Investigation of the Experience of Immigrant Nurses in a Diverse Cultural Setting

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ABSTRACT

Background: Work-related stress (WRS) is one of the most common stressors in healthcare workplace settings.

Purpose: This research study was designed to examine and discuss perceived WRS, job performance, social support, and the desire of immigrant nurses to work in a multicultural workplace.

Methods: A case research mixed-methodology approach, a quantitative survey, and semistructured qualitative interviews were used in this research study. Three hundred twenty-one respondents were invited, of which 246 (76.6%) returned valid questionnaires. A purposeful sampling technique was used in the qualitative portion of the study. A semistructured interviewing system was used on 20 nurses.

Results: “Workload” was the most common traumatic occurrence, whereas “treatment” and “death and dying” were the least common traumatic occurrences. Similarly, the mean of the social support scale, as defined using the McCain and Marklin Social Integration Scale, was moderate to high, suggesting that most of the participants received strong social support from their colleagues. The qualitative research found that the participants faced high pressures related to work and have struggled to acquire cultural skills, while having difficulties meeting their patients’ cultural and spiritual needs and sustaining high-quality nursing care.

Conclusions: The findings of this study support that immigrant nurses working in the Kingdom of Saudi Arabia are stressed. A significant difference between the qualitative and quantitative results was found. The findings further contribute to our understanding of WRS, social support, job performance, and intention to stay among immigrant nurses in the Kingdom of Saudi Arabia.

Key Words: work-related stress, immigrant nurses, social support, nurse experience.

Introduction

Worldwide immigration is a defining characteristic of modern Saudi Arabian culture and has become essential to the national economy (Almutairi, 2015). Saudi Arabia has been greatly affected by the oil business, leading the Kingdom of Saudi Arabia’s (KSA’s) transformation from a pastoral, agricultural, and business economy into an urban culture with extensive-scale base ventures, a far-reaching social welfare framework, and an economy commanded by outside professionals (Albaqme, 2014). From mid-2013, expatriates made up 32% of the KSA’s population, with most immigrating from South Asia. KSA is ranked among the top five migrant destination countries worldwide. Around a quarter of immigrant workers are domestic laborers, and Human Rights Watch estimates that nearly 1.5 million immigrant female domestic laborers live in the KSA. Most legal resident foreigners are of working age, whereas gender proportions vary by country of origin. Filipino foreign residents have one of the highest proportion of women, at 28.6%.

In contrast, only 17.6% of the KSA’s residents from Africa are women. Because the local population was unable to play a vital role in business ventures, organizations started to enlist highly skilled and lower-skilled specialists from abroad. Many people from South and Southeast Asia moved to Saudi Arabia. The immigration of Asian workers was particularly encouraged. It was considered that, in contrast to Arab immigrant laborers, they might be less motivated to settle, more averse to integration, and thus easier to control (Pakkiasamy, 2004). Despite the reduction in the pace of development in the 1980s, South Asians and Southeast Asians still constitute the largest number of noncitizens living in the Kingdom, indicating that interest in immigrant laborers has extended into other sectors of the economy.

In today’s work environment, work stress is widely spread across employment sectors and in different types of organizations. This research focuses on work-related stress (WRS) among the unique populations of the KSA with different cultural backgrounds. The research was designed to measure WRS among immigrant nurses in Riyadh and to explore the relationships between WRS and the variables of job performance, intention to stay within the organization, and social support from work supervisors and colleagues. The goal of the analysis was to propose a systematic management approach to reduce the adverse effects of WRS among workers in a diverse workplace.
The problem of WRS is huge in growing nations that are prone to fast and severe economic and social change (e.g., in KSA), where there is an expanded interest in the adjustment of immigrant workers, overriding of patient outcomes, reorientation of the work-related well-being framework, and generally poor working conditions (Maulik, 2017). WRS has been seen as an aftereffect of inconvenient working conditions and as causing physical and mental health disorders (Ortiz et al., 2015). WRS has been conceptualized as both a factor affecting and an outcome of anxiety, making it troublesome to differentiate between input and output (Ross, 2018).

Although an array of research has documented both the underlying reasons and the outcomes of WRS in developed and industrialized countries, WRS remains an issue that is a long way from being recognized. Therefore, almost no information is accessible from developing nations like KSA (Ortiz et al., 2015), which prevents scholars from evaluating the amount of employment strain because of psychosocial stressors in nations such as KSA and, in particular, restricts the possibility of contrasting the outcomes of these assessments with studies conducted in nations in which WRS has been measured more frequently. Thus, further evaluation is needed to increase awareness of WRS and to promote further study of this issue.

Nursing job performance, on the other hand, mirrors the quality of care provided and, subsequently, patient outcomes. Poor job performance is considered a factor that is detrimental to patient safety (Kieft et al., 2014). WRS has been associated with decreased work efficiency, reduced care quality, increased hospital infection, and lower patient satisfaction (Keykaleh et al., 2018; Kieft et al., 2014; Wang et al., 2016).

To guarantee working performance and good patient care, variables that alleviate tension and improve nurses’ health must be defined (Wang et al., 2016). Higher levels of stress are usually associated with greater dissatisfaction (Hoboubi et al., 2017). These stressors have been shown to lead to frustration and difficulties in dealing with customers and work colleagues, which may negatively affect the overall organization (Better Health Channel, 2012). One distinctive effect is high rates of staff turnover, which may negatively impact staff members' productivity and capacity to meet patient needs. Increasing amounts of work increase burdens on the remaining staff, decrease staff satisfaction, and consequently cause the quality of care to deteriorate (Otto et al., 2019). Furthermore, turnover influences the nurses who remain in the organization by decreasing their organizational commitment and increasing their WRS, resulting in additional turnover (O’Brien-Pallas et al., 2006).

Social support is a multidimensional factor that includes emotional and behavioral experiences and the belief that various forms of support are sufficient or available (Feeney & Collins, 2015). Social support improves quality of life as it moderates the relationship between healthcare-related, work-associated stress and the physical or psychological health of nurses (Hatamipour et al., 2017; Hou et al., 2020). In comparison, inadequate social support has been linked to inadequate physical and mental health and increases in nurses’ vulnerability to mental problems (Harandi et al., 2017). Social reinforcement has also been shown to improve well-being and minimize tension and burnout in the workplace and to increase job satisfaction (Gray et al., 2019; Kun & Gadanecz, 2019).

The purpose of this study was to explore, describe, and measure WRS at both the individual and organizational levels in immigrant nurses in the KSA in the realms of job performance, intention to stay, and social support from colleagues and supervisors. This is an underexplored issue in KSA. A broader aim of the study was to raise awareness of WRS. In this sense, it is hoped that this study will inform decision-makers and policymakers regarding the importance of WRS and its prevalence and impact on the nursing migrant population in the KSA to promote their health and well-being.

Methods

Study Design

This research study adopted a mixed-methodology approach, consisting of a quantitative questionnaire survey and qualitative semistructured interviews to analyze the results of WRS, employment performance, and social support and to incorporate these results into work in a diverse cultural setting.

In the KSA, most immigrant nurses have no power or part in making choices related to their occupation (common control), as they lack self-sufficiency, are paid low wages, and feel insecure concerning their employment. This has been acknowledged as a primary wellspring of WRS, which is considered a psychosocial risk. Unsurprisingly, nurses feel that other healthcare providers control them and subordinate them, as all other caring roles are prioritized over nursing care.

As all of the tools used in this study were originally developed in Western nations, an attempt was made during the pilot stage to explore input from respondents and work colleagues to check whether these instruments were sufficiently relevant to the immigrant nursing community in the KSA. A pilot study was conducted with 20 nurses to cover all nursing units in different specialties to determine the clarity of questions, the effectiveness of instructions, the completeness of response sets, the time required to complete the questionnaire, and the success of the data collection technique. Subjects in this pilot study were asked to comment on the applicability and appropriateness (validity) of the questionnaire to the KSA context. The results indicated that the tools appeared to be appropriate for the research questions being addressed. All of the questions were answered, and no additional clarification of questions was required. The researcher determined that it would take an average of 25 minutes to complete the questionnaire. The pilot study subjects were all immigrant nurses who had worked in Western-standard
healthcare facilities in the KSA. At the end of every survey, a free content section was included for the subjects to include extra remarks, which were analyzed and reported in the final result.

The Expanded Nurses Stress Scale (ENSS) was used to measure the independent variable of work stress. The ENSS is an expanded and updated revision of the classic Nursing Stress Scale (NSS) developed by Gray-Toft and Anderson (1981). The NSS was the first instrument used to specifically target nursing-related job stress. The original 34 items of the NSS measured the frequency and major sources of stress in patient care situations.

Job performance was measured using the Schwirian Six-Dimension Scale of Nursing Performance (SSDSNP) developed by Patricia Schwirian. This scale was developed and tested from 1974 to 1977 and has shown high reliability (Schwirian, 1978). This scale consists of a list of nursing activities that nurses engage in at different degrees of frequency and quality. The scale was chosen for its ability to evaluate the quality of performance and developmental patterns of immigrant nurses over the first 1–2 years of practice. The scale may be distinguished into subscales to assess six subcategories of nursing performance, including leadership, critical care, teaching/collaboration, planning/evaluation, interpersonal relations/communication, and professional development. In this study, this measure consisted of a 52-item scale, with 1 = not very well, 2 = satisfactory, 3 = well, 4 = very well, and 5 = not expected in my job.

The McCain Behavioral Commitment Scale (MBCS; McCloskey, 1990) was used. This is a commonly used tool to help determine the factors affecting nurses’ intent to continue working at their hospital. WRS has a significant effect on nurse retention, which is defined as the commitment of nurses to stay in their current position.

Social support was measured in this study using the McCain and Marklin Social Integration (MMSI) scale (McCloskey, 1990). This scale consists of eight items scored on a 5-point scale, where 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, and 5 = strongly agree. These items were designed to measure the social support provided by work colleagues. A Cronbach’s alpha test for internal consistency was performed to assess the reliability of the WRS (ENSS), job performance (SSDSNP), intention to stay (MBCS), and social support (MMSI) questionnaires. The reliability for all tools ranged between .76 and .93.

**Quantitative Method**

**Population sample and data collection**

Migrant nurses currently serving in hospital or ambulatory care departments were the target population for this study, and 360 immigrant nurses from a major private medical–surgical hospital in KSA were invited to participate. To determine the sample size necessary for the factor analysis for quantitative sampling, Comrey and Lee (1992) offered the following guidelines: A sample size of 50 is considered to be very poor, 100–199 is poor, 200–299 is fair, 300–499 is good, and > 500 is very good. As a general rule, although a sample size of 300 is acceptable when performing factor analysis, solutions that have several high-loading variables (> .80) do not require such a large sample size, and a sample size of 150 may be considered sufficient (Comrey & Lee, 1992). The statistical analysis performed in this study involved correlations and regressions. To determine an appropriate sample size, Tabachnick and Fidell (1996) recommended a margin of error less than 2.5%, with 95% confidence intervals above 90%. Thus, for this research, we aimed for > 90%.

\[ N \geq 50 + 8m \]

or testing multiple correlations or,

\[ N \geq 104 + m \]

where \( m \) is the number of independent variables and

\[ \alpha = .05 \]

and \( \beta = 0.20 \)

\( N \) was calculated using both procedures to determine which produced the highest number of cases. Using the first formula, a sample size of 178 was generated:

\[ N \geq 50 + (8)(16) = 178 \]

Using the second formula, a minimum sample size of 120 participants was required. So, 104 + 16 = 120. The statistical analysis performed in this study involved correlations and regressions. To determine the appropriate sample size, Tabachnick and Fidell (1996) recommended permitting a margin of error below 2.5%, with 95% confidence intervals above 90%. Thus, for this research, we aimed for > 90%.

The participant inclusion criteria included (a) being an immigrant nurse, (b) having worked a minimum of 3 months in the research setting, and (c) having a minimum of 3 years’ experience since attaining a nursing degree. These criteria were necessary to ensure that the respondents were sufficiently acclimated into the organization, had overcome the initial stress of working in a new environment, and had worked in similar situations. Registered nurses and licensed practical nurses were recruited because both encounter similar stressors and are regarded by the public as “nurses.”

Three hundred twenty-one nurses met the inclusion criteria. A representative random sample of these nurses was recruited from each ward at the research setting. Data were collected using a survey that included a demographics datasheet and four instruments respectively focused on nurses’ perceptions of WRS, intention to stay, job performance, and social support. Over 3 weeks, all of the nurses who met the research requirements (\( n = 321 \)) received a sealed envelope via internal mail that contained a cover letter explaining the research and questionnaires. Participation in the study was voluntary, and participants could withdraw at any time.

**Ethical Considerations**

Ethical approval was obtained from the Research and Development Department at the hospital, and permission
was subsequently given by the University of Nottingham School of Nursing Midwifery and Physiotherapy Ethics Committee (MS06122010).

**Statistical analysis**

The demographic data were analyzed using descriptive statistics. Analysis of variance (ANOVA) and post hoc comparisons were used to analyze the relationships between the demographic variables and the means for WRS (ENSS), job performance (SSDPSNP), intention to stay (MBCS), and social support (MMSI). Regression analysis was used to test the effect of WRS and social support on job performance. Regression analysis was also used to test the influence of WRS and social support on intention to stay, with correlations examined using a Pearson correlation test.

**Qualitative Method**

**Population sample and data collection**

The case study methodological approach was used to explore, understand, and describe the participants' experiences of workplace stress in a culturally different, acute, and rehabilitation hospital setting in the KSA.

The guiding principle for the sample size for the qualitative component was completeness, which refers to all of the information gained that provides an overall sense of the meaning of a concept, theme, and process and adequately answers the study question (Schutt, 2011). Thus, qualitative research focuses on gaining deep and rich information, regardless of the number of participants. Yelland et al. (2016) contended that a sample size of 90 in qualitative research is neither too large nor too small as long as it results in a new and richly textured understanding of experience. In this study, the sample size used was 20 immigrant nurses, all of whom met the inclusion criteria and were enrolled as participants.

These 20 participants were purposefully selected to participate in the interview. This study divided the sample population into four groups of five nurses based on unit experience, including (a) medical surgical units and spinal cord injury units; (b) emergency department, hemodialysis unit, and outpatient clinics; (c) intensive care unit, pediatric unit, and operation room; and (d) brain injury, women's health, and stroke units. A semistructured interview was used to explore the participants' experiences in terms of WRS, social support, intention to stay, and job performance. They were interviewed individually and face-to-face. The interviews were audio-recorded to ensure data collection accuracy.

**Data analysis**

The phenomenological psychological method developed by Giorgi (2012) was used to analyze the results using Giorgi's four essential steps (Van Manen, 2016).

**Quantitative Results**

Three hundred twenty-one invitation letters and questionnaires were placed in the nurses’ mailboxes in the study setting. Of these, 246 questionnaires (76.6%) were completed and returned (complete questionnaires). Nine of these had a significant amount of missing data and were excluded from the data analysis. The demographic data of the participants are shown in Table 1.

The final study sample consisted of 246 subjects (N = 246). About three quarters (n = 189, 77%) of the sample were female; 82.5% were aged between 20 and 40 years; and most (n = 170, 67.8%) worked rotating shifts, seven (3.0%) worked night shifts, and 69 (29.2%) worked day shifts. Moreover, most worked 48 hours per week (n = 122, 49.6%), whereas 53 worked less than 48 hours per week (21.5%), and 51 worked 49–60 hours per week (20.7%). On average, over two thirds cared for more than seven patients per shift.

Only four of the participants (1.6%) held a master’s degree in nursing, whereas most held a bachelor's degree in nursing (n = 158, 64.2%), and most of the remainder (n = 68, 27.6%) held a nursing diploma degree (≥ 3 years of study). Only four (1.6%) stated that they held another type of nursing degree.

Participants in the research setting were younger than the average age of 45 years in North America (61.8% of the participants were ≤ 35 years old). A significant number had immigrated from Southeast Asia (77%). The Southeast Asian group (Region D) consisted of participants from the Philippines, India, and Malaysia. There were fewer Western nationalities (Region B) in Saudi Arabia (n = 38, 13.5%) because of competition at home. The least represented nationalities were staff from the Middle East (Region M), with participants from this region coming from Jordan, Syria, Palestine, and Lebanon. Most participants were Christian (n = 174, 70.7%), with a smaller number being Muslims (24%). The 163 staff nurses accounted for 66.3% of the participants, whereas licensed practical nurses (LPNs) accounted for 33.7%. Most of the participants self-reported as being married (58.1%), and 33.7% self-reported as being single.

**Reliability of the questionnaires**

A Cronbach’s alpha test for internal consistency was performed to assess the reliability of the WRS (ENSS), job performance (SSDPSNP), intention to stay (MBCS), and social support (MMSI) questionnaires. The results of the Cronbach’s alpha reliability test for the ENSS test showed a high reliability for the ENSS used in this study (.96). Moreover, the coefficients for the subscales were almost equal to (workload, death, and dying) or higher than the coefficient alphas reported by Gray-Toft and Anderson (1981).

Regarding the internal consistency and reliability of the SSDPSNP, the reliability of the entire scale and its six subscales were compared with those reported by Schwirian (1978).
Means, Standard Deviations, and Ranges of the Scales

The reported average for the overall work stress scale shown in Table 2 was determined as “occasional,” with workload reported as the highest stressor. “Uncertainty over treatment” and “death and dying” were the subscales with the lowest average job stress scores. The overall job performance scale was reported as high for “professional development and critical care,” and the lowest average job performance subscale score was for “leadership.”

Table 2
Means and Standard Deviations for Each of the Scales Used

| Variable                                      | Mean  | SD   |
|-----------------------------------------------|-------|------|
| WRS (on a scale of 0–4)                      | 0.90  | 0.49 |
| Workload                                      | 1.50  | 0.81 |
| Inadequate preparation                        | 0.94  | 0.56 |
| Death and dying                               | 0.62  | 0.65 |
| Uncertainty over treatment                    | 0.50  | 0.37 |
| Conflict with doctors                         | 0.93  | 0.45 |
| Conflict with other nurses                    | 0.78  | 0.57 |
| Lack of support from supervisors              | 1.00  | 0.70 |
| Patients and their families                   | 0.63  | 0.66 |
| Discrimination                                | 0.65  | 0.67 |
| Job performance (on a scale of 1–5)           | 2.92  | 0.67 |
| Leadership                                    | 2.82  | 0.76 |
| Interpersonal relations/communication         | 3.09  | 0.73 |
| Professional development                      | 3.77  | 1.00 |
| Critical care                                 | 3.25  | 0.82 |
| Planning and evaluation                       | 3.05  | 1.00 |
| Teaching and collaboration                    | 3.09  | 0.78 |
| Intention to stay (MBCS; on a scale of 1–5)   | 3.04  | 0.91 |
| Social support (MMSI; on a scale of 1–5)     | 2.22  | 0.96 |

Note. WRS = work-related stress; MBCS = McCain’s Behavioral Commitment Scale; MMSI = McCain and Marklin Social Integration.
The reported mean on the Intention to Stay Scale was moderate, suggesting that most nurses expressed a desire to remain in their current job setting. Moreover, the social support mean score was moderate to high, suggesting that most participants believed their colleagues provided strong social support.

### The Relationship Between the Demographic Variables and the Scales

The dependent variables (job performance and intention to stay) and the key independent variables, including job stress, social support, and demographic variables, were entered into a correlation matrix to examine the relationships between the variables. The correlation matrix was done to help the researcher identify which variables would be entered into the regression analysis.

The correlation matrix identified significant correlations between the dependent variables (job performance and intention to stay) and between the independent variable of job performance and, respectively, educational level \((r = .18, p < .01)\) and shift worked \((r = .14, p < .05)\). A significant and moderate correlation was found between intention to stay (MBCS) and, respectively, job performance \((r = .25, p < .01)\), educational level \((r = .11, p < .05)\), shift worked \((r = .18, p < .01)\), and number of hours worked per week \((r = .16, p < .01)\).

Significant correlations were also found between WRS (ENSS) and, respectively, gender \((r = -.11, p < .05)\) and educational level \((r = .12, p < .05)\). In addition, social support (MMSI) was found to be significantly correlated with both job performance \((r = .18, p < .05)\) and gender \((r = .16, p < .05)\). ANOVA was used to further test the correlation between demographic variables and the recorded mean scores for job stress, job performance, intention to stay, and social support. The findings indicate that the demographic variables of gender, number of patients cared per shift, shift worked, educational level, and nurse level were all statistically significantly related to the other variables measured in the questionnaires, including job stress, job performance, intention to stay, and social support.

Significant differences were found between educational level and, respectively, job performance and social support, as shown in Table 3. Tukey’s test showed that nurses with 7–10 years of nursing experience reported a higher perception of job performance than nurses with 1–3 years of nursing experience. The difference in the mean was statistically significant \((F = 2.59, p = .04)\).

The result of the ANOVA test showed that work shift type was related significantly to intention to stay. A statistical difference between work shift and the intention-to-stay mean score was reported \((F = 2.69, p < .05)\). The participants who worked either day or night shifts reported higher mean intention-to-stay scores than their peers who worked rotating shifts.

Regarding gender difference, significant differences were found between gender and the mean WRS score \((F = 3.6, p < .05)\). Female nurses reported lower levels of stress than male nurses. In addition, significant differences were found between number of patients cared for during a shift and the reported mean score of WRS \((F = 2.2, p < .05)\), with higher numbers of patients under their care associated with higher levels of perceived work stress.

As shown in Table 4, significant relationships were identified between WRS level and, respectively, staff performance, job performance, and social support. The participants with higher levels of WRS reported lower performance, whereas those who perceived good support reported better performance and less WRS.

Regression analysis was used to test the outcome of work stress on job performance, and multivariate logistic regression models were developed. The model was first to run for each of the seven stress subscales in the ENSS to test for associations with job performance measures. Work stress and job performance were entered into the regression models as, respectively, the independent and dependent variables. The regression analysis showed that WRS variables explained only 1.7% \((R^2 = .017; F = 4.32, p = .04)\) of the variation in job performance.

### Table 3

**Analysis of Variance Indicating the Relationship Between Educational Level and Job Performance and Social Support**

| Variable            | n | Job Performance | Social Support |
|---------------------|---|----------------|---------------|
|                     |   | Mean | SD  | Mean | SD  |
| Nursing educational level |   |      |     |      |     |
| Diploma             | 10 | 2.97 a | 1.05 | 2.18 a | 0.99 |
| Bachelor            | 19 | 3.36 a | 0.56 | 2.26  | 0.89 |
| Master              | 18 | 3.86  | 0.22 | 1.79 a | 1.65 |
| Other               | 22 | 3.08  | 0.22 | 3.13 a | 0.96 |
| F                   |   | 3.84  | 2.59 |      |      |
| p                   |   | .005  | .040 |      |      |

*aTukey’s test (.05). The mean difference is significant at the .05 level.

### Table 4

**Summary of Pearson Correlations (r) Among the Variables Under Study**

| Variable            | WRS (ENSS) | Intention to Stay (MBCS) | Social Support (MMSI) |
|---------------------|------------|-------------------------|-----------------------|
| Job performance     | .13*       | .25**                   | .18*                  |
| Staff performance   | –          | .36*                    | .17**                 |

*Note. WRS = work-related stress; ENSS = Expanded Nurses Stress Scale; MBCS = McCain’s Behavioral Commitment Scale; MMSI = McCain and Marklin Social Integration.
*p < .05. **p < .01.
performance but nevertheless reached statistical significance ($p < .05$; Table 4).

To examine the impact of social support on job performance, social support was entered into the regression model as an independent variable and job performance was entered as the dependent variable. The regression analysis showed that the social support variable explained only 3.3% ($R^2 = .033; F = 8.38, p = .004$) of the variation in job performance but nevertheless reached statistical significance ($p < .05$; Table 5).

The results of the regression analysis when added to the educational level showed that the addition of these variables contributed an additional 9.3% ($R^2 = .93; F = 1.83, p = .04$) of the variation in job performance to the previous variables tested above (job stress and social support) and for the rest of the variables, as explained in Table 5. This relationship was found to be statistically significant ($p < .05$).

The relationship between social support and intention to stay was tested using regression analysis. Social support was entered into the regression model as the independent variable, and intention to stay was entered as the dependent variable. The regression analysis showed that social support was not statistically significant and contributed only 1.1% ($R^2 = .011; F = 2.64, p = .001$) of the variation in intention to stay (see Table 5). This relationship was not found to be statistically significant ($p > .05$). These results presented indicate that immigrant nurse workers in the KSA hold a generally average perception of WRS.

To compute the total stress score for the quantitative part of the research, the scores of all 57 items were summed, and the appropriate items were summed to measure scores on specific subscales. A list of situations that are commonly encountered by nurses in the work setting was provided, and nurses were requested to score how stressful each was for them using the following: $0 = \text{never stressful}$, $1 = \text{occasionally stressful}$, $2 = \text{frequently stressful}$, $3 = \text{always stressful}$, and $4 = \text{does not apply}$. Missing data were handled based on the extent of the problem. Although several options were available (some more complicated, such as using a regression method to estimate missed scores), the researcher substituted missing values with mean scores for individual items and proceeded to calculate the subscale score for any individual who had answered most items in any subscale. In the case of the “death and dying” subscale, for example, an individual must have answered at least four of the seven subscale items. Otherwise, the subscale was not constructed, and the individual was scored as “missing” for that subscale.

The reported mean of the overall job stress scale was moderate (0.9), indicating occasional occurrences of stress. The highest reported mean job stress subscale score was for “workload,” and the lowest was for “uncertainty over treatment” and “death and dying.”

Participants identified workload under work conditions as the most frequent issue they deal with while working in the KSA. The ENSS finding showed a mean average of WRS because of workload of 1.5 (indicating occasional/frequent occurrences). Participants noted that nurses are prevented from providing holistic care to patients because of increasing patient workloads. The survey found that the participants often began their career with strong ideals but, after only 2 years, many were disillusioned and the standards they had held had become compromised and difficult to uphold.

### Qualitative Results

#### Demographics

In this study, eight conceptual categories emerged when the participants were asked about the sources of WRS, including workload, cultural competency, interrelational conflict, language barrier, physical environment, family-related matters, death and dying, and discrimination.

The 14 female and six male participants in this phase of the study had a mean age of 33 years. All worked full-time (48 hours of duty per week).

#### Sources of occupational stress

The eight study dimensions and the subtopics were extracted from the study data. The following eight themes and subthemes provided below highlight the findings of the qualitative interviews. Workload was identified as one of the constant factors in the workplace of the nurses during the interviews. Eight nurses (40%) verbalized that they experienced a high stress level at work. The nurse–patient ratio, documentation requirements, float, and time pressures were the subthemes that emerged from the theme of workload. The nurses expressed their frustrations at having to provide nursing care to more than six patients at a time. They felt that this requirement created risks not only for the patients but also for the nurses. In terms of specific sources of stress, nine nurses (45%) pointed to the high number of patients under their direct care, seven nurses (35%) pointed to documentation requirements, and four nurses (20%) pointed to the need to float to other units. Four nurses (20%) also reported time pressure during shifts as a source of stress.

Cultural competency is a very important factor in ensuring proper preparation when workers start new jobs in

| Table 5 | Predictive Interaction Between Variables |
|---------|----------------------------------------|
| Variable                  | $R^2$ | $F$ | $p$  |
| WRS variables             | .02   | 4.32| .040 |
| Social support            | .03   | 8.38| .004 |
| Educational level         | .93   | 1.83| .040 |
| Shift worked              | .74   | 510.32| < .001|
| Number of patients cared for per shift | .79 | 337.17 | < .001|
| Number of hours worked    | .80   | 237.14| .005 |
| Age of 25–30 years        | .81   | 184.54| .014 |

*Note. WRS = work-related stress.*
culturally diverse settings. Problems with adjustment relate to work performance and work effort (De Guzman et al., 2016). Variations in culture, especially when working in Saudi Arabia, also constitute a source of stress for expatriate nurses. The two subthemes that emerged from the theme of cultural competency in this study included culture shock and cultural knowledge. Eight nurses (40%) highlighted their concerns with regard to Saudi culture and that they found it very difficult to cope. Five nurses (25%) explored their prejudices toward the practice of Saudi nationals, using their own cultural background as their standard of acceptable culture.

Collaboration among healthcare providers, managers, and patient families is necessary to ensure that patients are adequately cared for and treated appropriately. Unfortunately, the mutual trust necessary is often lacking, which may lead to disputes between the nurse and the other stakeholders. Shimizutani and Todo (2008) noted that an interrelationship exists among all modes of conflict. Five nurses (25%) shared that, as they were in touch at these times with their supervisors, they tended to work shifts during the night and at weekends.

Conflicts between nurses and doctors were a factor identified by six nurses (30%) as a source of stress. Five nurses (25%) identified the nurse–doctor relationship as a potential source of conflict and discord. Another frustration that nurses experienced was tied to language difficulties (Galinato et al., 2016). Seven nurses (35%) expressed that the language barrier exacerbated workplace stress, especially when dealing with non-English speakers.

Physical labor influences the efficiency and quality of jobs (Clark, 2015). Three nurses (15%) raised concerns regarding their physical environment. Other stressors outside the workplace include conflicts between home and work life for those who have young children to care for (Adams, 2014). Three of the nurses (15%) found it hard to work effectively when they thought of their family back home and wished they could be with their family after work.

Three of the nurses (15%) identified their daily interaction with death and dying and the need to console distressed families as a source of stress. In addition, 13 nurses (65%) described feelings of discrimination in several aspects, including differences in salary and benefits compared with nurses from other nationalities, being looked upon as servants and treated as such, and being culturally discounted by patients and family.

Many stressors that confronted the participants in this study were alleviated by their use of coping mechanisms. Coping techniques used included physical activities such as walking and spending time in the gym, making friends, praying and communicating with family members via email and phone calls, and self-appeasement by laughing off stressful conditions to be more at peace with themselves and to not think about their stress.

**Intention to stay**

Job satisfaction is the main reason for immigrant nurses to stay in their current job (El-Jardali et al., 2009). If employees are satisfied, their performance and productivity increases (Edwards, 2015). When the participants in this study were asked about their intention to stay in the hospital setting, the conceptual categories included salary and benefits and job satisfaction. The participants generally expressed a willingness to stay in their current position because they anticipated receiving performance-based promotions. Believing that conditions would improve and that they would receive a salary increase was associated with willingness to stay. This was a surprising finding for the researcher, as seven nurses (35%) had shown some degree of frustration when asked about their feelings, and it was expected that many of them planned to leave.

**Social support**

Social assistance from managers and peers is important and necessary to develop a safe, positive, and healthy nursing work environment. Roussel et al. (2006) explained that a supportive environment produces consistent communications, which support nursing team productivity and allow for accurate problem identification. In this study, six nurses (30%) clarified that their nurse managers did not provide appropriate support and that this was a serious problem for them.

**Perception of job performance**

The immigrant nurses’ performance and perception of WRS were affected by their level of job satisfaction/dissatisfaction. They experienced satisfaction when they felt that they were well supported by their direct supervisor and when they received recognition and positive feedback for excellent performance. Five nursing participants (25%) did not feel supported in their job, although they communicated effectively and constructively with their supervisors.

**Discussion**

The quantitative results presented indicate that immigrant nurse workers in the KSA hold a generally average perception of WRS. The mean score for the overall job stress scale was moderate (0.9), indicating the occasional occurrence of stressful incidents. The highest job stress subscale mean score was for “workload,” whereas the lowest mean scores were for the “uncertainty over treatment” and “death and dying” subscales.

The relationship between WRS and job performance was found to be significant. The participants with higher levels of WRS reported poorer performance, whereas those reporting better performance had lower levels of WRS. In addition, the participants rated themselves as high performers, with the more experienced individuals reporting the highest performance levels. Many organizations fail to recognize the actual cost of WRS each year because they do not address triggers for stress effectively (Lee, 1997; Michie, 2002). Other studies have reported on the relationship between WRS and job performance in the working environment (Ahmed, 2012). WRS has the potential to be a major cause of diminished productivity, reduced efficiency, poor staff performance, and reduced quality of work (Halkos & Bousinakis, 2010).
In the qualitative part of this study, the researchers asked the respondents to define the difficulties and stressors in their work. They were asked to evaluate stress and share their personal insights and experiences. Overall, job stress levels were found to be very high, and job stress incidents were reported as frequent. As described earlier, eight conceptual categories emerged when the participants were asked about the sources and levels of WRS. These categories included workload, cultural competency, interrelational conflict, language barrier, physical environment, family-related matters, death and dying, and discrimination.

This study uncovered new understandings related to cultural diversity in the multicultural context. Many participants experienced a dual culture shock because of their involvement in an unfamiliar culture and of their interacting with multiple cultures and different languages.

Immigrant nurses reported that the social support and recognition they received from their supervisors and work colleagues were inadequate, leaving them feeling unsupported. Support from supervisors was identified as a very important factor, which agreed with Miao et al.’s (2020) study. Moreover, job stress was one factor identified as positively correlated with likelihood of turnover and negatively correlated with intention to stay. The participants showed a moderate level of intention to stay.

With regard to their perception of discrimination, most of the participants (65%) who were interviewed believed that discrimination is triggered by a struggle for power or promotion or to maintain one’s place in the hierarchy. They described discrimination as favoritism toward a particular group or nationality, for example, Saudi nurses, Western nurses, and nurses from the Middle East, in terms of stereotypes and wages.

The importance of this study is that it provides reliable and validated data that may be used to strategically plan changes within relevant nursing departments. In addition, the study provides a basis for nursing departments to improve the management of WRS and the recruitment and retention of immigrant nurses, especially during nursing shortages.

The qualitative data corroborate the quantitative findings regarding the presence of WRS. However, the nurses who participated in the qualitative phase of the study indicated a frequent/very frequent occurrence of stress in all subthemes, whereas the quantitative results indicate that nurses experience either “no occurrence” of stress or “occasional occurrences” of stress. This is the main significant difference between the results of the quantitative and qualitative approaches in the study.

### Strengths and Limitations

The integration of quantitative and qualitative structures represents a key strength of this research. Although the broad sampling approach adopted a quantitative approach, a qualitative approach provided rich and significant information on the perceptions of the participants with regard to stress and stress-related concepts. This offered a thorough and systematic explanation of how immigrant nurses in the KSA view stress and how stress impacts them and their practice. The exceptionally good response rates ensured that the results of the survey represented the target population. A 76% answer rate suggests that the findings are adequately precise and useful.

This research was affected by several potential limitations. The use of a self-administered questionnaire instead of physiological and/or biochemical assessments to gather stress-related information may limit the accuracy of the findings and subsequent analysis. Subjective indicators reflecting people’s perceptual experiences are a factor that restricts self-reported questionnaires on WRS. In addition, the participants were multilingual, and their first language was not always English. Nonetheless, because the triangulation technique allowed for cross-checking and validation of the data, the approach used may be expected to “self-correct.”

### Conclusions

The results of this study indicate that immigrant nurses in the KSA are stressed and that the qualitative and quantitative findings vary in significant ways. Moreover, the findings increase the general scholarly understanding of WRS, social support, job performance, and intention to stay and work as immigrant nurses in the KSA. Job workload, tension, and lack of support from colleagues were the most significant stressors identified for the immigrant nurses in this study. However, despite the relatively high levels of perceived stress, the participants expressed a continued intent to stay in their current jobs in anticipation of future success and improved compensation.

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### Author Contributions

Study conception and design: HAN
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Critical revision of the article: RA

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