated Taiwanese Nurses' Training and Communication Experiences in the United States.
Efendi, 2016	Lived experience of Indonesian nurses in Japan: A phenomenological study.
Primeau, 2021	Correlates of career satisfaction in internationally educated nurses: A cross-sectional survey-based study.
Itzhaki, 2013	Job satisfaction among immigrant nurses in Israel and the United States of America.
Pitman, 2014	Perceptions of Employment- Based Discrimination Among Newly Arrived Foreign-Educated Nurses.
Rodríguez, 2014	Cultural experiences of immigrant nurses at two hospitals in Chile.
Wheeler, 2013	The experiences of internationally educated nurses in the southeastern United States of America.
Blythe, 2009	Nurse migration to Canada: pathways and pitfalls of workforce integration.
Kawi, 2009	Facilitators and barriers to adjustment of international nurses: an integrative review.
Bond, 2020	The experiences of international nurses and midwives transitioning to work in the UK: A qualitative synthesis of the literature from 2010 to 2019.
Sherman, 2008	Transitioning internationally recruited nurses into clinical settings.

Chege, 2010	Adaptation challenges facing internationally educated nurses [corrected] [published erratum appears in DCCN 2010 Sep-Oct;29(5):210].
Smith, 2011	Rediscovering nursing: A study of overseas nurses working in Western Australia.
Alexis, 2009	Overseas trained nurses' perception of UK nurses' caring attitudes: a qualitative study.
Lin, 2009	A synthesis of the literature on Asian nurses' work experiences in the United States.
Larsen, 2007	Embodiment of discrimination and overseas nurses' career progression.
Hawthorne, 2001	The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia.
Bieski, 2007	Foreign-educated nurses: an overview of migration and credentialing issues.
Goh, 2016	Job satisfaction, work environment and intention to leave among migrant nurses working in a publicly funded tertiary hospital.
Brown, 2000	Physiological stress responses in Filipino-American immigrant nurses: the effects of residence time, life-style, and job strain.
Omeri, 2002	Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning.
Oakley, 2020	Telling their story: A qualitative descriptive study of the lived experience of expatriate palliative care nurses in the United Arab Emirates.
McGonagle, 2004	The expectations and experiences of Filipino nurses working in an intellectual disability service in the Republic of Ireland.
Dijkhuizen, 1995	Meeting the basic and educational needs of foreign nurses.
Zhou, 2010	Ambivalence and the experience of China-educated nurses working in Australia
Withers, 2003	Focus. Adapting to a new culture: a study of the expectations and experiences of Filipino nurses in the Oxford Radcliffe Hospitals NHS Trust.
Yahes, 1996	Enculturation of foreign nurse graduates: an integrated model.
Ncube, 2017	Influence of Leadership Styles on Expatriate Nurses' Professional Integration in the UAE.
Beriones, 2014	Adaptation experiences of internationally educated Filipino nurses employed in the United States.
Ibitayo, 2010	Factors affecting the relocation and transition of internationally educated nurses migrating to the United States of America.
Hearnden, 2008	Coping with differences in culture and communication in health care.
Davis, 2003	How to help international nurses adjust: use these practical tips to help international nurses make an effective transition to U.S. practice.
Woodbridge, 2010	Supporting Indian nurses migrating to New Zealand: a literature review.
Ryan, 2010	Adjusting to the United States healthcare workplace: Perceptions of internationally born and educated registered nurses.
Liou, 2007	The relationships between collectivist orientation, perception of practice environment, organizational commitment, and intention to leave current job among Asian nurses working in the United States.
Lopez, 1990	The acculturation of selected Filipino nurses to nursing practice in the United States.

Charest, 1992	Analysis of a transcultural innovation: the socialization of Filipino graduate nurses into an acute health care organization in the United States.
Foo, 2024	Facilitating acculturation of internationally educated nurses: A meta-synthesis of social integration strategies.
Rajpoot, 2024	Transitioning experiences of internationally educated nurses in host countries: A narrative systematic review.
Balante, 2021	How does culture influence work experience in a foreign country? An umbrella review of the cultural challenges faced by internationally educated nurses.
Lum, 2015	Challenges in oral communication for internationally educated nurses.
Primeau, 2014	Foreign-trained nurses' experiences and socioprofessional integration best practices: an integrative literature review.
Salami, 2014	Workforce Integration of Philippine-Educated Nurses who Migrate to Canada through the Live-in Caregiver Program.
Ronquillo, 2012	Leaving the Philippines: oral histories of nurses' transition to Canadian nursing practice.
Jones, 2009	Caribbean nurses migrating to the UK: a gender-focused literature review.
Omeri, 2006	Workplace practices with mental health implications impacting on recruitment and retention of overseas nurses in the context of nursing shortages.
Xu, 2004	Conflict management styles of Asian and Asian American nurses: implications for the nurse manager.
Dicicco-Bloom, 2004	The racial and gendered experiences of immigrant nurses from Kerala, India.
Bae, 2012	Organizational socialization of international nurses in the New York metropolitan area
Alreshidi, 2021	Turnover among foreign nurses in Saudi Arabia
Walani, 2015	Global migration of internationally educated nurses: Experiences of employment discrimination
Vesperoni, 2015	Strangers in a strange land: work experiences of foreign nurses in Parma's territory
Blythe, 2009	Internationally educated nurses: Profiling workforce diversity
Ea, 2008	Job satisfaction and acculturation among Filipino registered nurses
Winkelmann-Gleed, 2005	Strangers in a British world? Integration of international nurses.
Baxter, 2017	Philippine nurse migration to the Canadian prairies: challenges and opportunities
Belay, 2013	A qualitative investigation of the communication experiences of international nurses who participated in a 13-week accent modification program
Gonzalvo, 2009	Acculturation, individualism, and job satisfaction among immigrant nurses from the Philippines
Hale, 2013	The lived experiences of Indian nurses working in the United States: Perceptions and attitudes towards nurse-physician collaboration
Mongwa, 2017	The Lived Experience of Foreign Educated Nurses from Africa Practicing in the United States
Onyeibe, 2021	Experience of Native Ethnic African Minority Nurses Working in United States Public Hospitals

Shima, 2014	Language socialization process of Indonesian and Filipino nurses in Japan
Smith, 2011	Exploring the learning experiences of Filipino nurse immigrants new to the U.S. healthcare industry
Tangwar, 2014	Adaptation of Kenyan-Born Registered Nurses into the American Healthcare System
Thompson, 2022	Nurse Migration to the United States and Staffing of Foreign Educated Nurses in Long Term Care: Employment Outcomes and Professional Experiences
Tiburan, 2016	Breaking the Bamboo Ceiling: Stories of Success of Filipino American Nurses
Walker, 2010	A Clash of Cultures: A Model for Supporting Adaptation Nurses
Zhang, 2009	The experiences of immigrant nurses in Lowell, MA: A case study
Context eligibility criteria not met (*n*=13): host country Classification (HICs) Not Verified/ Non-Practice Setting	
First author/ year of publication	Title of evidence
Cubelo, 2024	Factors influencing job satisfaction and professional competencies in clinical practice among internationally educated nurses during the migration journey: A mixed methods systematic review.
Correa-Betancour, 2023	Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review.
Efendi, 2024	Mental health challenges faced by foreign nurses: a scoping review.
Sheehy, 2024	The reported experiences of internationally qualified nurses in aged care: A scoping review.
Olanrewaju, 2024	Internationally Educated Nursing Staff Caring for Older Adults: A Scoping Study.
Dahl, 2022	Internationally educated nurses and resilience: A systematic literature review.
Viken, 2018	Foreign educated nurses' work experiences and patient safety: systematic review of qualitative studies.
Montayre, 2018	The global Filipino nurse: An integrative review of Filipino nurses' work experiences.
Zhong, 2017	What are Chinese nurses' experiences whilst working overseas? A narrative scoping review.
Covell, 2016	Scoping review about the professional integration of internationally educated health professionals.
Tuttas, 2015	Perceived Racial and Ethnic Prejudice and Discrimination Experiences of Minority Migrant Nurses: A Literature Review.
Balante, 2021	How does culture influence work experience in a foreign country? An umbrella review of the cultural challenges faced by internationally educated nurses
Newton, 2012	The migration and transitioning experiences of internationally educated nurses: a global perspective.

Appendix C

Data Extraction Table

Table C

Summary of Findings from the Results of the 37 Included Sources

• **Title** •**Authors** • **Year of publication** • **Type of evidence** • **Country** • **Setting** • **Aim**	• **Design** • **Methodology** • **Data collection** • **Sample** • **Studies focus**	• **Key finding related to emotional, cognitive and behavioural responses**
• The (mis)management of migrant nurses in the UK: a sociological study • Radha Adhikari and Kath M. Melia • 2015 • Primary research article • United Kingdom • Private nursing homes and long-term care facilities • To examine Nepali migrant nurses' professional life in the UK, focusing on their employment experiences, career aspirations, and professional integration	• Qualitative •Ethnographic • In-depth interviews, informal discussions, telephone conversations, focus groups when appropriate, and review of relevant policy documents •21 Nepali nurses working in the UK; participants were highly qualified and experienced nurses, some with Masters Degrees, with expertise in specialized areas such as critical care, management, education, theatre nursing, maternity care, and ICU/CCU • The professional experiences and career pathways of Nepali migrant nurses in the UK, experiences of migration, professional integration, and job expectations/ focusing	• Emotional responses: Frustration and lack of job satisfaction (when unable to work in areas matching their expertise)/ Shock (when first encountering the reality of nursing-home work that differed from their expectations)/ Feeling trapped in elderly care sector (after losing professional confidence and due to work permit restrictions preventing movement to NHS jobs)/ Loss of professional confidence (during adaptation to UK nursing homes and after being placed in roles that do not utilize their clinical expertise)/ Disappointment (when realizing career aspirations could not be fulfilled and when experiencing job realities different from expectations)/ Feeling deskilled (when unable to practice advanced nursing skills and when experiencing job realities different from expectations) • Behavioural responses: Taking jobs in nursing homes and accepting jobs below their skill level despite having specialized skills and due to lack of alternative opportunities • Cognitive responses: Perceiving a significant downward professional mobility (when comparing their previous roles to current positions) / Recognizing gradual deskilling of their professional abilities (after time spent in care work) / Perceiving "90% wrong" expectations about UK nursing (when comparing pre-migration expectations with reality) / Recognizing a professional identity shift from specialized nurse to care provider (describing their work as "British Bottom Care" BBC)/ Seeing their situation as a form of "mismanagement" of migrant workforce (reflecting on systemic issues)

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
	on the mismatch between their skills/qualifications, their job placements and skills utilization	
• Internationally educated nurses' experiences in a hospital in England: an exploratory study • Obrey Alexis • 2013 • Primary research article • United Kingdom • District General Hospital • To gain an understanding of IENs's experiences of working in the National Health Service (NHS) in England	• Qualitative • Hermeneutic phenomenology • Phase 1: 12 individual semi-structured interviews/ Phase 2: Four focus group interviews (six participants per group) • 36 total participants - 12 in individual interviews (7 women and 5 men) for phase one, plus 24 participants in focus groups (6 participants in each of 4 groups) for phase two. Participants originated from the Philippines, South Africa, the Caribbean and Sub-Saharan Africa. • Exploring the lived experiences of internationally educated nurses working in the NHS in England, with particular attention to their transition journey and acculturation process.	• Emotional responses: Fear and anxiety (when leaving their home countries and entering an unfamiliar work environment)/ Frustration (due to inability to perform routine procedures they were familiar with) / Shock (when experiencing different nursing practices in the UK)/ Disillusionment (when experiencing workplace discrimination and racism)/ Pride and validation (when receiving appreciation from patients for their care)/ Unhappiness (in work environments where they felt unwelcome)/ Anxiety (when navigating differences between personal beliefs and host culture values)/ Feeling like an "outcast" (when experiencing difficulties integrating with UK counterparts)/ Feeling isolated (when unable to express themselves well due to language barriers)/ Apprehension, frustration, and stress (when adapting to unfamiliar documentation systems)/ Feeling professionally undervalued (when their previous experience was not recognized) • Behavioural responses: Avoiding interactions with local nurses (due to fear of discrimination or exclusion)/ Seeking support from colleagues of the same nationality (forming close-knit communities within the workplace)/"Keeping to themselves" (in response to difficulties integrating with UK counterparts)/ Enduring and Tolerating unacceptable or unfair treatment (to maintain employment and residency status)/ Proving competency (actively working harder to demonstrate equal skill levels as UK nurses)/ Planning to seek new work environments (where they might feel more accepted) • Cognitive responses: Recognizing the mismatch between expectations and reality(expecting smooth transition but facing major cultural and systemic barriers)/ Desire to leave

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
		(considering relocation to a more welcoming work environment)/ Perceived inequality (believing they were treated differently based on race and nationality)/ Recognizing the need to adapt to cultural differences and "learn a new way of nursing" (despite challenges)/ Questioning the loyalty and professionalism of UK managers (leading to reluctance to share problems)
• Exploring the perceptions and work experiences of internationally recruited neonatal nurses: a qualitative study • Obrey Alexis and Adeline Shillingford • 2011 • Primary research article • United Kingdom • Two teaching hospitals (neonatal units) • To explore the perceptions and work experiences of internationally recruited neonatal nurses	• Qualitative • Husserl's phenomenology • Semi-structured interviews • 13 internationally recruited neonatal nurses (all female), who originated from either Jamaica or the Philippines. • The lived experiences of internationally recruited neonatal nurses working in NHS neonatal units in London, with attention to their perceptions, challenges, and coping mechanisms.	• Emotional responses: Frustration and stress (when placed in an unfamiliar system without adequate support and preparation)/ Anxiety and humiliation (when experiencing racial discrimination from patients and lack of managerial intervention)/ Frustration (when previous experience was disregarded)/ Feeling devalued (when their prior experience was not recognized or respected)/ Relief and confidence regain (when receiving support from colleagues and managers) • Behavioural responses: Creating support networks and "Sticking together" with other internationally recruited nurses/ Avoiding direct confrontation (to prevent conflicts and maintain job security)/ Withdrawing from interactions with local nurses (due to exclusion or discrimination)/ Working harder to prove competence (to counteract perceptions of inferiority)/Developing adopting survival strategies (e.g., watching motivational movies, being open-minded, and staying vocal about concerns) • Cognitive responses: *Perception of bias* (feeling their experience was undervalued compared to UK, Australian, and New Zealand nurses)/ *Expectation vs. reality mismatch* (expecting equal treatment but experiencing discrimination)/ *Recognition of professional stagnation* (realizing limited career growth despite qualifications)/ Feeling "back to square one" and "back to zero" (when previous experience was dismissed)/ Perceiving a loss of professional independence (when professional experience wasn't recognized)/ *Understanding systemic barriers* (realizing that a structured mentorship and induction program could have helped)

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
• The experiences of overseas black and minority ethnic registered nurses in an English hospital: A phenomenological study • Obrey Alexis and Vasso Vydelingum • 2005 • Primary research article • United Kingdom • NHS hospitals in south of England • To explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses working in the NHS in the south of England	• Qualitative • Phenomenology (Heidegger's hermeneutic) • Semi-structured interviews • 12 overseas black and minority ethnic nurses (7 females and 5 males) who originated from the Philippines, South Africa, the Caribbean, and Sub-Saharan Africa. • The lived experiences of overseas black and minority ethnic nurses working in the NHS, with particular attention to how they were treated in the workplace, their perceptions of integration and related Challenges	• Emotional responses: Frustration and disappointment (when experiencing racial discrimination in promotions and training)/ Humiliation and distress (when subjected to unfair performance reviews and negative perceptions from colleagues)/ Feeling unappreciated (despite working extra shifts and contributing significantly to patient care)/ Isolation and exclusion (when facing a lack of support from UK-born colleagues)/ Feeling inadequate (when facing criticism about professional competence)/ Feeling unwelcome (creating disappointment and questioning their decision to work in the UK)/ Discomfort and anger (when facing situations that made them feel inadequate)/ Loss of confidence (when unable to use previously acquired skills)/ Disillusionment (about the NHS workplace culture) • Behavioural responses: Avoiding additional responsibilities like deciding not to do extra shifts(due to lack of recognition for their efforts)/ "Sticking to own ethnic group" for support (rather than approaching white British colleagues)/ Trying to prove competence (working harder than UK-born colleagues to gain recognition)/ Limiting career aspirations (due to perceived discrimination in opportunity allocation)/ Avoiding complaining (when recognizing that complaints would not be supported)/ Withdrawing from workplace interactions (to avoid discrimination or workplace conflicts) • Cognitive responses: Expectation vs. reality mismatch (expecting fairness in job opportunities but facing discrimination)/ Recognition of workplace power dynamics (acknowledging that maintaining employment required enduring discrimination and proving competence continuously)/ Perceiving unfairness in nursing practice (particularly in assignment of difficult patients)/ Questioning the usefulness of performance reviews (when development needs weren't addressed)/ Recognizing "boundaries" between themselves and white British colleagues/ View that contributions were merely seen as "filling the gaps" rather than valued

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
• Experiences in the UK National Health Service: The overseas nurses' workforce • Obrey Alexis and Vasso Vydelingum • 2009 • Primary research article • United Kingdom • NHS hospitals in London and non-London areas • To determine how overseas nurses perceive equal opportunity and opportunities for skill development and training in the NHS in the UK	• Quantitative • Survey • Questionnaire • 188 overseas nurses From Philippines (50%), India (12.2%), South Africa (6.4%), Malaysia (5.9%), various African nations. Most were female (81.9%) and the majority were D grade nurses (54.8%) • How overseas black and minority ethnic nurses perceive equal opportunity and opportunities for skill development and training	• Emotional responses: Frustration and resentment (when denied promotions due to perceived racial discrimination)/ Feeling undervalued (when not given opportunities for skill development)/ Disillusionment (when experiencing disparities between policy and actual practice)/ Stress and disappointment (when facing barriers to career advancement)/ African nurses felt more marginalized and treated unfairly compared to Filipino, Indian, and Pakistani nurses (particularly in non-London NHS hospitals) • Behavioural responses: Withdrawing from career progression efforts (after experiencing repeated rejection in promotions)/ Avoiding training applications (due to perception of bias in training selections)/ Developing coping strategies based on ethnicity (forming support networks with others from same background)/ Seeking alternative career opportunities (considering migration to other countries for better opportunities)/ Greater likelihood of remaining in lower-grade positions despite qualifications • Cognitive responses: *Expectation vs. reality mismatch* (realizing the NHS career structure does not favor all ethnic groups equally)/ *Perceived job stagnation* (acknowledging that overseas nurses, particularly from Africa, have fewer career advancements compared to their counterparts from the Philippines and India)/ Perceiving unequal treatment based on ethnic background and being treated as outsiders (particularly among African nurses)
• Overseas nurses experiences of discrimination: a case of racist bullying? • Helen T. Allan, Helen Cowie, and Pam Smith • 2009 • Primary research article • United Kingdom	• Qualitative • Case study • Semi-structure interviews • Three overseas nurses originated from the Far East, South Africa, and a Black African nurse, purposively selected from a sample of 93	• Emotional responses: Humiliation and distress (when subjected to racist bullying by managers and colleagues)/ Crying after work due to bullying (feeling horrible and isolated)/ Feeling scared and nervous when experiencing bullying/Frustration and helplessness (when complaints about discrimination were ignored)/ Emotional breakdown (due to prolonged bullying and lack of support)/ Profound distress from being fired without warning/Depression from feeling discriminated

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
• Various NHS hospitals and care home sectors • To explore and analyze overseas nurses' (ONs) experiences of discrimination in the NHS, specifically focusing on racist bullying as a workplace phenomenon.	overseas trained nurses (Re-analysis of qualitative data from a larger national study) • How overseas nurses experience discrimination that can be understood as racist bullying, with attention to abusive power relationships, communication difficulties, emotional reactions to racist bullying, and responses to bullying.	against/ Feelings of isolation (doctors and staff changing their communication patterns and excluding from team) • Behavioural responses: Withdrawing from workplace interactions (to avoid further discrimination)/ Seeking support from trade unions and professional organizations or Seeking help from religious communities (to address workplace injustices)/ Withdrawing from applying for promotion despite being qualified/ Leaving jobs due to racist bullying/ Re-channeling energies into family support • Cognitive responses: Developing Paranoia and self-doubt (after experiencing repeated exclusion and negative treatment)/ Questioning personal competence constantly due to persistent negative feedback/ Rationalizing withdrawal from career advancement as self-protection/Perceiving stigmatization related to language ability ("she can't speak English")/Viewing visa status as a tool used to control overseas nurses/ Expectation vs. reality mismatch (expecting fair treatment but encountering discrimination).
• Investigation of the Experience of Immigrant Nurses in a Diverse Cultural Setting • Hussam Al-Nusair & Rafi Alnjadat • 2022 • Primary research article • Kingdom of Saudi Arabia (KSA) • Major private medical-surgical hospital • To investigate work-related stress (WRS), job performance, social support, and the	• Mixed methods • Quantitative survey and qualitative interviews • Survey and Semi-structured interviews • 246 immigrant nurses from diverse backgrounds completed the quantitative portion (76.6% response rate); 20 immigrant nurses participated in the qualitative interviews. 77% were female; 77% from Southeast Asia (Philippines, India, Malaysia); 13.5% from Western countries;	• Emotional responses: Felt unsupported and unrecognized when supervisors failed to provide appropriate support/*Disillusionment and disappointment* (when experiencing discrimination in salary, benefits, and promotion opportunities)/ Experienced job satisfaction when receiving recognition and positive feedback (when performance was acknowledged)/ Felt discriminated against (when experiencing different treatment compared to local or Western nurses) • Behavioural responses: Used coping mechanisms including physical activities, socializing, prayer, and communication with family (when experiencing workplace stress)/ Expressed intent to stay in current positions despite challenges (when anticipating improvements in conditions and compensation)/ *Overworking to meet expectations* (despite feeling undervalued) Use of coping mechanisms (including physical activities, making friends, praying)/ Communication with family via

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
intention of immigrant nurses to stay in a multicultural healthcare workplace in Saudi Arabia.	9.5% from Middle East; most were Christian (70.7%). • Perceived work-related stress, job performance, social support, and desire of immigrant nurses to work in a multicultural workplace.	email and phone calls/ Self-appeasement through laughing off stressful conditions/ Seeking support from colleagues • Cognitive responses: Expectation vs. reality mismatch (expecting a fair working environment but facing power hierarchies favoring local or Western nurses)/ Experienced cultural shock and struggled to adapt to Saudi culture (when encountering unfamiliar cultural practices)/ Perceived that documentation requirements created risks for both patients and nurses (when dealing with administrative tasks)
• Expectations, Experiences and Plans of Internationally Recruited Nurses in the UK: a Case Study in a NHS Acute Trust in London •Alonso-Garbayo Alvaro • 2007 • Doctoral dissertation • United Kingdom • NHS Acute Trust in London, comprising three teaching hospitals • To improve understanding of the recruitment and retention of internationally recruited nurses (IRNs) in the UK, by exploring their expectations, experiences during recruitment and adaptation, and their future plans.	• Qualitative • Case study with longitudinal and cross-sectional elements • Semi-structured interviews, documentary review, reflexive diary • 21 internationally recruited nurses from India and Philippines and additional participants of 4 ward sisters, 4 adaptation mentors, and 2 hospital managers • The study examined nurses' motivation to emigrate, their expectations about the UK, their experiences during recruitment and adaptation, and how these influenced their plans for career progression and intention to stay or leave.	• Emotional responses: Initial excitement and optimism upon arrival, followed by a period of culture shock and disillusionment when reality didn't match expectations/Isolation and loneliness (due to lack of institutional support for cultural and professional adaptation especially during first weeks of adaptation)/ Sense of being undervalued by mentors and managers who underestimated their capabilities/ Self-doubt and decreased confidence after failing promotion interviews or being discouraged from progression/ Satisfaction from unexpected positive aspects of UK nursing like professional autonomy, evidence-based practice, and better patient communication/ Disappointment when their experience and qualifications weren't recognized, being treated as newly graduated nurses despite years of experience/ Financial stress (as salary expectations did not match reality; remittances to families became a burden)/ Reluctance to pursue advancement among some Filipino nurses, particularly those who had failed promotion interviews previously • Behavioural responses: Some opted for career shifts (moving to private healthcare or planning migration to other countries)/ Cultural withdrawal and tending to isolate themselves and interact primarily with nurses from the same country and formation of social support networks/ Increased communication with family back home to cope with isolation/ Different migration paths - Indian nurses tended to bring families

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		and plan longer-term stays, while Filipino nurses often focused on remittances to support families at home/ Strategic compliance (avoided conflict and accepted lower-status roles to secure employment). • Cognitive responses: Expectation vs. reality mismatch (many expected a structured transition but found NHS adaptation challenging)/ Adaptive re-evaluation (some nurses recalibrated expectations, focusing on financial stability rather than career growth) and Professional identity re-adjustment - needing to adapt their self-perception as nurses to match UK nursing values and practices/ Perception of discrimination in career advancement opportunities compared to UK-trained nurses/ Perceived lack of recognition of previous experience and Concerns about deskilling due to lack of opportunity to practice previously used skills
• A Descriptive Phenomenology Approach to Understanding the Lived Experience of Foreign born Nurses Caring for Inpatient Saudi Military Personnel with Post-Traumatic Stress Disorder • Alshayeg, Ibraheem Mohammed • 2023 • Doctoral dissertation • Kingdom of Saudi Arabia • Prince Sultan Military Medical City (PSMMC), military hospital	• Qualitative • Husserlian phenomenology (descriptive phenomenology) • Semi-structured interviews • 15 Filipino foreign-born nurses (10 female, 5 male) working in surgical and rehabilitation wards of PSMMC. • Foreign-born nurses' responses to workplace integration while caring for Saudi military personnel with PTSD	• Emotional responses: Sense of opportunity and excitement (initial positive impression of KSA's work environment)/ Culture shock and distress (difficulty adjusting to strict religious and cultural norms)/ Feeling hopeless and overwhelmed when unable to communicate effectively with patients/Fear and helplessness (uncertainty about their role)/ Frustration and stress (language barriers impacting communication with Saudi patients) • Behavioural responses: Adjusting communication methods (using translators or simplified language to bridge the language gap)/ Seeking external emotional support (relying on colleagues and expat communities for stress relief)/ Developing adaptation strategies (seeking mentorship and peer support to navigate cultural differences) • Cognitive responses: Expectation vs. reality adjustment (realizing their role involved more cultural adaptation than expected)/ Understanding of resilience-building (learning to cope like through cultural immersion)/Perceiving workplace as both challenging and opportunity for growth

• Title •Authors • Year of publication • Type of evidence • Country • Setting • Aim	• Design • Methodology • Data collection • Sample • Studies focus	• Key finding related to emotional, cognitive and behavioural responses
• To explore and understand foreign-born nurses' lived experiences in caring for inpatient Saudi military personnel with Post-Traumatic Stress Disorder (PTSD)		
• Intention to leave of Asian nurses in US hospitals: does cultural orientation matter? • Cheng, Ching-Yu and Liou, Shwu-Ru • 2011 • Primary research article • United States of America(US) • Hospitals • To measure the predictability of cultural orientation on organizational commitment, perception of practice environment and intention to leave amongst Asian nurses working in US hospitals.	• Quantitative • Cross-sectional • Survey questionnaires • 195 Asian nurses working at least six months in US hospitals. Most participants were Filipinos (44.1%) or Chinese (32.8%), married (70.5%) and worked full-time (83.0%), most were females (90.3%) • Examining relationships between cultural orientation, perception of practice environment, organizational commitment, and intention to leave among Asian nurses.	• Emotional responses: Higher job satisfaction and commitment to their current practice environment when having more collectivist orientation (during workplace integration)/ Lower emotional distress and anxiety (among nurses with a stronger collectivist orientation, as they adapted better to organizational goals)/ Frustration and dissatisfaction (when nurses perceived their work environment as unsupportive or lacking professional development opportunities) • Behavioural responses: Lower intention to leave shown by nurses with collectivist orientation/ Increased effort to align with workplace values and norms (when cultural orientation matched the hospital's expectations)/ Greater intention to leave the organization (when work environment was perceived negatively or when commitment was low). • Cognitive responses: Developing willingness to accept the goals and values of the organization (when exhibiting collectivist cultural orientation)/ Positive perception of practice environment (when having collectivist orientation)/ Acceptance of goals and values of the organization in new environment (when having collectivist cultural orientation)
• The Impact of Acculturative Stress on the Mental Health of Filipino Nurse Immigrants Working in Emergency Rooms • Althea Baranda Clark	• Quantitative • Cross-sectional • Online Self-reported survey • 102 Filipino nurse immigrants (FNIs)	• Emotional responses: Emotional vulnerability from acculturative stress (high prevalence of depression at 53.9% and generalized anxiety disorder at 23.5% of participants/Increased anxiety and depression symptoms (when experiencing acculturative stress in the workplace)/ Lower emotional distress and better mental health (when strong social support systems

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• 2020 • Doctoral Dissertation • United States • Emergency Rooms across US • To To explore the statistical relationships between acculturative stress and associated variables on the mood disorders (anxiety and depression) of Filipino nurse immigrants working in US emergency rooms.	• Examining how acculturative stress and acculturation impact the mental health (depression and anxiety) of Filipino nurse immigrants working in high-stress emergency room environments.	were present)/ Feelings of isolation and frustration (when struggling with cultural adjustment and workplace discrimination)/ feelings of vulnerability and psychological withdrawal when facing workplace discrimination (during initial adjustment period)/ More emotional exhaustion related to high levels of general stress and nursing stress (when working in high-stress emergency settings) • Behavioural responses: Behavioural withdrawal including tardiness, absenteeism, and intention to leave employer (when facing persistent discrimination)/showing more perseverance despite challenges in the workplace integration (to maintain employment)/ Higher likelihood of burnout and work disengagement (when experiencing high acculturative stress and lack of workplace support)/ • Cognitive responses: Recognition that workplace integration challenges are more severe in high-stress environments like emergency rooms (highlighting the need for targeted mental health support)/ cognitive appraisal of workplace stressors becomes more manageable with length of time in the US (during long-term adaptation)/
• Cultural Influence on Coping Strategies of Filipino Immigrant Nurses • Jorgia B. Connor • 2016 • Primary research article • United States • Healthcare facilities • To gain a deeper understanding of the strategies Filipino IENs use to cope with work-related and nonwork-related stress within the	• Qualitative • Qualitative descriptive • Semi-structured interviews • 20 Filipino female IENs • Exploring cultural influence on coping strategies used by Filipino immigrant nurses to manage stress in their personal and professional lives after immigrating to the United States.	• Emotional responses: Feelings of loneliness (when separated from family)/ Feeling comforted (when working with other Filipino nurses)/ feeling pride in the nursing profession (to counterbalance difficulties)/ expressing contentment with simple living (despite financial challenges)/ Resilience and emotional strength (developed through faith and belief in fate to endure workplace challenges). • Behavioural responses: Seeking social support primarily from family members and other Filipino workers; petitioning parents and siblings to come to the United States to help with childcare and household responsibilities (to balance work-life demands)/ maintaining connection to spiritual/religious practices for emotional coping (when feeling stressed)/ Avoiding confrontation and conflict (by stepping away from stressful

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context of immigration and adaptation.		situations instead of addressing them directly)/ working harder to gain acceptance and respect from colleagues • Cognitive responses: Developing a belief that enduring workplace hardships will lead to long-term benefits (viewing sacrifices as necessary for career growth and financial stability)/ Viewing stress as inevitable part of nursing work (when facing workplace stressors)/ Perception of stress as an inevitable part of nursing (and reframing it as a normal occupational challenge)
• Does Being a Visible Minority Matter? Predictors of Internationally Educated Nurses' Workplace Integration • Christine L. Covell, Shamel Rolle Sands • 2020 • Primary research article • Canada • Healthcare facilities • To Examine IENs' perceptions of the extent to which they have integrated in their workplaces and the individual and contextual factors that supported their workplace integration, Explore whether IENs' perceptions differed by visible minority status, and Identify the key factors that predict IENs' workplace integration	• Quantitative • Cross-sectional • self-reported survey • 1,215 IENs; 80% female, 60% visible minorities, 84% registered nurses. Mostly from Philippines, India, Lebanon. • Perceived workplace integration and factors that supported workplace integration	• Emotional responses: Feelings of exclusion and devaluation (among visible minority IENs, when their previous nursing knowledge was unacknowledged)/ Visible minority IENs indicated that they felt significantly less integrated into their workplaces (compared to non-visible minority IENs/ Lower sense of belonging and workplace satisfaction (when experiencing racial discrimination or professional marginalization)/ IENs who were recipients of racism or discrimination experienced more mental and physical abuse and reported feeling / Increased confidence and job satisfaction (when receiving mentorship and positive workplace relationships).unwelcomed and unappreciated • Behavioural responses: Increased efforts to develop nursing knowledge and perfect communication skills (to integrate better and gain professional credibility)/ Higher likelihood of workplace retention (when supported by managers and having positive coworker relationships)/Trying to build good relationships with coworkers (as a strategy for successful integration) • Cognitive responses: Believing visible minority status negatively influenced workplace integration (during the integration process)/Perceiving racism and discrimination as barriers to workplace integration (by visible minority IENs)/ Belief that professional development and mentorship are key to overcoming integration challenges (highlighting the importance of employer-provided training)

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• "Are we on the same wavelength?" International nurses and the process of confronting and adjusting to clinical communication in Australia • Tonia Crawford, Peter Roger and Sally Candlin • 2017 • Primary research article • Australia • Private hospital in Sydney • To examine intercultural nurse-patient communication from the perspective of four Registered Nurses (RNs) from culturally and linguistically diverse (CALD) backgrounds working in Australia	• Qualitative • Qualitative descriptive • Semi-structured interviews • Four registered nurses from culturally and linguistically diverse backgrounds (from Zimbabwe, China, Iran, and the Philippines) • Experiences and perceptions of CALD nurses regarding communication with their patients	• Emotional responses: Feelings of vulnerability when patients or colleagues made assumptions about their ability to communicate effectively (when their English skills were questioned)/ Feelings of embarrassment when their communication was undermined in front of patients (during interactions with colleagues)/ Emotional strain when attempting to provide empathic care to patients (when feeling overwhelmed by workload) • Behavioural responses: Developing communication strategies including asking for clarifications, paraphrasing, using body language, and non-verbal cues (e.g., smiling) when interacting with patients/ Developing an "indifferent face" as a protective mechanism (when feeling emotionally vulnerable)/ Avoiding confrontation(Nurses avoided speaking up or defending themselves when reprimanded by colleagues to show respect for authority during interactions with colleagues)/ • Cognitive responses: Perceiving Australian communication style as "direct" and initially finding it confronting or rude (during early adjustment period)/ Perceiving cultural differences in showing respect as a source of misunderstanding (when interpreting interactions with colleagues and patients)
• Transition Program for Internationally Educated Filipina Nurses • Amelia E. Delos Reyes • 2019 • Doctoral dissertation • United States • Urban, suburban, and rural community hospitals in Alabama	• Qualitative • Narrative inquiry • Semi-structured interviews and Collection of written artifacts such as diaries or notes from participants • 12 internationally educated Filipina nurses. All female	• Emotional responses: Feelings of isolation and loneliness (during initial workplace integration due to lack of structured support and social exclusion)/ Frustration (when facing language barriers, particularly in understanding idioms, slang, and different accents)/ Experienced fear and anxiety (when interacting with doctors who were perceived as intimidating)/ Felt embarrassed and humiliated (when mocked for accent or food choices)/ Felt demoralized and inferior (when required to repeat themselves due to accent)/ Felt frustrated and angry (when facing discrimination or stereotyping)/

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• To explore the lived experiences of internationally educated Filipina nurses related to socio-cultural differences, language barriers, and adaptation to their new living and working environment, and to use these experiences to contribute to the development or enhancement of transition programs.	• Explored how IEFNs experienced transition to the U.S. nursing workforce and how their experiences could inform transition programs	• Behavioural responses: Avoided initiating conversations with American colleagues (during interactions where they felt marginalized)/ Carried notebooks to write notes(when verbal communication was difficult)/ Worked extra shifts and overtime (to prove competence and earn additional income)/ form social support with Filipino colleagues (as a coping mechanism to counter feelings of exclusion)/ Avoidance of confrontation and passive compliance (when experiencing discrimination or unfavorable work conditions to maintain job security) • Cognitive responses: Developing self-doubt (when facing language barriers)/ Perceived themselves as outsiders or "second-class citizens" (in workplace relationships)/ Recognized lack of respect for their educational background and clinical competence (when undermined by colleagues)/ Re-framed difficulties as challenges to overcome (to maintain motivation)/ Recognized discrimination patterns in scheduling and patient assignments (when noticing unfair treatment)/ Identified need for more structured and targeted transition programs (based on their experiences)/ Adjustment to new workplace norms and expectations (as a gradual process, requiring self-initiative to learn protocols and cultural practices)
• “It’s only the skin colour, otherwise we are all people”: the changing face of the Australian nurse • Sophia Dywili, Louise O’Brien, Judith Anderson • 2021 • Primary research article • Australia • Rural healthcare facilities in New South Wales	• Qualitative • Hermeneutical phenomenology • Interviews and one focus group discussion • 18 black sub-Saharan African overseas qualified nurses (17 female, 1 male) • Explored the experiences of racial discrimination among black sub-Saharan overseas qualified nurses	• Emotional responses: Felt unwelcome by colleagues and patients (when colleagues avoided interaction or patients displayed discomfort with black nurses)/ Experienced loneliness and stress (when marginalized in the workplace)/ Felt humiliated (when discriminated against based on skin color)/ Felt undervalued and not trusted (when their nursing skills were questioned)/ Felt stressed and not trusted when their professional competence was questioned (during medication rounds or patient care) • Behavioural responses: Trying to block their minds to negative behaviours and focused on migration goals (to cope with discrimination)/ Reciprocated negative behaviours in some cases (when experiencing selective help from colleagues)/ Downplayed

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• To explore the experience of racial discrimination among Black sub-Saharan African internationally educated nurses working in rural Australia and To investigate how these nurses cope with discrimination and marginalization in their workplaces		racist incidents without officially reporting them (to avoid confrontation)/seeking support and Increased reliance from other IENs (to cope with feelings of exclusion). • Cognitive responses: Acknowledged that racial differences were the basis for discrimination (recognizing that skin color was the primary factor)/ Recognized that patients had cultural shock when being nursed by black nurses (understanding patient reactions)/ Perceived the need to work harder to be accepted as professionals (to overcome negative perceptions)/ Acknowledgment that workplace diversity and inclusion policies need improvement (to better support internationally educated nurses)
• Experiences of Racial Microaggression Among Migrant Nurses in the United Kingdom • Emee Vida Estacio and Sirandou Saidy-Khan • 2014 • Primary research article • United Kingdom • Hospitals in the midlands of England • To explore the experiences of racial microaggression and examine how migrant nurses interpret and cope with these experiences	• Qualitative • Qualitative descriptive • Diary writing and a group discussion • 11 migrant nurses (originally 12, with one dropout); 9 from the Philippines, 1 from Kenya, 1 from Zimbabwe, and 1 from Zambia. All females. • To explore the experiences of racial microaggression in workplace integration and impact of racial microaggressions on emotional well-being and professional identity	• Emotional responses: Felt inferior and different when working with racially abusive colleagues (during interactions with certain staff members)/ Experienced anger and frustration (when abilities were questioned or undermined)/ Felt paranoid about others talking about their inadequacies (during workplace interactions)/ Felt miserable and tearful (when experiencing racially charged comments)/ Felt demoralized (when repeatedly excluded from training lists)/ Felt confusion about experiences due to the vague nature of microaggressions (during social interactions) • Behavioural responses: Trying to confront racist behaviours directly and report incidents to managers (when experiencing bullying)/ Downplayed incidents as trivial (due to the vague and subtle nature of microaggressions)/ Avoiding confrontation and accepting racial microaggressions as part of the work environment (to maintain employment stability)/ Working harder than local colleagues (to prove competence and counteract negative stereotypes). • Cognitive responses: Starting to question whether incidents were actually racist or not (due to subtle nature of microaggressions)/ Developed awareness of new forms of racism that are

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		covert, subtle and sometimes unintentional (throughout their work experience)
• The lived experience of foreign-educated Filipino nurse working in a large suburban teaching hospital • Karen R. Hughes, • 2008 • Master's dissertation • United States • Suburban teaching hospital • To explore and describe the lived experiences of foreign-educated Filipino nurses working in a large suburban teaching hospital in the U.S., and to understand their transition into nursing practice.	• Qualitative • Hermeneutical phenomenology • Semi-structured interviews • 6 Filipino nurses (five female one male) • Lived experiences, challenges and responses of foreign-educated Filipino nurses to workplace integration	• Emotional responses: Experienced psychological stress and feelings of inadequacy despite prior experience (when encountering unfamiliar technology and communication subtleties)/ Felt nervous and anxious when communicating(when interacting with physicians)/ Felt discriminated against and undervalued (when making errors or when colleagues specifically looked for mistakes and during interactions with some preceptors)/ Felt anxious, frustrated, and isolated (when adjusting to cultural differences in communication and societal norms) • Behavioural responses: Avoided confrontation or chose the "path of least resistance" (when facing challenges)/Became less communicative than expected (during shift interactions)/ Avoided delegating tasks to patient care assistant-PCAs and uncomfortable to impose during daily practice/ Asked to be treated like new graduates (during orientation period)/ increase connections with family (during adjustment period) • Cognitive responses: Experienced "intense fear of the unknown, fear of what will be, fear of not knowing everything" and reported low self-esteem and confidence (during initial transition period)/ Perceived themselves as novices despite extensive nursing experience in their home country/ Certain U.S. nursing attitudes and behaviours, including autonomy, advocacy, and directness, were initially seen as threatening but later became valued
• Accent bias: A barrier to Black African-born nurses seeking managerial and faculty positions in the United States • Kechi Iheduru-Anderson	• Qualitative • Focused ethnography • Semi-structured interviews • 15 Black African-born nurses (13 women, 2 men) originally from three sub-Saharan	• Emotional responses: Feeling frustrated when having to constantly repeat themselves due to accent (during workplace communication)/ Feeling unwelcome and unwanted (when entering prestigious healthcare organizations)/ Feeling socially distant and uncomfortable with colleagues (during workplace interactions)/ Experiencing emotional distress and mental exhaustion due to rejection and devaluation

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• 2020 • Primary research article • United States • Healthcare settings • To examine the perceptions of Black African-born nurses (BABNs) with non-native accents regarding their nursing career advancement to managerial or faculty roles within nursing professions in the United States	African countries (12 from Nigeria, 2 from Ghana, 1 from Kenya) • Perceptions of how non-native accents affected career advancement opportunities in nursing, particularly in seeking managerial or faculty positions • Thematic analysis	(when seeking career advancement)/ Feeling anxious and distressed when ridiculed about their accent (when being made fun of by colleagues) • Behavioural responses: Withdrawing from participation and becoming silent during discussions (during meetings when not heard or acknowledged)/ Avoiding applying for managerial or faculty positions (when anticipating rejection based on accent)/ Working longer and harder than peers to prove themselves worthy (when seeking promotional opportunities)/Developing adaptive strategies or proactive behaviours like taking accent modification classes to improve communication and watching television programs to adapt to American communication styles • Cognitive responses: Developing self-doubt when ridiculed about their accent (when being made fun of by colleagues)/ Perceived systematic bias limiting their career growth (when repeatedly overlooked for promotions or managerial roles due to accent bias)/ Felt compelled to continuously defend their competence and qualifications (when peers or supervisors openly questioned their abilities because of accent)/ Internalizing negative stereotypes and questioning their own abilities (after experiencing repeated discrimination)/ Perceiving being stuck in lower-level positions with limited advancement opportunities (when comparing career trajectory with White counterparts)/ Believed they were judged as less intelligent or professionally incapable (when their accent led colleagues to ignore or dismiss their ideas).
• African born black nurses' perception of their U.S. work environment: Race matters • Kechinyere C. Iheduru-Anderson, Chimezie J. Agomoh, Joseph Inungu	• Qualitative • Qualitative descriptive • Unstructured interviews • 17 African-born Black nurses (14 women and 3 men) from five different African	• Emotional responses: Feeling dismissed, disregarded, and devalued as individuals (when treated as "less of a person")/Experiencing emotional distress, anxiety, and mental exhaustion (when navigating hostile workplace environments)/ Experiencing isolation and lack of belonging (when experiencing poor communication and exclusion in team interactions)/Developing frustration,

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• 2021 • Primary research article • United States • Healthcare organizations (clinical settings and academia) • To describe how African-born Black nurses felt their race affected their experience of the work environment and whether these experiences contributed to perceptions of unhealthy work environments.	countries (Nigeria: 9, Ghana: 2, Kenya: 3, Cameroon: 2, Uganda: 1), working in clinical practice settings (15) and academia (2) • African-born Black nurses' perceptions of racial influence on their experiences within U.S. nursing work environments.	hopelessness and burned out (when contributions are not recognized) • Behavioural responses: Adopted silence, withdrawal, and reduced participation in workplace activities (when repeatedly experiencing exclusion or unfair treatment from peers and leadership)/ Limiting communication with colleagues (when repeatedly interrupted or ignored)/ Sought therapy or professional help to manage workplace stress and emotional distress (when experiencing ongoing racial discrimination and bullying)/ Left jobs or academia or considered job changes to escape unhealthy workplace environments (when facing persistent disrespect, discrimination, or lack of managerial support)/ Developed coping mechanisms such as spirituality, religion, and positive self-affirmations to maintain emotional well-being (when experiencing ongoing negative workplace interactions)/ • Cognitive responses: Perceiving a need to "hide true feelings" to survive in the workplace (when managing racial oppression)/ Developed perceptions of distrust towards leadership and colleagues (when management failed to address their concerns or appeared complicit in maintaining discriminatory or hostile work environments)/ Viewing their status as outsiders not belonging to the team (when excluded from social interactions)/ Developing a mindset of invisibility as self-preservation (when repeatedly ignored or dismissed)/ Perceiving experiences of discrimination as "part of life" (when seeking meaning and control)
• Experiences of Nigerian Internationally Educated Nurses Transitioning to United States Health Care Settings • Kechinyere C. Iheduru-Anderson, Monika M. Wahi	• Qualitative • Descriptive phenomenology • Semi-structured interviews • 6 female Nigerian internationally educated nurses • Experiences, including facilitators	• Emotional responses: Fear and anxiety (when trying to adapt to new workplace)/ Anger and disappointment (when experiencing racism and discrimination)/ Frustration (when feeling invisible and not given a chance to demonstrate competence)/ Feeling of "dying in silence" (when afraid to ask questions)/ Loneliness (when isolated in workplace and missing home environment)/ Disappointment (when experiencing unequal treatment)/ Emotional distress (when experiencing racial discrimination)/ Felt emotionally unsupported (when

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• 2018 • Primary research article • United States • Healthcare facilities • To describe the experiences of Nigerian internationally educated nurses (NIENs) transitioning into clinical practice in the United States, identifying factors that facilitated or hindered their transition.	and barriers, during transition into clinical practice in U.S. healthcare settings • Thematic analysis	preceptors and colleagues failed to provide appropriate orientation and mentorship)/ Feeling proud and feelings of achievement when developing a sense of belonging (after connecting with other West African nurses) • Behavioural responses: Actively sought mentoring and education to overcome barriers (when experiencing difficulties adapting to the new nursing culture and healthcare system)/ Supporting other IENs (helping newer Nigerian nurses navigate the transition process)/ Learning to stand up for themselves (developing assertiveness)/ Exhibited resilience and persistence (when faced with challenging workplace dynamics) • Cognitive responses: Developing a sense of belonging (when connecting with other foreign educated nurses)/trying to be more optimistic ("looking on the bright side")/ Perceived a need for structured transitional programs to better prepare IENs (when reflecting on their initial transitional experiences and challenges)/ Viewing differences in healthcare practice as opportunities for specialization (appreciation for specialized nursing model)
• Lived Experience of Migrant Filipino Registered Nurses in Nonprofit Hospitals in California • Ronald Johnson • 2018 • Doctoral dissertation • United States • Nonprofit hospitals • To understand the lived experience of migrant Filipino registered nurses working in nonprofit healthcare in California, with a focus	• Qualitative • Interpretive Phenomenological Analysis • Semi-structured interviews • 8 Filipino migrant registered nurses (6 female, 2 male) • Emotional, social, and communicational experiences during workplace acculturation among migrant Filipino nurses in their early	• Emotional responses: Experienced feelings of isolation upon arrival and throughout early transition period (during first months in the workplace)/ Felt inadequate in both personal and professional environments (when unable to communicate effectively or meet workplace expectations)/ Experienced stress and frustration when expectations about life and work in the US did not align with reality (during early transition)/ Reported disappointment about what they thought living and working in the US would be like (when experiencing the reality of high cost of living and difficult work schedules)/ Felt upset and frustrated when patients or colleagues couldn't understand them (during communication challenges)/ Feelings of disorientation regarding their roles and responsibilities (when faced with conflicting expectations from the new workplace

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on their workplace acculturation experience.	employment period in California.	environment compared to previous experiences or training). • Behavioural responses: Developed avoidance behaviours to protect themselves both at work and in social settings like avoided answering phones or sitting with American colleagues at lunch to minimize speaking English (when feeling insecure about language skills) (when feeling stressed or overwhelmed)/ Created dual identities - "acting" as an American nurse at work while being Filipino at home (to cope with cultural differences)/ Sought support from other Filipino nurses rather than engaging with American colleagues (during breaks and social time)/ Worked excessive hours to cope with feelings of inadequacy (during early months of employment)/ • Cognitive responses: Replayed workplace interactions in their minds, increasing feelings of homesickness (after difficult work experiences)/ Perceived communication as the most significant barrier to workplace integration (during all workplace interactions)/ Viewed their early difficulties as a "rite of passage" that had to be endured (when reflecting on their adaptation process)/ Some felt they never fully integrated and continued to feel like outsiders even after many years (when considering their place in the workplace)/
• Lived experiences of internationally educated nurses in hospitals in the United States of America • Jose, Mini M • 2010 • Primary research article • United States of America • Hospitals • To elicit and describe the lived experiences of	• Qualitative • Phenomenology • Interviews • 20 new immigrant IENs who had migrated from the Philippines (8), Nigeria (5), and India (7) to the US; all had less than 5 years of experience in the US and an average of 7.4 years nursing experience in their	• Emotional responses: Feelings of being overwhelmed (when facing everything new in life and work)/ Shock (when discovering differences in healthcare delivery and workplace expectations)/ Happiness (when adaptation to living and working in the US became easier and after finding support networks)/ Loneliness and loss (when experiencing distance from loved ones and familiar cultures) • Behavioural responses: Developing persistence and willingness to learn new ways (when rising above challenges)/ Building support networks (to overcome workplace difficulties)/ Offering to help newer IENs (after making successful adaptations

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IENs who work in a multi-hospital medical centre in the urban US	homelands. 7 female and 3 male • The lived experiences of IENs in US hospitals, including their migration stories, adaptation challenges, stressors, and coping strategies	themselves)/ Seeking support networks (when struggling with workplace challenges) • Cognitive responses: Understanding cultural diversity as difficult to cope with (during workplace integration)/ Development of resilience and self-reliance (after learning coping strategies for workplace and social adaptation)/ Recognizing the need to concentrate on building inherent strengths (during adaptation)
• Transition Experiences of Indian Nurses Into Australian Mental Health System • Bindu Joseph, Michael Olasoji, Cheryl Moss, Wendy Cross • 2021 • Primary research article • Australia • Mental health settings • To explore the transition experiences of overseas-trained nurses from India working in Australian mental health settings	• Qualitative • Hermeneutic phenomenology • Interviews • 16 overseas trained nurses from India; average age 33 years • The lived experiences and transition challenges of Indian nurses working in Australian mental health settings	• Emotional responses: Feelings of loneliness and isolation (during initial transition period)/ feeling incomplete despite achieving material goals (after settling in Australia)/ sadness about missing home and family (throughout integration process)/ feeling horrible, angry and sad (when experiencing discrimination)/ worry about children's cultural identity (during cultural adaptation) • Behavioural responses: Adapting communication strategies (learning about Australian culture through TV and newspapers to fit in socially at work)/ Deliberate social engagement (actively seeking friendships and social activities to cope with loneliness)/ Withdrawing from social interactions (when facing discrimination from colleagues)/ Seeking institutional support (raising workplace discrimination issues with supervisors to resolve conflicts)/ maintaining frequent contact with family in India (to cope with loneliness)/ working hard to avoid confronting situations with discriminatory staff (when facing workplace discrimination) • Cognitive responses: questioning their decision to migrate and contemplating returning to India (after settling in Australia)/ rationalizing incidents of racism from clients due to their mental state (when experiencing discrimination)/ recognizing the need to adapt balance between Indian and Australian cultures while struggling with cultural conflicts (during cultural adaptation)

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• Experiences of African nurses in the UK National Health Service: a literature review • Likupe, Gloria • 2006 • Evidence synthesis • United Kingdom • National Health Service (NHS) • To highlight the experiences of black African nurses in the United Kingdom National Health Service	• Evidence synthesis • literature review • Analysis of published literature from database searches and reference lists of research articles • Not applicable (African nurses recruited to the UK) • The experiences of African nurses working in the UK National Health Service, including their motivations for migration, pay and conditions, discrimination	• Emotional responses: Feeling frustrated when they could not be understood because of their accents (during communication with colleagues and patients)/ feeling socially isolated and misunderstood (when experiencing cultural differences)/ feeling their competence as nurses was questioned (when their skills and experience were not recognized)/ feeling a sense of injustice (when their previous experience was not taken into account in the grading system)/ feeling homesick (during initial adaptation period) • Behavioural responses: Changing their personality to become more assertive (when adapting to UK workplace culture)/ Withdrawing socially (when feeling unwelcome or discriminated against)/ requesting more fundamentally to be respected (when experiencing discrimination or racism). • Cognitive responses: Interpreting small and insignificant differences in daily practices as leading to unfortunate mistakes (when adapting to new workplace)/ Perceiving themselves as being exploited (when managers used them to cover undesirable shifts, when they were charged high fees by agencies, when employed at lower grades, or when their terms of employment were altered)
• Experiences of African nurses and the perception of their managers in the NHS • Gloria Likupe • 2013 • Primary research article • United Kingdom • National Health Service (NHS) hospitals • To explore experiences of racism, discrimination, and	• Qualitative • Not explicitly stated • Interviews and focus group discussions • 30 black African nurses from Malawi, Kenya, Ghana, Nigeria, South Africa, Zambia, Zimbabwe, and Cameroon. Also included 10 managers (8 white females, 1 black Caribbean female, and 1 white male)	• Emotional responses: Frustration and unhappiness when intelligence and skills were not recognized (during workplace interactions)/emotional distress and confusion when experiencing racism from colleagues and patients (during daily nursing practice)/ Feeling "invisible" when bypassed by patients' relatives (during patient care interactions)/ Feeling devalued and disenfranchised because of their backgrounds (throughout workplace integration)/ Fear and anxiety (when working with patients with racist tendencies or fearing false accusations)/ • Behavioural responses: Avoiding attending to patients with racist tendencies due to fear of false accusations (during patient care assignments)/ eventually confronting discrimination by speaking up

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equality of opportunity among black African nurses, as well as the perceptions of their managers regarding these issues.	• Experiences of racism, discrimination and equal opportunities for black African nurses in the UK NHS, and their managers' perceptions of these issues	about unfair treatment (when witnessing favoritism toward other overseas nurses)/ Pursuing additional qualifications and education to prove themselves (when seeking career progression)/ Disengagement and reduced effort over time when experiencing lack of recognition (after completing professional development courses)/ • Cognitive responses: Perceiving they had to work twice as hard and have better qualifications to get similar posts to white British nurses (regarding career advancement)/ Perceiving that their knowledge and experience in nursing was not respected (during clinical practice)/ Attributing lack of recognition partly to ignorance about their nurse education and to inaccurate portrayal of Africa by the media (when reflecting on treatment by colleagues)/ Self-blame and loss of confidence when repeatedly told they were not good enough (during skill evaluation and performance assessment)/ Internalized discrimination(Some nurses began to believe they were not good enough due to constant negative feedback)
• Filipina Nurses' Transition into the US Hospital System • Li-Chen Lin • 2013 • Primary research article • United States • Hospital setting • To examine how Filipina nurses transition into their role as nurses and adapt to nursing practice in the US-Texas	• Qualitative • Grounded theory • Semi-structured interviews • 31 Filipina RNs(all female) • Perceptions of role transitioning from Philippine to US nursing practice	• Emotional responses: Fear and anxiety (when facing unfamiliar medical equipment)/ Frustration (when their experiences did not match expectations)/ Feeling intimidated (when entering new workplaces)/ Feeling scared (when required to make independent decisions)/ Feeling alienated (during early adaptation)/ Sense of accomplishment (when mastering independent nursing roles and feeling more confident in decision-making) • Behavioural responses: Seeking social support (actively engaging with other Filipinos and mentors for guidance and stress relief)/ Avoidance and silence (during early adaptation when unsure of their role and experiencing difficulty delegating tasks to aides)/ Learning assertiveness (adopting a proactive approach to voicing concerns and advocating for patients) • Cognitive responses:

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		Reconstructing their professional identity (shifting from a hierarchical, physician-dependent model to an autonomous nursing role)/ Recognition of self-worth (to overcome perceived mistreatment)/ Understanding the importance of legal liability (becoming aware of malpractice risks and the need for detailed documentation).
• Experiences of a Taiwanese Nurse in the United States • Shwu-Ru Liou and Ching-Yu Cheng • 2011 • Primary research article • United States • Community hospital in California • To explore and interpret the lived experience of a Taiwanese nurse working in a U.S. hospital	• Qualitative • Hermeneutic phenomenology, single-case study • One female Taiwanese nurse • Experiences of a Taiwanese nurse working in a U.S. Healthcare environment	• Emotional responses: Frustration and unhappiness (during language and communication difficulties with physicians and patients)/ Job insecurity (due to immigration process and other requirements)/ Discouragement (when patients refused care due to her language proficiency)/ appreciation (when receiving support from colleagues and some patients) • Behavioural responses: Avoidance of complex communication situations (colleagues helped by not assigning her to language-intensive cases)/ Wanting to "run-away" due to language barriers (during difficult communication situations)/make more efforts to learn English/ Seeking support from nurse colleagues (to handle communication challenges) • Cognitive responses: Decreased self-confidence (when unable to communicate effectively)/ Perceived inadequacy (felt unable to provide the highest quality care due to language limitations)/ Acknowledgment of benefits in U.S. healthcare system compared to Taiwan's nursing system
• Understanding the experiences of Pakistani educated nurses working in the United Kingdom: A phenomenological approach • Muhammad Dildar • 2015 • Doctoral dissertation • United Kingdom	• Qualitative • Hermeneutic phenomenology • Interviews • 21 Pakistani educated nurses (11 females, 10 males) • The lived experience of Pakistani educated nurses working in the UK, including their migration motivations, workplace integration	• Emotional responses: Feelings of dissonance and disappointment when expectations were unmet (during/when transitioning to UK healthcare system)/ Sense of vulnerability related to UK professional regulations and fear of making mistakes (during/when adapting to new clinical settings)/ Feelings of isolation and being "outsiders" in the workplace (during/when working with predominantly white British colleagues)/ Feelings of fear of being stereotyped due to their Pakistani/Muslim identity (during/when interacting socio-political climate)/ Homesickness and feeling of disconnection from family and culture (during/when adjusting to life in the UK)/ Feelings of rejection and

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• Primarily private care homes and NHS settings • To explore the lived experience of Pakistani-educated nurses working in the UK	experiences, and socio-cultural adaptation	racism (when experiencing discrimination in the workplace) • Behavioural responses: Moving to areas with established Asian/Pakistani communities for support (during/when coping with isolation)/ Accepting work in care homes despite deskilling to secure employment (during/when facing labor market barriers)/ Reluctance to report discrimination (due to fear of professional repercussions)/ Adopted coping strategies (such as forming small ethnic support groups at work) • Cognitive responses: Feelings of loss of professional identity and devaluation when relegated to lower-status positions in care homes (during/when experiencing the contrast between specialist roles in Pakistan and basic care work in UK)/ Recognition of being positioned as "the other" based on ethnicity, culture and religion (during/when experiencing racism and discrimination)/ Recognition of the need to adapt to British cultural values and expectations (during/when navigating workplace relationships)/ Expectation vs. reality mismatch (realizing that UK nursing jobs were not as professionally fulfilling as expected)/ Optimism despite challenges (when viewing migration as a step toward a better future)
• Actualizing the Dream: experiences of internationally educated nurses • Sandra Murphy • 2008 • Doctoral dissertation • Canada • Various healthcare settings in Toronto, Ontario • To explore and explicate the experiences of IENs as they begin their journeys to practice as	• Qualitative • Grounded theory • Interviews, field observations, field notes, one group meeting • 17 IENs from 8 countries (England, Hong Kong, India, Iran, Mainland China, Nigeria, Philippines, and Poland) and sample included 16 females and 1 male • The experiences of IENs integrating into	• Emotional responses: Feelings of anxiety and insecurity due to language barriers and limited understanding of nursing practice in Canada/ Feelings of shock, humiliation, frustration, anxiety and intimidation during transition to practice/ Experiencing stress related to perceived lack of acceptance by colleagues/ Feeling of triumph and exhilaration upon achieving registration status and gaining employment/ Feelings of isolation when unable to develop a sense of belonging/ Fear and nervousness about making mistakes/ Frustration over lack of recognition of previous experience • Behavioural responses: Developing creative strategies like "shadowing" and "copy-cat" to learn new ways of practice/ Utilizing mentorship/buddying opportunities to integrate into the healthcare system/ Withdrawing and self-isolating when

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registered nurses in a Canadian healthcare system	Canadian healthcare, including acculturation, role adaptation, and professional integration	experiencing discrimination or lack of receptiveness/ trying to Confront colleagues directly when feeling taken advantage of in the workplace/ Pursuing further education and professional development opportunities once established/ Working diligently to prove competency and worthiness to others • Cognitive responses: Feeling "stupid" and lacking confidence when discovering differences in nursing practice/ Experiencing self-doubt (when struggling to meet Canadian nursing standards)/ Discovering differences in scope of practice, professional values, cultural beliefs, and approaches to patient care/ Recognizing the need to develop confidence in practice to gain sense of belonging/ Viewing the first employment as a stepping stone to more advanced opportunities/ Maintaining hope as a cognitive strategy to overcome obstacles in integration process/ Redefining professional identity as a nurse in Canadian context
• South-East Asian Nurses' Experiences Under the Economic Partnership Agreement (EPA) in Japan: How Language Ability Affects Self-Confidence and Interpersonal Relationships • Yoshiyuki Nagaya, Nicola Gillin, David Smith • 2024 • Primary research article • Japan • Healthcare institutions (hospitals and nursing homes)	• Qualitative • Constructivist Grounded Theory (CGT) • interviews • 20 IENs (11 males, 9 females) from Indonesia, Philippines and Vietnam • Language acquisition difficulties, self-confidence in communication, and effects of language proficiency on workplace relationships	• Emotional responses: Feeling depressed or losing confidence when patients requested Japanese nurses instead of IENs (during patient care)/ Frustration and anxiety (when struggling to understand Japanese dialects and medical terminology)/ Feeling hurt by complaints from Japanese nurses who spoke too quickly (during busy work periods)/ Feeling a sense of alienation when unable to participate in conversations about non-work topics (during social interactions with colleagues)/ Feeling happy when patients understood their situation and showed concern for them (during patient care interactions)/ Feeling anxious when communication was inadequate (during healthcare delivery)/ Feeling discouraged from seeking promotion due to language limitations • Behavioural responses: Refusing promotion opportunities despite being qualified (when offered more senior positions requiring higher language proficiency)/ Seeking Japanese language improvement beyond the examination requirements (after passing the National Nursing Examination)/ Avoiding

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• To explore how language ability affects self-confidence and interpersonal relationships of South-East Asian nurses working in Japan under the Economic Partnership Agreement (EPA)		participation in conversations about topics other than work (during social interactions with colleagues) • Cognitive responses: Perceiving handwritten patient records and medical terms as overwhelming (when reading documentation)/ Perceiving rural dialects as difficult to understand (when communicating with patients from different regions)/ Perceiving a gap between Japanese language learned in preparation for examinations versus Japanese needed in everyday nursing practice (during workplace integration)/ Perceived inequality (when expected to perform at the same level as native Japanese nurses despite language challenges)
• Lived experiences of Filipino internationally educated nurses working in the United States: Facing discrimination in the workplace • Jonathan Pettey • 2016 • Doctoral dissertation • United States • Hospitals in California and Texas • To explore the lived experiences of Filipino internationally educated nurses working in the United States, specifically examining their experiences with perceived threats of discrimination and how they responded to these threats.	• Qualitative • Grounded theory • Semi-structured interviews • 8 Filipino IENs(all female) • examining how Filipino IENs were affected by and responded to perceived threats of discrimination in the workplace, and to provide recommendations for healthcare leaders to address challenges facing Filipino IENs.	• Emotional responses: Stress when facing discriminatory treatment/ Fear and anxiety related to potential immigration status/ Feelings of isolation when excluded from social interactions with American colleagues/ Emotional exhaustion from constant criticism about accent and language skills/ Pain and hurt during experiences of isolation from colleagues • Behavioural responses: Avoiding situations that could trigger discrimination (staying away from phones, avoiding certain colleagues)/ Working harder to prove competence and gain respect from colleagues/ Using passive responses (smiling and remaining quiet) during early career stages and becoming more assertive over time as they gained experience/ Seeking support from other Filipino nurses/ Using marriage as a strategy to secure immigration status/ Drawing on the Filipino cultural value of "matiyaga" (patience) to persevere through challenges • Cognitive responses: Diminished confidence and self-doubt when compared to their confidence levels in the Philippines/ Developing inner strength and resilience mechanisms/ Maintaining focus on long-term career and financial goals/ Shifting perspective to emphasize job satisfaction despite challenges/ Using internal validation strategies within the Filipino nurse community/ Adopting Filipino cultural values (Kapwa) (to

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		maintain resilience and perseverance in the workplace)/ Recognizing the systemic nature of discrimination (leading to lower expectations for workplace equality)
• International Nurse Migration Experience of the First Two Years: A Mixed Methods Study • Charlene Pressley, Dillon Newton, Linda Sanderson, Bibha Simkhada, John Stephenson, Precious Adade Duodu, Warren Gillibrand, Manju Pallam, Joanne Garside • 2024 • Primary research article • United Kingdom • National Health Service (NHS) healthcare facilities • To explore experiences of internationally educated nurses' first 2 years working and living in England in an age of contemporary migration.	• Mixed methods • Mixed methods • Online survey with Open-ended text boxes embedded within the online survey • 773 IENS and majority from India (41.6%), the Philippines (23.5%), Nigeria (17.4%) - 82.2% female, 17.7% male • IEN's professional and personal experiences of working and living in England, including professional integration, communication, housing situations, cost of living, social support networks, family separation, mental well-being, and intentions to stay in England.	• Emotional responses: Feeling discouraged and demotivated when specialist skills were disregarded (when assigned to different areas than their expertise)/ Experiencing anxiety about work (when facing challenges with communication and workplace integration)/ Feeling judged and experiencing irritation from colleagues (when asking colleagues to repeat themselves due to accent barriers)/ Feeling sad and useless (when needing to constantly ask for help with unfamiliar procedures or device)/ Feeling "left out and alone" (when colleagues were unwilling to work with them)/ Frustration with rigid policies (such as contractual payback clauses that restricted job mobility) • Behavioural responses: Considering migrating to other countries with "better healthcare systems" (when experiencing pressure from work, short staffing, and low salaries)/ Asking colleagues to speak audibly, slowly and clearly (when experiencing communication challenges)/ Crying before going to work (when experiencing workplace anxiety)/trying to Learn from experiences of fellow international nurses in their ward (when formal support was unavailable) and Networking with fellow IENs • Cognitive responses: Perception of being undervalued (due to lack of recognition for prior experience and skills in job assignments and pay)/ Recognition of adaptation as a learning process (realizing that communication barriers were temporary and improved with time)
• Understanding West African migrant nurses' work experiences in the United Kingdom: A phenomenological study	• Qualitative • Phenomenology • Interviews • 15 West African migrant nurses (12 female 3 male)	• Emotional responses: Feelings distrust (during perceived unfair or opaque managerial decisions and perceived broken promises about support or career development)/ Displayed anxiety during calls from their workplace/ feelings of being considered outsiders at work, with a sense of non-inclusivity and a

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• Chinedu Uwabuike • 2021 • Doctoral dissertation • United Kingdom • Nursing homes • To understand West African migrant nurses' work experiences in the United Kingdom.	• To understand the reasons/motivations for West African migrant nurses' (WAfMNs) relocation to the UK and to explore how cultural conceptions shape their perceptions, expectations, and responses to work experiences in the UK.	lack of response to their personal needs/ feelings of lack of empathy from their colleagues and managers/ Stress, despondency, and emotional labor (when they sensed a lack of organizational or supervisor support, or felt isolated in predominantly British teams) • Behavioural responses: Adopting a "non-voice" or repressive approach (when confronting conflict or perceiving discrimination, participants often withdrew rather than openly challenging situations)/ Avoidance coping and self-isolation (when experiencing low trust)/ Reduced engagement or minimal participation in group activities (when perceiving unfair allocation of tasks or limited development opportunities, participants described "keeping their head down" and doing only what was required)/try to Engage with their ethnic and religious groups which provided them with social identity platforms/ Engaging with elderly residents to enhance their job satisfaction • Cognitive responses: Rationalization of experiences (when confronted with power-distance norms that conflicted with their own cultural beliefs, participants described accepting hierarchical structures and attributing difficulties to "the system")/ developing spiritual mindset (some nurses coped by reminding themselves of personal or religious convictions, e.g., "God will see me through," which helped them persevere in a stressful environment).
• Nursing in Saudi Arabia: Reflections on the experiences of South African nurses • Dalena van Rooyen, Colette D. Telford-Smith, Johanita Strümpher • 2010 • Primary research article	• Qualitative • Phenomenology • Interviews and personal journals • 11 South African nurses • Explored and described nurses' lived experiences (including personal and professional adaptation) while	• Emotional responses: Feeling worthless and disrespected during workplace integration (when covering up and wearing abaya)/ Experiencing frustration and exhaustion (during Ramadan when covering for Muslim colleagues who worked reduced hours)/ Feeling fear and anxiety (when uncertain about religious restrictions affecting their communication and practice)/ Experiencing guilt and emotional pain (when away from their families)/ Feeling inadequate and insecure (when lacking certain knowledge or skills compared to international standards)/ Experiencing anger and demotivation (when discovering salary inequities based on

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• Kingdom of Saudi Arabia • Hospital setting • To describe and reflect on the lived experiences of South African nurses residing and working in the Kingdom of Saudi Arabia	integrating into the Saudi Arabian healthcare environment	nationality)/ Relief and happiness (when achieving financial goals, such as paying off debts, and when receiving positive recognition for their clinical skills) • Behavioural responses: Forming support networks with other South African nurses and expatriates (during adaptation period)/ Adapting religious practices to restrictions (conducting "underground" religious gatherings using code words)/try to engage in social activities organized by the hospital or expatriate communities (during free time to overcome social isolation)/ Pursuing educational opportunities to address knowledge gaps (after identifying deficiencies in professional skills)/ Leaving the position early (resigned from their contracts when they felt the emotional and cultural demands were overwhelming) • Cognitive responses: Shifting perspective on “sacrifice” vs. “benefit” (when weighing emotional hardships against the financial and professional advantages, many concluded the experience was still “worth it”)/ Perceiving discrimination in salary scales and promotional opportunities (when learning about zone-based salary categorization by nationality)/ Reframing cultural restrictions as opportunities for personal growth (when dealing with cultural differences)
• Professional Adaptation Experiences of Chinese Migrant Nurses in Australia: A Qualitative Study • Yaping Zhong, Lisa McKenna, Beverley Copnell, Wenjuan Zhao, and Cheryle Moss • 2023 • Primary research article • Australia • Healthcare settings	• Qualitative • Qualitative descriptive • interviews • 17 Chinese-educated nurses (all female) • Professional adaptation experiences and evolution during workplace integration	• Emotional responses: Anxiety and stress (when experiencing communication barriers with colleagues and patients)/ Frustration (when adapting to communication in native languages at work)/ Sense of fulfillment and importance (when able to apply critical thinking to patient care)/ Feeling relaxed (when able to express professional opinions freely and authentically)/ Felt inadequate when patients perceived them as less competent due to communication barriers/ Experienced feelings of disconnectedness in workplace relationships with local colleagues/ feel Difficulty building strong social connections with colleagues (due to cultural differences in work-life boundaries) • Behavioural responses:

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• To examine how Chinese migrant nurses adapt and evolve professionally while pursuing nursing careers in Australia		Proactive self-upskilling (during/when recognizing the need to expand clinical knowledge and coordinate patient care in a new system)/ Practicing more direct self-expression (during/when previously they might have remained silent to maintain group harmony)/Try to build relationships with colleagues while respecting work-life boundaries • Cognitive responses: Growing openness toward individual differences and diversity (during/when working alongside a multicultural workforce and caring for diverse patient populations) / Perceiving workplace culture as "more transparent" and "fairer" compared to China/ Gained new perspectives about professional identity and roles/
• The Experience of China-Educated Nurses Working in Australia: A Symbolic Interactionist Perspective • Yunxian Zhou • 2014 • Primary research article • Australia • Hospital settings and nursing home • To explore the ways in which China-educated nurses construct meaning regarding their experience of working in Australia and to produce an in-depth theoretical understanding of that experience.	• Qualitative • Constructivist grounded theory • Interviews • 28 China-educated nurses who had been working as registered nurses in Australia for at least 6 months. All female • The experiences of China-educated nurses working in Australia with focus on how they construct meaning regarding the experience	• Emotional responses: Feelings of ambivalence toward migration and work in Australia (during reflection on their experiences)/ Feelings of shame/embarrassment when performing basic nursing care (when realizing tasks considered "low status" in China were expected of nurses in Australia)/ Feelings of embarrassment to tell families in China about performing basic care tasks (when discussing their work with family)/ Feelings of alienation and homesickness (when experiencing social isolation)/ Feeling vulnerable due to their foreign status (when working in clinical settings)/ Homesickness and a sense of loss (when lacking family support networks and familiar social ties) • Behavioural responses: Concealing doubts or gaps in knowledge (when unsure about local policies or “common-sense” procedures, to avoid appearing incompetent)/ Strategic social participation (when attending workplace social events but remaining guarded, to be polite yet protect personal identity)/ “Switching off” or compartmentalizing cultural identity (when at work, intentionally adopting more Westernized behaviours, while reverting to Chinese cultural norms at home)/Remaining silent during interactions (when fearing ridicule due to language barriers)/ Forming communities with other Chinese people

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		(when feeling alienated from Australian society)/ Try to work "very carefully" and slowly to avoid mistakes (when feeling scrutinized as foreign nurses)/ Learning how to communicate differently, including appearing warmer and more suggestive (when making requests) • Cognitive responses: Realizing the need to be humble and less ambitious (when reconstructing their self-concept)/ Perceiving relationships in workplace as superficial (when comparing to relationships in China)/ Awareness of being situated as "the other" (when experiencing differences in communication, values, and expectations)/ Perceiving that their mistakes would be more visible than those of local nurses (when working in clinical settings)/ Dilemma about cultural identity regarding whether to be Chinese or Australian (when caught between two cultures)/ Perception that as Chinese nurses they would have limited career advancement (when considering their future)/ Acknowledging a 'middle position' identity (when recognizing they would never be fully Australian but were no longer the same as nurses in China)/ Developing resilience (when realizing that hardships spurred growth and maturity, leading them to adjust their expectations and sense of self)