An-Najah National University

Faculty of Graduate Studies

THE SOURCES OF PSYCHOLOGICAL DISTRESS AND THEIR RELATIONSHIP TO RESILIENCE AND BURNOUT AMONG HEALTHCARE PROVIDERS IN PALESTINE

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Dedication

Then, after many months, even after many years of work and research, I will put in writing what I want to sustain, my academic presentation with respect to sources of psychological distress and its relationship with resilience and burnout among healthcare providers in occupied Palestine.

I dedicate my dissertation work to my family. A special feeling of gratitude to my loving parents, whose words of encouragement and push for tenacity ring in my ears.

My sisters Dania and Rola have never left my side and are very special., I dedicate it also for my brothers Mohamad and Ashraf.

I also dedicate this dissertation to my husband Obaida who have supported me throughout the process, for being there for me throughout the entire MA program. You have been my best cheerleaders, I will always appreciate all they have done, and finally for my wonderful children Hasan and Sarah, I hope to be the mother you are proud of.

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I would also like to give my special thanks to my husband Obaida and my children Hasan and Sarah, for their continuous support and understanding when undertaking my research and write my project.

Declaration

I, the undersigned, declare that I submitted the thesis entitled:

THE SOURCES OF PSYCHOLOGICAL DISTRESS AND THEIR RELATIONSHIP TO RESILIENCE AND BURNOUT AMONG HEALTHCARE PROVIDERS IN PALESTINE

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: Fatina Ahmad Anis Mahamd

Signature: Fatina

Date: 01/06/2023

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THE SOURCES OF PSYCHOLOGICAL DISTRESS AND THEIR RELATIONSHIP TO RESILIENCE AND BURNOUT AMONG HEALTHCARE PROVIDERS IN PALESTINE

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Abstract

The aim of this study is to investigate the level and the relationship between psychological distress, burnout and resilience among health care workers in occupied Palestine. The study also attempts to discover the effects of some demographic variables, i.e., gender, age, monthly income, years of experience, and employment on psychological distress, resilience, and burnout.

The study was conducted using the available sample of 153 health care workers in medical centers, hospitals, and emergency departments, in occupied Palestine. Samples indicated that 34.8% of respondents were male, and 56.2% were female. The results of the study revealed that the degree of psychological distress and resilience among health care workers in occupied Palestine were high, while burnout was very high. The results also indicated that psychologicaldistress has effect on burnout.The results also showed that there were differences in the total score of resilience and burnout among health care workers on the variable of age in favor of +50 years old statistically significant differences were present in the total score of psychological distress and burnout. In conclusion, the study recommends holding more rehabilitation workshops for healthcare providers on a continual basis in order to offer the latest developments in their field. This may encourage and help them to perform their work in a more positive manner.

Keywords: Healthcare providers, psychological distress, resilience, burnout.

Chapter One
Introduction and Theoretical Background

1.1 Introduction

Psychological distress may occur among individuals in all professions, but among health care providers it is almost certain that most will experience this type of distress sometime during their career. Healthcare providers comprise an important role in society, and sometimes this can lead to heightened levels of psychological distress given their unique work environment(Birhanu, Gebrekidan, Tesefa, & Tareke, 2018).

In addition to incidents of patient aggression, abuse, and death, participating in patient recovery poses a challenge to the workers' lives and mental health that can lead to burnout (Ahwal, & Arora, 2015).

The job of a healthcare provider entails high levels of emotional work, either from health or medical related jobs. Not only is the rate of burnout from such work on the rise, the number of workers with mental as well as physical health problems is increasing exponentially (Zapf &Holz, 2006).

The three stages of the burnout process are: the presence of pressure resulting from an imbalance between the requirements of the work and the capabilities required to carry it out, the emotional reaction to the state of imbalance, and the changes in the individual's attitudes and behavior (Al Rabeeh& Al Jarrah, 2009).

Resilience can combat burnout, however, at the time of the current study, it's still unclear as to how resilience manifests in doctors, or how to improve or maintain it (Profit, Sharek, Amspoker, Kowalkowsk, Nisbet & Thomas, 2014).

Resilience is discussed in the context of various professions including healthcare (Jackson D, 2007). It is a personality trait that is inherited (Taku, 2014), and a social adjustment process in the face of challenges that arise at various stages of life (Herrman, Stewart, Diaz-Granados, Berger, Jackson, & Yuen, 2011). However, there is a scarcity of research that focuses solely on medical professionals.

In addition, studies have shown that healthcare workers who do not engage in public relations have negative consequences on their patients (Mills et al., 2016). When

studying how to support resilience, research on public relations between paramedics and firefighters has emphasized the importance and benefits of focusing on organizational factors (Scully, 2011).

Gaining an understanding of how to manifest resilience in the context of organizational factors can contribute to effectively addressing stress and burnout, as research in these occupations has shown (O'Dowd, O'Connor, &Lydon, 2018). This gap in the field of psychological studies affecting medical personnel in occupied Palestine (AlRabeeh ,2009), prompted the researcher to focus on this area and conduct a study to determine the level of psychological stress and its relationship to burnout and resilience.

1.2 Psychological distress

1.2.1 Historical background to the term distress

The linguistic definition of "stress" is an English phrase derived from the Latin word "stringere," which means "to bind", and communicates a sense of fatigue and stress. The term "pressure" has multiple connotations in this context (Paul-Jean, 2010).

1.2.2 Definition

According to Martin (2016), to define psychological distress more precisely, it is the condition caused by what the individual perceives as life demands that exceed in intensity the amount of one's energy and the limits of his or her potential, to the point where they threaten one's own being.

1.2.3 Characteristics of psychological distress

Characteristics concentrate on the sources of psychological distress, in a broad sense, while some definitions emphasize some of the sources of these pressures such as external stress events, the reaction to distress varies from person to person, and within a person, from situation to situation (Ganem, 2009).

1.2.4 Psychological distress levels

1- The stimulus: refers to environmental forces or situations that cause psychological distress in the individual as a result of their effect on them.
2- Receptivity: refers to the cognitive and perceptual processes within the individual that work to clarify and explain the stimulus.

3-Response: t is an awareness of stressful situations as well as a physiological, behavioral, and psychological response to these stimuli and variables.

4- Perception of response results for the individual and his environment: the individual recognizes the outcomes of his or her responses and their effects on themselves and the environment in which he or she lives.

5- Feedback: is given to each of the preceding stages, (Ganem, 2009).

1.2.5 Sources of psychological distress

Hussein and Hussein (2006) identified the sources of psychological distress as follows:

Internal sources: those that originate within an individual, such as aspirations and goals.

External sources: those that arise from the outside environment, such as noise, earthquakes, hurricanes, pressures on values and beliefs, and conflicts between customs and traditions (Abu-Helalah,2014).

Two types of sources:

- Psychosocial sources: They are a source of stress based on the individual's cognitive interpretation of them.
- Biogenic sources: This category includes physical, neurological, and genetic responses (Al-Taha, Ziad Khamis. (2013).

According to Lazarus, physical and nervous stimuli can be a source of psychological distress by causing the stress response by using psychosocial mechanisms to interpret the stimulus (Al-Sayed, Magda Bahaa Al-Din, 2008).

Miller (1979) classified stress sources into two categories Internal sources They are the result of false beliefs and ideas that are not realistic assumptions, because the individual is not perfect, he feels and is confronted with multiple needs and many daily problems, and his attempt to live above his personal abilities inevitably leads to stress (Hassan ,2002).

Internal sources also include:

- Chemical sources: can be found in the misuse of medicines, drugs, and food.
- Organic sources: These include illness, sleep problems, and a dietary imbalance (Yousefi, 2016)

External sources cannot be confined to specific points because they change with changing circumstances and life situations, and every day a person faces new challenges and stressful situations, which may increase his strength, psychological immunity, and toughness, which is what the underlying forces are exacerbating, and this is what the pressure is exacerbating (Ihssan Al-Agha 2002)

1.2.6 Symptoms of psychological distress

There are various signs and symptoms that appear as a result of exposure to psychological distress:

Organic symptoms

- Nervous system symptoms: They appear in muscle tension in the neck and back, causing tremors, tension headaches, and cold extremities.
- Digestive system symptoms: they appear as heartburn, nausea, flatulence, constipation, loss of appetite, and diarrhea.
- Sleep problems: These are insomnia, the beginning or the end of sleep, disturbing dreams.
- Multiple pains: this appears in dental pain, for example.
- Heart disturbance: such as an increase in the heartbeat.
- Disturbed breathing: such as difficulty breathing, chest pain.
- Sexual disorders: such as frigidity or impotence (Ismail, 2008).
- Psycho-emotional symptoms: malaise, depression, sadness, loss of interest, rapid arousal, hyperactivity, motor and psychological instability, anger, speech difficulties, boredom, lethargy, fatigue, exhaustion, poor concentration, mental confusion, negativity, lack of the ability to make a decision.
- Mental symptoms: loss of concentration, impairment of memory power, difficulty making decisions, confusion and confusion, deviation from normal, panic attacks (Ben Zeroual, 2006).

Behavioral symptoms

Change in appetite, eating disorders (loss of appetite, or bulimia), increased intake of alcohol and drugs, excessive smoking, anxiety with nervous movements, biting nails,

whispers of illness, emotional symptoms, depressive episodes, irritability, outbursts of extreme anger (Ali Askar ,2003)

Cognitive symptoms

Irrational thinking, indecision, loss of confidence, lack of focus, distraction or forgetfulness, ill-advised decision-making, low self-esteem (Ali Askar ,2003).

1.2.7 Effects of psychological distress

The cognitive effect of stress appears in the lack of attention span and capacity, deterioration of long- and short-term memory, increased rate of errors in performance, and the increase in intellectual disturbances (Yousefi, 2016).

1- Emotional influences: present an increase in physiological and psychological tension, an increase in the rate of obsession and in personal problems, irritability and mood swings, nervousness, a feeling of psychological burnout, depression, and a sense of acute self-assertion.

2- Behavioral effects: manifest lack of inclination and enthusiasm, increased rates of an individual's absence from work, reduced energy levels, disturbance of one's habits, increased insecurity, suspicion of others, increased misuse of medical drugs (i.e. overuse), lack of interest in relationships with others... etc. (Askar, 2003).

3- Physiological effects: present an increase in exposure to psychological distress, which leads to a deterioration in the individual's health, while a decrease in the level of stress is accompanied by good health. Several studies revealed that there is a strong relationship between occupational stress and physiological disorders. The results of medical research also showed that more than 50% of the diseases that an individual faces are inherently related to the pressures that the individual is exposed to during his or her lifetime (Yousefi, 2016).

1.2.8 Types of psychological distress

The types of psychological distress that people face vary and may include light, moderate, or severe pressures. Some of the psychological distresses may be temporary while others may become permanent.

The following are some of the types of psychological distresses:

1- Current psychological distress: is the result of a specific situation (for example a contest), and if controlled becomes effective.
2- Expected psychological distress is related to taking a specific exam and becomes harmful when the individual gives it great importance.
3- Acute psychological distress: is the individual's response to an immediate and direct threat, i.e. trauma, as the individual finds him or herself in a situation that threatens their safety and is unable to prevent it (Issa , 2008).
4- Chronic psychological distress: is a type of pressure that grinds people day after day, month after month, and year after year. It is worse for chronic stress, as people get used to it, and only pay attention to acute pressures when it is new, but ignore chronic pressures because of old age (Boudarene, 2005).

1.2.9 Components of psychological distress

It has three (3) interconnected elements:

1. Stressors: These are situational requirements that require individual adaptation, such as conflict.
2. The individual's perception and evaluation of these pressure forces, their nature, dynamism, and effects, and his ability to deal with, control and contain them.
3. The individual response to pressure forces according to the nature of their awareness and evaluation, so this response is often a mixture of psychological and physical reactions.(Zeroual, 2006)

1.2.10 Explaining theories of psychological distress

Physiological theory -Cannon and Cely:The physiologist Walter Cannon is considered one of the first to use the phrase psychological distress and defined it as an emergency response or a military response rather than its connection to the emotion of fighting and confrontation. Which made him suggest that maintaining the vital balance in the face of changes in the environment and in situations of fear and helplessness is due to what the law of confrontation has called fight or flight, where the physiological events (increased respiratory rate - heart rate .) the emotion caused by a defense posture in order to adapt to the new circumstances. Canon identified one of the models explaining the stress response, which is the fight-or-flight response. Where his experiments reached the

conclusion that the body expressions associated with behaviors such as fleeing or attacking in front of risk factors are due to the release of the hormone adrenaline in the blood. (M Boudarene, 2005)

Then the contributions of Selye H continued to emphasize that psychological distress is a syndrome or a group of non-specific responses of the body to various environmental factors harmful of a physical or chemical nature in the sense that Selye emphasized the importance of the concept of vital balance (Ben Zeroual, 2006)

He noticed that when a group of mice was exposed to stressful situations (starvation, restricted movement, or injection ...), a group of non-specialized physiological reactions appeared (increased secretion of adrenaline. The appearance of an ulcer is contagious ...) and found that these responses appeared with sources other stress, such as heat or cold, wounds, etc.

According to Cely, it is not important that the source of stress be physical or psychological, because these responses are non-specific and not related to the nature of the threatening factor. (Graziani P &SwendsenJ 2004)

Cely divides the individual's distress response into three stages, which we summarize as follows:

The first stage: the alarmed phase: which is characterized by rapid heart palpitations, lack of muscle vitality, decrease in body temperature, yellowing of the face, secretion of sweat, urinary retention, and stomach acids. It lasts from several minutes to 14 hours, even if it is not fatal, followed by a counter-shock period, in which the body directs its defenses as the adenoids and thymus glands enlarge and reflect most signs of the shock period, increasing temperature and blood pressure, and preparing the body for confrontation and if the stimulus continues, the body enters the next phase.

The second stage: the résistance de phase: the body's resistance occurs as a result of the metabolism (food transformation). Métabolisme, whereby the adrenal cortex increases in size and activity, thus reversing most of the characteristic features of the first stage. (Bin Zeroual,2006)

The third stage: the phase of exhaustion or fatigue, during which what Sili called adaptive diseases (psychosomal diseases) that result from the organism's exhaustion of

its energy in resistance, it becomes difficult for the organism to adapt to the stress factors and retain its defense capabilities, which may lead to death. (Ben Zeroual, 2006)

Perceptual theory: Spielberger

This theory is based on the overall perception of situations, and its owner believes that psychological distress plays an important role in differences on the level of reality, each according to his perception of distress. He also formulated a theory on stress, anxiety and learning. It emphasizes that the overall theory must take into account the following factors:

- Nature and importance in stressful situations.
- A measure of the level of severity of stress caused by stress in different situations
- Provide appropriate behavior to overcome stressful anxiety situations in various situations.
- Explain the effect of the psychological defenses used by those on whom learning experiences are conducted to relieve anxiety (Ben Zeroual, 2006)

Murray needs theory:

Murray's theory of needs is based on the premise that the concept of need and the concept of psychological distress are basic concepts, given that the concept of need represents the essential determinants of behavior, and the concept of psychological distress represents the influencing and intrinsic determinants of behavior in the environment, and the separation between these two concepts is a dangerous distortion. (Othman, 2001)

Both psychological distress and need meet in a dynamic dialogue that appears in the concept of Thema, by which Murray means an interactive overall behavioral unit that includes the motivational attitude (distress) and the need.

Murray's approach to a study of stress is characterized by psychodynamics, as it separates personality theorists with a depth of understanding of the dynamics that occur within the human being in order to bring about psychological balance.

He distinguished between two types of stress:

- Alpha Stress: These are characteristics of environmental issues as they exist in reality or as the research actually shows.
- Stress Beta: This is a sign of environmental issues as perceived by individuals.

When studying and explaining pressures, he was interested in Beta pressures because they express the significance of things and topics, and they arise when the individual has an excited need, and the satisfaction of that need is linked to some people, forces and social situations, and when the individual interprets those forces as pressure in a direction towards satisfaction, this interpretation that the individual perceives So that the subjects and things are not pressures in themselves, but rather when he perceives them or interprets them as such. (Khamis,2013)

Cognitive theory Lazarus:

Lazarus theory arose (1970) as a result of the interest in the perception process and the sensory-motor therapy, and the cognitive appreciation is a basic concept that depends on the nature of the individual, as the threat appreciation is not just a perception of the elements that make up the situation, but rather a link between the environment surrounding the individual and his personal experiences with the psychological distress. (Othman, 2001)

The process of cognitive assessment of the threat or danger according to Lazarus is the central concept of understanding the nature of psychological distress, as it includes the cognitive assessment process, and this depends on the nature of the individual's assessment of the situation and the ability to confront it, as the individual decides whether the situation is harmful or threatening or otherwise. (Hussien,2005)

His knowledge assessment process passes through several stages, which are:

- Initial evaluation stage: in which an attempt is made to assess the situation and the extent of its threat through the individual's cognitive style and his personal experiences.
- Secondary evaluation stage: in which the individual assesses his personal capabilities and his ability to face the situation by identifying appropriate mechanisms to overcome it.

• The confrontation phase: In this phase, a cognitive or behavioral strategy is used to face the stressful situation.

The stage of the results of the confrontation: in which the extent of the influence of the strategies of confrontation on the cognitive, physiological, emotional, and behavioral activity is determined, as the consensus response of the individual depends on the extent of his success in using the appropriate strategy (Ikhalaf, 2001)

In her interpretation of psychological stressors, she focused on the stages of development to provide an explanation for each psychosomatic disorder, for example, the basis of gastric ulcers is due to the early stages of development in the child's life, where he was facing problems related to nutrition, causing the mother's refusal behavior that creates painful emotional situations in him, and colon ulcers refer to the training process on hygiene In childhood and the accompanying emotional situations related to the strict orders of the parents to regulate the process of controlling the output, which creates a desire to punish the child.

As for bronchial asthma, it arises from the child's suffering when the parents reject some of his demands, which generates a hostile attitude towards them, and according to this theory, skin infections are due to the feeling of conflict that includes aggression against others and dependence on the symbol of authority, with a low self-esteem, so the individual finds in skin disorders a method of Self-mutilation as punishment for her. (Ben Zeroual, 2006)

Behavioral theory: This theory stems in its interpretation of stress from its general concepts about the stimulus, the response, and the products of behavior (reinforcement and punishment), and based on those concepts it can be indicated that stresses are stimuli to which the individual responds in an inappropriate way that generates a feeling of psychological distress. (Osman ,2001)

This school considers the determinants of functional dysfunction as a response to previously learned emotional situations and that the link between the emotional situation (stress) and the response to it with a reward for the individual supports this response, and when stressful situations are repeated enough and severe, the functional dysfunction appears strongly as a response to that.

- Peripheral influences: It concerns all factors affecting a person's growth, that is, all the peripheral and social as well as economic and cultural spheres.
- Psychosocial influences: trauma, lack of tenderness, family disintegration and organ disturbances.
- Preparedness: It is manifested in the individual's psychological and mental capabilities that help him cope with the various stress factors. The individual faces facts and events through hereditary and acquired factors, and the external factors represented in the economic and professional level either accelerate or slow the course of the stress phenomenon. . (Al-Ahrash, 2012).

Hence, the theory of readiness in its interpretation of psychological distress on the basis of the interaction between the factors causing stress, is concerned with studying all variables and factors as an integrated unit in its study of the individual.

The theory of Schaefer & Moss (1986, Theory Schaefer & Moss):

This theory provides a basic model affecting an individual's response to psychological distress, as the processes of coping with behavioral and cognitive factors that the individual exerts during his dealings with and adapting to pressures include stressful situation efforts.

Moss and Scheffer defined an individual's response to a stressful situation in three stages:

- The first stage: the personal and demographic factors of the individual:
  It includes the gender, age, social and economic status of the individual, cognitive and emotional maturity, self-strength, self-confidence and previous experiences, in the face of events and includes factors related to stressful experiences such as the type of stressful event, whether it is disasters on nature such as earthquakes and hurricanes Or on the human being such as wars, and includes biological factors such as: death and disease, the extent to which the individual is exposed to the stressful event and his ability to confront it and control the excitement of the possibilities of its occurrence. It also includes factors related to the social and physical environment, such as the relationships between individuals and their families, the extent of community cohesion and the cooperation of individuals in facing the stressful event and bear the implications of it.

- The second stage: Perception of an agreement with the stressful event, and includes:
  A. The individual’s perception of the stressful event: Here the perception is after the stressful situation (event) has occurred.

     At the beginning, then its features, dimensions and consequences become clear, it may be ambiguous, and perception may occur gradually.

     Potential, which may make it easier for the individual to agree with him in an appropriate manner.
  B. Performing actions in harmony with the stressful event: It is represented by the individual having strong and intimate personal relationships with individuals who can provide assistance in facing the stressful event, such as family members, friends or others, while the individual tries to maintain his balance and control his negative feelings that were a result of the stressful event, This may help him regain his self-confidence and increase his efficiency in controlling a stressful situation.
  C. Employing skills or consensual strategies:It occurs through focusing on and understanding the stressful event, and discovering the appropriate method to deal with it. With the aim of returning the individual to his balance.

This may be by facing the stressful event, mitigating the severity of its effects, or getting rid of this event and the negative emotions that accompany it. Moss and Scheffer indicates that the individual can adopt one or more methods in dealing with the stressful event.

- The third stage: The results of the stressful event, and its effects on the individual:

  This stage is the result of the interaction of the previous elements. It expresses the extent of the individual's compatibility in facing.

As the individual can benefit from the experiences of a stressful event or situation. This compatibility may be successful that he obtained during the event in the continuation of his life, or he failed to achieve compatibility and symptoms of mental and physical disorder appear on him (Al-Ahrash, 2012).

House's Model of Occupational Stress:

House (1974, Hous) formulated a stress model that he called the Occupational Stress Model in which he collected data from previous studies related to stress and then tried to

relate these studies to heart disease. In other words, he tried to use the results of research related to the social factor and the psychological factor in science. Causes of chronic diseases, especially heart disease. (Al-Ahrash, 2012)

1.2.11 Previous studies of psychological distress

The goal of Okwaraji's (2014) study was to ascertain the frequency of burnout and psychological distress among nurses employed by a tertiary healthcare facility in Nigeria. The Maslach Burnout Inventory (MBI) and the General Health Questionnaire (GHQ-12) were the study instruments used to evaluate the symptoms of burnout and psychological distress in 210 nurses working in healthcare institutions. High levels of burnout were found in the areas of emotional.

l exhaustion in 42.9% of respondents, depersonalization in 47.6%, and reduced personal accomplishment in 53.8% of respondents. Additionally, 44.1% of respondents scored positively on the GHQ-12, indicating the presence of psychological distress.

Astudy by Chou, Chaung, and Sausan (2013) determined the percentage of psychological distress and therapeutic factors by psychological penetration of 5 medical specialties at the provincial hospital in TaiwanAccording to the findings, nurses experienced work stress at a prevalence of 66%, followed by assistant physicians at 61.8%, doctors at 38.6%, office workers at 36.1%, and medical technicians at 31.9%. Regarding the pre-burnout components, the decline in hierarchical regression revealed that excessive social isolation and work stress account for 32.6% of psychological tiredness.

A study of Siau, Wee, Ibrahim, Uma Visvalingam, Yeap, Yeoh, and Wahab (2018) aimed to study the risk factors associated between psychological distress and burnout across specialties and professions of various medical specialties and professions in Malaysian hospitals. Specialties include psychiatry and orthopedics, and professions included physicians, nurses, paramedical officers, and hospital personnel. The presence of psychological distress among healthcare workers was assessed using the depression Anxiety and Stress Scale (DASS-21). The analyses showed that, compared to other professions, 70% of physicians reported experiencing psychological distress.

1.3 Resilience

1.3.1 History of the term "resilience"

The term "resilience" has a long history. It was first used by researchers in the nineteenth century (Jackson, Firtko, &Edenboroug, 2007). The word 'resilient' comes from the Latin word 'resilire', which means 'to rebuild / recoil' (Phaneuf, 2008).

The word "resilience" means "to rise" in English. The concept of resilience has become one of the most widely used in everyday life, implying that everyone must deal with the pressures to which he or she is subjected to, as this necessitates flexibility in dealing with them, as well as recovery and growth afterward. Medicine, nursing, microbiology, mental health, and psychology are just a few of the scientific fields that study resilience (Maddi,2004).

1.3.2 Definitions of resilience

Adapting well in the face of adversity is the process of resilience. It is required in situations involving trauma, tragedy, threats, or major sources of stress, such as troubles with family and relationships, severe health problems, work-related pressures, and/or financial stressors. (American Psychological Association, 2010).

1.3.3 The importance of resilience

1- People with high resilience believe that positive events are meaningful because they occur as a result of internal reasons that belong to them and that they are responsible for their decisions or actions, and negative events are insignificant.

2- Its importance also lies in relieving psychological distress and alleviating the severity of stresses facing the individual. Stressful events can lead to relapses that may lead to the excitement of the autonomic nervous system becoming chronic. Chronic stress may later develop into fatigue and the accompanying physical diseases and psychological disorders, which start with stress and end with burnout. It accomplishes this through a variety of methods, as it modifies the perception of events, making them appear less stressful, and leads to active coping methods (Hamada & Abdul Latif, 2002).

1.3.4 Characteristics of resilience

"Kopasa" discovered that individuals with resilience have: resistance, better achievement, ability to control things, activity, and better motivation through her research from 1989 to 1979. (Abu Al-Nada, 2007)

1.3.5 Some concepts related to resilience

1- Ego strength: It is the fundamental pillar of mental health, and it refers to compatibility with oneself and with society, as well as the absence of neurotic symptoms and a positive sense of sufficiency and satisfaction, and it is the polar opposite of neuroticism. (Zainab, 2008)

2- Self-esteem: "It is one of the most important personality variables, representing protection or immunity in the face of stressful events on the individual's physical and psychological health." (Zainab, 2008)

3- Self-efficacy: "It is the individual's belief in his sufficiency, ability, empowerment, and self-worth that gives him a sense of self-confidence and the ability to overcome his life's problems and breakdowns." It reflects an individual's ability to deal with stressful situations with adequacy, ability, and confidence. (Dre. 2016)

1.3.6 Theories explain resilience

The Lazarus model (1961) is one of the most important models on which this theory was based as it was discussed in terms of its relationship with a number of factors and was defined with three main factors in mind: internal environment, cognitive and perceptual style, threat and feelings of frustration. According to Lazarus, the occurrence of stressful events is determined first and foremost by how the individual perceives the event and views it as a coexisting situation. The secondary perception process entails assessing one's own abilities and determining one's effectiveness in dealing with difficult situations (Odeh, 2010).

Maddi (2004) conducted a 12-year longitudinal study with his students. A company decided to cut its workforce in half. Maddi and his team conducted a study on a sample of 400 people for the company and their supervisors at work, before and after reducing the number of employees.

According to the findings, and as a result of being exposed to severe stress, two-thirds of the remaining workers had a decline in performance and leadership skills, as well as health disorders such as heart attacks, obesity, depression, and drug abuse. The other third, on the other hand, maintained their health and enthusiasm despite being subjected to the same conditions. Then a "materialist" question arose: what caused the disparity between the two groups?

In accordance with Maddi’s findings, individuals who faced psychological distress used three traits that helped to see distress as an opportunity for strength and survival: commitment, challenge, and control. They were motivated by a commitment to participate in events rather than to avoid them, by a need to confront conflict, and by a challenge to see stress-related changes as a new opportunity for learning (Maddi, 2004).

Barton relied on the theories of Maddi (2004) and Kopasa (1979) and adopted the same definition of resilience as a structure of three components in personality that can be acquired and strengthened, indicating that strengthening resilience leads to achieving a high level of health and performance as well as preventing psychological stress. Barton's foundation was founded on the premise that people work in diverse and complex environments, which increases psychological stress and leads to professional and health problems.

On the other hand, there are individuals who remain resilient and persistent in the face of psychological distress (Barton, Spinosa, Robb, & Pastel, 2008)

People who are resilient, according to Barton,are more receptive to change, have a better sense of control, and have a strong sense of life (2008) emphasized the importance of social background, family circumstances, the individual's personality, previous experiences, level of intelligence, and physical health in developing resilience.

1.3.7 Previous studies of Resilience

In their 2008 study, Dyrbye, Thomas, Power, and Massie examined 1321 medical students. Students' resilience was compared to that of non-resilient students using the Wilcoxon-Mann-Whitney test. The findings showed that when it came to the topics of sex and age, there were no differences between the resilient students and non-resilient pupils. Resilient students also demonstrated lower rates of depression, more life

satisfaction, fewer stressful life events, higher levels of social support, a more favorable perception of their learning environment, and less stress and burnout from other students.

According to a study by AI Lala, Sturzu, Grama, and Bobirnac (2016), the resilience stress elements of employees at the French Regional Emergency Medicine Unit were evaluated. 366 emergency medical unit staff members, including resident doctors, medical nurses, and ward auxiliaries, took part in the study. The participants were 33 years old, on average. The findings revealed no gender, marital status, or professional category differences. The results showed that there were considerable differences across occupational categories, with medical personnel having significantly higher workload (PWO) and poorer perceived personal competency (PPE) than paramedics.

A descriptive study by Diaz and Zeballos (2020) dealt with determining the resilience of professional health workers in emergency services and their relationships with social, demographic, and work conditions. The results showed that doctors are the most resilient group, and their ability to be resilient is heightened if the doctor works in mobile units. As for patients, they were less resilient. The lack of a life partner was one reason for the decrease in resilience, but in terms of work experience, it increases levels of resilience.

The study of Rippstein, Leuenberger, Mauthner, Sexton, et al. (2017) was conducted on 32 specialists in the ICU unit where it focused on exploring the content of good things that revealed elements of resilience among specialists. These resulted in three important elements: having a productive day at work, having relationships that are encouraging, and using time wisely. For a good day at work, common responses included: had a professional discussion with colleagues, the work environment is generally supportive, and the management is good. As for the presence of supportive relationships, the following responses included: my family and I ate a meal together, we spent a beautiful time together, we laughed together. The emphasis was on the importance of family well-being and spending time with them. For purposeful use of time, responses centered around time to relax, enough time to fall asleep, and time to splurge on energy.

The goal of the study by Matheson, Robertson, Elliott, Iversen, and Murchie (2016) was to examine what primary health workers working in difficult situations view as one of the most crucial features of resilience, as well as what supports and inhibits it. A

particular focus group in North-Eastern Scotland conducted this investigation. Six general practitioners, nine nurses, and four pharmacists were among the twenty (20) health professionals who took part in the study in five groups. The findings indicate that the workplace, information overload, time constraints, and environmental aspects, particularly those related to rural labor, were the three factors that had the greatest impact on resilience. Strong administrative backing, team culture, the capacity to "buffer", work-life balance, which includes supporting home and leisure activities, as well as contingency preparation, are all factors that contribute to resilience.

1.4 Burnout

1.4.1 History of the term burnout

This term was popularized in the seventies and eighties by Maslach (1976; 1982), who is considered one of the pioneers in the field of burnout, as she contributed to many researches explaining and understanding this phenomenon in various professions. She and her colleague Jackson (Maslach & Jackson, 1984) indicated that burnout expresses a "common language", as it is the term used by most individuals to describe the syndromes and the resistances with which they resist.

1.4.2 Definitions of Burnout

Youssef (2006) defines burnout as a state of physical, emotional, and mental weariness brought on by a sustained focus on emotionally charged and stressful situations along with high personal expectations for how well people perform.

Aronson and Pines (1983) define Burnout that it is a syndrome that develops after working with people and engaging with them for a long time in situations that demand a twofold emotional effort. It is characterized as a state of physical, mental, nervous, and emotional stress. (Muhannad Abdel Salim Abdel Ali, (2003).

1.4.3 Indicators of psychological burnout

1. Permanent preoccupation and haste to finish the long list that the individual writes to themselves every day, so when the worker falls into the trap of permanent busyness, he or she sacrifices the present time and what it requires of work. This is embodied in the nature of what is embodied in the world. An emotional connection, as what

concerns the individual is speed and number, not mastery and attention to what is between their hands.

2. Living according to the “should and should” rule, where this rule increases the pathogen’s sensitivity to what others think, such that the individual becomes unable to satisfy themselves. Even if one wants to please others that implement this rule, he or she finds that implementing this is not easy for them.

3.Postponing the good things and social activities through the self-conviction that there is always time for these, and that postponement becomes the rule or standard in the life of the individual’s activities, but "afterwards" will not come.

4.Loss of vision or perspective so that everything becomes important and urgent, and the result is that the individual becomes involved in their work to the point where they lose the spirit of fun and finds themselves very hesitant at the union of decisions.

This is linked to what is known as “work addiction,” as work becomes the main focus of one’s life and the center of his or her personal interests in a way that disrupts the balance required to avoid the physical and emotional problems that accompany such a defect (Askar, 2004).

1.4.4 Stages of burnout

Hartawi (1991), contained in Abd al-Ali (2003) believes that the psychological burnout of the individual develops through three stages:

The first stage: in which the individual feels the pressures of work as a result of imbalance between work requirements and the self-ability necessary to meet those requirements.

The second stage: in which the individual suffers from stress and tension, which are a natural, direct, and emotional response to work pressures.

The third stage: in which the individual has a set of changes in attitudes and behavior, such as the tendency to deal with the beneficiary in an automatic way, and the preoccupation with satisfying personal needs, and the consequent lack of commitment to responsibility (Abd al-Ali, 2003).

1.4.5 Dimensions of burnout

According to Maslach and her colleagues 1986-1987, the clash of stressful professions causes intense and lasting feelings of tension with people, which is based on loss of interest and lack of commitment, and they are the opposite of the original trends of the worker. These feelings appear in the form of three dimensions:

A. Emotional exhaustion: Since the emotional feelings have drained, the workers cannot or do not have the ability to give as they were before and these feelings are represented in the intensity of tension and stress and the feeling of the worker that he has nothing prior to giving to others.

B. Sagging feelings: It illustrates the negative trends the direction of those with whom the burned worker works psychologically, and these negative trends, which are sometimes sarcastic (sarcastic), do not represent the distinct characteristics of the worker. Both Maslash and Pinz 1977 define this dimension as “the image of the clients and the sense of humor in humanity. During the transaction.

C. Lack of personal achievement: This dimension occurs when individuals begin to evaluate themselves negatively, when they lose enthusiasm for achievement, and when the worker feels that he is no longer competent in working with his other clients' responsible and in his inability to fulfill. (Badran, 1997).

1.4.6 Burnout symptoms

In the labor organization, some of the basic symptoms can be identified. Psychological burnout manifests itself as a group of symptoms of nervous stress, exhaustion of emotional energy, deprivation of personal characteristics and a feeling of dissatisfaction with personal achievement in the professional field.

According to Cordes Carol and Dougrty Thomas, which balance five basic types, which are organic, emotional, interpersonal, attitude (attitudes) and behavioral reactions in which social reactions are observed at the individual level in the organization that limit the work:

A. Physical symptoms: Various clinical studies have proven that the burnout syndrome is known as chronic fatigue, emotional stress and the feeling that a burning individual is empty as well as sleep disorders, psychological and physical disorders, and pain disorder such as abdominal pain, digestive pain, and joint pain. High blood pressure,

frequent colds for a long time and muscle spasms. As for individuals with severe or advanced burnout, they have high levels of cholesterol and sugar, and a sharp rise of cortisol throughout the work day.

B. Behavioral symptoms: At the individual level, as the studies of the French doctor, Susan Jackson, showed that there is an important connection between the psychological combustion and the intake of various psychological services psychological resources such as poor self-esteem, the state of grief and loss of hope, anxiety and feelings of helplessness from the use of defensive withdrawal mechanisms (denial - avoid - justify). With children in a functional way, in addition to the weakness of positive trends towards oneself and others. What lacks social interaction and leads to isolation and withdrawal leads to a right in the professional sphere until combustion leads to a lack of professional gratification, a decrease in commitment and seriousness in work and a loss of friendship relations with colleagues, clients, and a desire to lose love Effectively, all these symptoms and others may lead in a specific case to suicide. (Al-Batal, 2000).

1.4.7 Causes of burnout

All theories revolving around psychological combustion methods are based on three levels:

the societal level, the organizational level, and the individual level, though social and individual causes are crucial, but they contribute less to the organizational factors to the emergence of the burnout.

1-Factors related to individual differences: Individual differences play an important role in compensating the individual for pressures to consider that the individual is unable to tolerate and adapt to any kind of health complications.

1.The sex of the worker: Studies have focused on highlighting the relationship between the sex of the worker and his exposure to psychological burnout. Work relations and the professional environment. Men are exposed to more psychological burnout.

2. Age: Age is not considered a significant indicator of a worker's exposure to psychological burnout, as no study was found that exposed this element, while the importance of years of work was given.

3. Beliefs and values: The scholars were interested in studying the effect of beliefs and values that a worker adopts during his daily practice of his profession, so that it was noticed that the thinking pattern that the worker adopts is based on his beliefs and values on his own influence of his work on the path of pressure. There are two basic patterns of thinking, and this is what "Roter" referred to, and it is represented by two types of people in dealing with things around them:

- People with outside control: These people are characterized by a positive outlook, impulsivity, and self-satisfaction, which makes them able to face pressures and avoid their symptoms.

- People with internal control: People here tend to be dissatisfied, negative and subject to external conditions, and as they are inevitable, they tend to be introverted and their inability to face the pressures. This group is more vulnerable to psychological burnout. (Shehata ,2006).

2-Social factors: The individual can list social and historical factors that can be considered from contributing factors that are manifested in three factors:

1. There is an increasing reliance on formal institutions and specialized professionals to provide services, and care in our community, and services that were provided by official bodies.

Although these institutions are still playing their role in providing services, the phenomenon that we touch is the attempt of official institutions to assume full responsibility in this regard, which has led to a significant increase in the number of these institutions that does not keep pace with the growing need.

2. The mental, ethical and cultural character, as burnout increases in areas of work and goals that do not receive public support. For example, the phenomenon of support emerges in the case of alternatives to deal with the problems that appear in society. an tended to fade after they play their role and despite the presence of statistics or research supporting this, we believe that there is a problem in institutions. Job ambiguity in this type of profession. There is a set of expectations about the nature of professional work and those who do it, which most members of society participate.

Qualifying competence:

- Clients in general are distinguished by the cooperation and provision of the service or treatment provider.
- Professional work is distinguished by reference and diversity.
- The friendly relationship between workers in the same job.
- The phenomenon of independence of the professionals regarding their decisions and the quality of services they provide. (Al-Ghirir& Abu Asaad 2009).

1.4.8 Theories and models explaining burnout

The Canadian physiologist, Hans Seeley (2010), classified burnout as among the most important stages that the individual undergoes in order to achieve agreement as to the importance of when the adaptive pressure stimulates the energies of an individual to face dangers and deal with painful stimuli. However, he warned of the drawbacks when it develops into severe pressure as the exhausted individual efforts create dumbstruck pressures in their repeated exposure, resulting in negative impacts, and confusion in the life of the individual.

These include the inability to adopt decisions and the emergence of diseases or physical manifestations of disorders of other organisms. Instances include frequency of daily and increasing pressure intensity which constantly cause the individual to suffer from symptoms of physiological pressure (i.e. high blood pressure, arthritis disease). In the case of only theoretical fibrinogen, the inability of the individual to deal normally with the pressure in the same position leads to the development of burnout. It is in the burnout syndrome as a final stage of severe stress and therefore cannot be disposed of positively during the stressful situation (Ali, 2009).

Psychological distress is positive at the beginning, such that the body is alerted to the danger and stimulates itself to confront and resist the source of pressure or frustration. It makes one depleted of strength, exhausted, or afflicted with organic-physiological diseases (Ali, 2009).

Behavioral school is considered one of the schools of psychology most concerned with external factors and apparent behavior. Human behavior is often developed as a result of interacting environmental factors that the individual has acquired (Maimoni, 2011).

The role of conditionality in the learning process must be emphasized. To indicate that individuals will be equal means they learn well in positive ways. However, if they are

not equal, this may be due to the individual's learning of bad habits that did not enable them to reconcile their habits in a positive way. This thinking is putting off how the re-acquisition modifies the behavior and heals the disorder, especially since they consider the symptom to be a disease and its demise means healing.

In this regard, Esik says for those in psychiatry, the symptom is a disease, as all symptoms are emotional responses resulting from inappropriate conditions (Maimoni, 2011).

And it means that the individual, or "the worker" suffers from burnout as a result of learning negative habits and methods of dealing with psychological distress, instead of responding to frustrations with consensual coping strategies.

The individual responds to them in bad ways, and this is a result of the multiplication of psychological distress factors that are present. With their repetition and persistence of severity, they are environmental factors outside of one's self, and so their effects can be easily remedied by means of modification of the workers' behavior (Odeh,2010).

Psychoanalysis theoryis considered one of the most important theories of psychology that analyzes human behavior and explains the causes of the unrest and factors leading to the deviation from both. Thanks to the findings on human personality studies, leading psychoanalyst, Sigmund Freud said it was considered personal. (Ali, 2003)

Composed of three pillars: id, ego, and superego, every corner of one's functions and attributes, components, and dynamics interact with each other and behavior. A person's overall character is the result of the relationship between these three pillars (Ali, 2008), where the superego represents the internal moral perception of the external world in the very same individuals, and it consists of a late stage in childhood (Ali, 2003).

The accumulation of pressing unconscious factors coupled with the inability to monitor the potentials of two frustrating external factors leads to the individual working in the humanitarian professions to invest all their energy in exchanging emotional relations and goals in their work, in order, starting from the two examples (Hamada,2002).

In oneself and in society, one can become frustrated and depressed to the point that they lose motivation to work, and performance becomes practical. This means that the ideal perception of one's abilities and positive outlook are separated from the emotions that

were associated with them, such as love of work, self-confidence, and self-gratification (Askar, 2005).

Hence, failure in professional harmony will lead to depression, frustration, and burnout that occurs when an individual is exposed in trying to achieve compatibility against the adaptation of obstacles that prevent him or her from being satisfied.

If one is not able to remove the obstacle through harmony and tension, the goal will increase and bring about excessive anxiety. Therefore, the individual suffers from frustration, which represents a group of painful feelings resulting from the inability of the person to reach the goal necessary to satisfy an urgent need in themselves (Askar, 2005).

1.4.9 Previous studies of burnout

Based on the Fifth National Health Services Survey, a study by Yang, Liu, Liu, Zhang, and Duan (2017) explored the relationship between burnout, work-family conflict, social support, and job satisfaction among medical professionals in Southern China in 2013.

1,382 medical professionals took part in this investigation. The findings revealed that while the three aspects of the conflict between work and family showed a positive relationship with burnout syndrome, the dimensions of job satisfaction and self-reported social support were shown to be adversely associated correlation.

The researchers discovered that job satisfaction accounted for 2.6% of burnout syndrome, conflict between work and family accounted for 2.6%, and demographic factors represented 5.4%. In terms of the gender variable, females had a higher prevalence of burnout syndrome. Medical staff who did not have administrative responsibilities experienced greater degrees of burnout than those who did.

According to numerous factors (such as gender and marital status), a sample of nurses working at Al-Assad University Hospital were found to be experiencing professional psychological discomfort, according to a study by Sabira and Ismail (2015). It had 120 nurses as the sample. In order to emphasize professional psychological suffering, the researcher created a questionnaire.

The investigation came to the following conclusions: In the study, a large number of the nurses (64.59) displayed signs of psychological discomfort. Financial problems were

the main cause of psychological anguish, followed by the work environment factor and then the psychological factor.

According to this study, there were statistically significant disparities in favor of women in the psychological dimension and in favor of men in the financial and relationship with doctors dimensions. Additionally, the findings indicated that there were statistically significant variations in professional psychological discomfort. These distinctions were in favor of single people and connected to psychological factors.

The assessment of burnout levels and related risk factors among medical staff for EDs in Palestinian hospitals was included in the study by Hamdan and Hamra (2017). Researchers utilized a cross-sectional design using a self-administered questionnaire to collect data from all employees in 14 Eds: 8 from the West Bank and 6 from the Gaza Strip. This allowed them to analyze the connection between burnout and workplace violence. To gauge burnout, the researchers employed the Maslach Burnout Inventory-Human Services Survey. The anticipated total number of employees in the chosen hospitals was 596. According to the findings, medical professionals had the highest rates of emotional burnout (72.3%), followed by nurses (69.8%) and office employees (51.4%). As a result, 64% reported having experienced severe burnout, 38.1% on depersonalization, and 34.6% on the sub-measures of personal achievement.

Guiyuan, Xiuying, Xiaohong, Chunqin, Guopeng, Linghua, and Ping (2015) conducted a study on 366 female nurses, whose average age was 29.1 years. The burnout rate among the nurses was 41.8. The results indicated that there were positive relationships between psychological stress and burnout dimensions. As for psychological rigidity, it was negatively related to the dimensions of emotional exhaustion, depersonalization, and psychological distress. The signs did not differ with age. The inter-correlation among burnout dimensions were positively related. However, emotional exhaustion was not related to personal accomplishment.

According to the study, depersonalization, psychological distress, and emotional weariness are all positively correlated. Mental toughness was not linked to stress, although resilience mitigated the link between burnout and psychological suffering. According to the findings, psychological hardness may be intermediate between emotional burnout, personality dissolution, and psychological discomfort since it lessens the effects of emotional exhaustion and personality dissolution. (Maimoni, 2011).

1.5 The relationship between studies variabes

the study of Zou, G., Shen, X., Tian, X., Liu, C., Li, G., Kong, L., & Li, P. (2016) nvestigated the link between Chinese female nurses' resilience, burnout, and psychological discomfort. used self-reporting surveys. Results showed that 85.5% of nurses reported feeling depressed.Burnout was strongly correlated with psychological distress, however there is no association between resilience and burnout and psychological distress.

While taking into account their socio-demographic characteristics, a study by Stefanovska-Petkovska, M., Stefanovska, V. V., Bojadjieva, S., &Bojadjiev, M. I. (2021) sought to determine the degree and the relationship between psychological distress, burnout, job satisfaction, and intention to quit among primary healthcare nurses in public and private practices. There were 173 primary health care nurses in the study. Nursing staff burnout and psychological distress were evaluated using the Oldenburg Burnout Inventory and the General Health Questionairre-12. Results showed that the intention to stop was substantially correlated with high psychological distress, which was present in 21.38% of all respondents. The findings showed that the private sector had higher job satisfaction than the public sector, with a mean score of 3.54.

The goal of Segers' paper from 2020 is to compile and evaluate the research that has already been done on the resilience, burnout, and stress-related psychiatric problems that occurred among healthcare professionals during the COVID-19 crisis. Researchers conducted analyses and made projections regarding how hospital administrators ensure that their facilities survive the COVID-19 crisis, the worries of healthcare professionals during COVID-19, their opinions on the severity of the COVID-19 health risks, and their worries about being hospitalized.

The aim of Veronese, G., & Pepe, A. (2022) study is to model the cumulative network of associations between trauma-related symptoms, professional burnout, and psychological distress in health care workers in emergency settings.it was conducted with Palestinian health care workers in Gaza and the West Bank. Results showed that trauma-related symptoms wielded a direct effect on professional burnout and psychological distress .

1.6 Problem statement

Health care providers are more vulnerable to psychological and social distress than the generalpublic, as they are subjected to high psychological pressures in terms of increasing the volume of 34 work to a reasonable limit during non-working hours while lacking material support, resulting in psychological distress and burnout. To the feeling of boredom, frustration, fatigue, and exhaustion, even emotional exhaustion, due to his frequent absence and passivity in dealing with those around him.

This is due to the critical role played by health-care providers, and the study was designed to

track the sources of their psychological distress, determine their symptoms, and determine thepercentage of burnout and its relationship to resilience(Bacho,2017).

1.7 Questions of study

The following questions will be especially addressed by this study:

1. What is the level of (psychological distress, resilience, and burnout) among health care workers in occupied Palestine?
2. What is the relationship between (psychological distress, resilience, and burnout)among health care workers in occupied Palestine?
3. Is there a relationship between psychological destress andburnout of health care providers in occupied Palestine?
4. Is there a relationship between resilience and burnout forhealth care providers in occupied Palestine?

TheHypothesis according to the demographic variables

1. There are no statistically significant differences in the levelof psychological distress, burnout and resilience for health care providers inoccupied Palestine due to the gender variable.
2. There are no statistically significantdifferences in the level of psychological distress, burnout and resilience of healthcare providers in occupied Palestine due to the age variable.
3. There are no statistically significantdifferences in the level of psychological distress, burnout and resilience of healthcare providers in occupied Palestine due to the variable monthly income.

4. There are no statistically significantdifferences in the level of psychological distress, burnout and hardness of healthcare providers in occupied Palestine due to the variable years of experience.
5. There are no statistically significantdifferences in the level of psychological distress, burnout, and resilience of healthcare providers in occupied Palestine due to the variable of the field of work.

1.8 Significance of the study

This study concentrates on selecting a sample from the category of healthcare providers, asthey are subjected to a different level of stress than the general public. Furthermore, it focused ondetermining the nature of the relationship between the sources of psychological distress and bothvariables: burnout and resilience, a topic that researchers in occupied Palestine have not beenexposed to (to the best of the researcher knowledge). The most important aspect of this researchis that the results can be used to plan and develop programs to strengthen the resilience of healthworkers.

1.9 The aims of the study

1. Understanding the relationship between psychological distress, burnout, and resilience in a sample of occupied Palestinian healthcare providers.

2.Determining the level of psychological distress, burnout, and resilience among a sample of Palestinian healthcare providers.

3.Determining whether there are differences in the levels of psychological distress, burnout, andresilience based on gender,age, years of experience,employment.

1.10 The study limitations

The following are the research primary limitations:

1- Sample of this study: Only health-care providers in occupied Palestine in 1948 will be chosen.

2- Resilience Scale, Maslach Burnout Inventory TM (MBI), and psychological distress scale.

3- Research period: This study took place during the first semester of the academic year 2020- 2023.

1.11 Definitions of key terms

Psychological Distress

Any variety of internal-life-related signs and experiences, including feelings of unease, confusion, or unusualness persons going through difficult times are more likely to experience it, as are persons who lack energy or attention It can also be a symptom of mental diseases, although it's important to remember that not everyone experiencing psychological distress is suffering from a mental illness (Darby, 2021).

Resilience

Resilience It's a way of adapting well in the face of adversity, trauma, tragedy, and threats,such as family and relationship issues, looming health issues, or workplace and financialstressors. It refers to "bouncing; from adversity. (American Psychological Association,2010).A general belief in an individual's ability to realize, explain, and effectively face stressful life events, as well as his ability to develop specific strategies in situations where he is exposed to psychological pressures that help him solve the problems caused by these pressures(Bayraktar,2011)

Burnout

It is characterized by a grim feeling of a depletion of physical and psychological energy, withoutthe presence of any source of renewal, it is also an individual experience of psychologicaldistress that occurs in the context of public relations, exhaustion includes the individual negativeperception of himself and others in the job (Maslach & Leiter, 2007).

Healthcare provider

A health care provider is someone who examines people for health issuesHCPs can assistwith overall health management (Types of health care providers. 15 April 2021).

Physicians and doctors, nurses, pharmacists, administrative staff who handle appointments, Pharmacists, Technologists, and technicians who analyze patient samples, such as blood, are divided into six groups by the National Institute of Health Policy. Therapists, too (Johanna, Jens, Joe, Sebastian, Krummenacher, Werner, and Heike Gerger 2017).

Chapter Two

Methodology

2.1 Introduction

In addition to describing the study variables and the statistical techniques used in data analysis, this chapter also includes a description of the method and procedures used by the researcher to choose the study population and its sample, the study tool (the questionnaire), and the steps to verify the validity and reliability of the questionnaires.

2.2 Study design

In this study, the descriptive and correlational method was used, which is the method that is based on describing a specific phenomenon and collecting information about it (Amsha, 2015), and the researcher used the descriptive approach as a study method, in order to fit the nature of the study.

2.3 Study population

The study population included participants of HCPs both male and female who were Arabic speakers living in occupied Palestine (1948) and working in hospitals, emergency departments and primary healthcare centers during the period 2020-2023.

2.4 Study sampling

The study choose an accessible sample representing a number of health care providers in the occupied Palestine, Online software (Google forms) was used to design an electronic web-based questionnaire.the study sample consisted of (153) health care providers, according to the Thompson equation, which is as follows:

$$n = \frac{N \times p(1-p)}{[[N - 1 \times (d^2 \div z^2)] + p(1-p)]}$$

whereas

N sample size

Z Standard score of significance level (1.96) = (1.96)

D error ratio equal to .05

The characteristic availability and neutrality ratio is equal to (.5)

Where the forms were distributed to them electronically, and after collecting the form, about 153 forms were retrieved, and 7 forms invalid for statistical analysis were excluded, i.e. 85% of health care providers inside the Palestinian territories Table 1 shows the distribution of the study sample according to the independent variables (gender, age, monthly income, years of experience, field of work).

Table 1

The distribution of the study sample according to independent variables (n= 156)

Independent variables	Levels of variable	frequency	Percentage %
	Male	67	%43.8
Sex	Female	86	%56.2
	Less than 25	26	17.0%
Age	26-35	59	38.6%
	36-45	33	21.6%
	46-55	25	16.3%
	More than 50	10	6.5%
Monthly income	Less than 3000	4	2.6%
	3100-5000	6	3.9%
	5001-7000	14	9.2%
	7001-9000	37	24.2%
	More than 9000	92	60.1%
Years of Experience	Less than 5 years	53	34.6%
	5-10	31	20.3%
	11-15	30	19.6%
	16-20	20	13.1%
	More than 20 years	19	12.4%
Field of work	Nursing	81	22.9%
	Administrative	45	4.6%
	General Medicine	35	13.1%
	Radiography	7	11.1%
	Specialist doctor	20	9.8%
	Medical analysis	17	10.5%
	Other	15	28.1%

It is clear from the previous table that 34.8% were males, 56.2% were females, and 17% were under 25 years old, and 38.6% were between 26 and -35 years, while 21.6% were aged 36-45, 16.3% were 46-55 years old, and 6.5% were over 50 years old.

As for the monthly income, as can be seen from the same table, 2.6% of the sample had a monthly income of 3000 shekels or less, 3.9% was 3100-5000, and 9.2% had a monthly income of 50001-7000, and 24.2 % of them had a monthly income of 7001-

9000 shekels, and 60.1% had more than 9000, which is the largest percentage among the study sample.

As for the years of experience, as shown in the previous table, 34.6% had less than 5 years of experience, 20.3% had 5-10 years of experience, and 19.6% had 11-15 years of experience years, 13.1% were 16-20 years old, and 12.4% were more than 20 years old.

It was also found that 22.9% were nursing, 4.6% were administrative, 13.1% were general medicine, 11.1% were radiology, 9.8% were specialized doctors, 10.5% were medical tests, and others were 28.1%.

2.5 Study instruments

1) Resilience scale, by Thabit Abd Al-Alziz, (2017)

The resilience scale has ten items in its original form, and it uses a five-point Likert system for correction). It is worth noting that all of the scale items are positive, and the total score is calculated as follows: strongly opposed= 1, opposed= 2, not sure= 3, agree= 4, strongly agree= 5.

2) The Maslach burnout inventory

The 16-item Maslach Burnout Inventory-General Scale, which gauges emotional weariness, depersonalization, and poor personal accomplishment, will be used to determine each person's level of burnout. Each item was rated by participants using a 7-point Likert scale. ranging from 0 (never) to 6 (always) translated and adapted to Arabic by (AlAtaf ,Anam, Rajesh, and Amber , 2019).

3) Psychological distress scale by: Wafaa Al-Da'mas, (2018)

The 40-item scale identifies the sources of psychological destress among health-care professionals. It's worth noting that this scale's entire contents are positive. The answers were never = 1, rarely = 2, occasionally = 3, frequently = 4, always = 5, translated and adapted by (Wafa Al-Dams, 2018).

2.6 Validity

The Tables 2,3,4 shows the existence of an internal correlation and consistency between the item of the questionnaire through the study, the Pearson correlation, and this was an indication of the existence of internal consistency between the paragraphs of the fields of

study with their total degrees, as all correlation coefficients are high and statistically significant at the level (0.01).

Table 2

The validity of internal consistency for the psychological distress scale

N	Items	R
1	Talking to Companions of Frustrated Patients (Family Members, Friends)	0.366
2	Poor organization of work when there are a lot of patients.	0.474
3	My personal life and family are impacted by my work hours.	0.392
4	Fear of inappropriate decisions and reactions to them.	0.547
5	Demanding patients.	0.462
6	Dealing with patient cases.	0.355
7	Lack of time to do the whole task.	0.377
8	The shift system affects my family and my personal life.	0.452
9	problems in relationships with colleagues.	0.576
10	Inappropriate demands of patients.	0.639
11	Being subjected to violence or threats.	0.336
12	how job has affected my personal life.	0.516
13	Lack of sleep.	0.017
14	Coordination of decisions within the team.	0.504
15	Disagreements with patients are troublemakers.	0.606
16	The patient dealt with his disease, which was diagnosed as advanced.	0.449
17	Shortage of necessary equipment and materials.	0.309
18	Lack of time to do research.	0.417
19	The conflict between nurses and technicians.	0.653
20	Dealing with high and unrealistic patient expectations.	0.537
21	I Expect a call from patients for help.	0.385
22	The patient refused the proposed treatment methods.	0.559
23	Divide time between work and private matters.	0.272
24	The struggle between the new and the old doctors.	0.433
25	Fear of infection from an infectious disease.	0.210
26	The need for continuous learning.	0.210
27	Lack of support from colleagues.	0.542
28	High and unrealistic expectations from colleagues.	0.611
29	Inability to provide appropriate treatment.	0.486
30	Performing administrative tasks.	0.289
31	Professional isolation.	0.402
32	Lack of relevant data to make appropriate decisions about diagnosis and treatment.	0.375
33	Lots of responsibility.	0.234
34	Negative advertising in the media.	0.498
35	Feeling of ineffectiveness at work.	0.521
36	Dealing with emergency accidents in inappropriate places and conditions.	0.441
37	Dealing with a rare and unknown disease.	0.446
38	Anticipate urgent and unexpected situations.	0.383
39	Bad working conditions.	0.364
40	Specific recommendations from the Ministry of Health.	0.427

*Accordance with the previous table, paragraphs with low validity were omitted.

Table 3

The validity of internal consistency for the resilience scale

N	Items	R
1	I have the ability to adapt to changes in life	0.549
2	I have the ability to handle anything that happens to me.	0.721
3	I see the funny side of bad things.	0.727
4	Coping with different pressures makes me stronger.	0.764
5	I benefit from my illness and the misfortunes that befall me.	0.733
6	I achieve the goals I set.	0.673
7	I Focus and think clearly under various distress	0.683
8	I don't get frustrated when I fail	0. 802
9	I think of myself as a strong person.	0.709
10	I can deal with my bad and painful feelings.	0.582

Table 4

The validity of internal consistency for the burnout scale

N	Items	R
1	My work has emotionally depleted me.	0.610
2	At the end of the workday, I'm worn out.	0.713
3	When I wake up in the morning to begin another workday, I am exhausted.	0.747
4	I feel like dealing with people all day stresses me out.	0.639
5	I deal very efficiently with work and colleagues problems.	0.326
6	Because of my job, I feel internally burned out.	0.581
7	My internal burnout is a result of my employment.	0.263
8	I have become less interested in my job since I started this job.	0.436
9	I feel less enthusiastic about my work.	0.520
10	In my opinion, I'm good at my job.	0.239
11	I feel joy when I get something done at work.	0.280
12	Many worthwhile things have been accomplished in this job.	0.300
13	I just want to do my job and it annoys me otherwise	0.660
14	I'm becoming more and more pessimistic about whether my work contributes to anything.	0.530
15	I doubt the importance of my work.	0.485
16	In my work, I feel confident that I am effective at getting things done.	0.247

*Accordance with the previous table, paragraphs with low validity were omitted.

2.7 Reliability

In order to verify the stability of the internal consistency of the scale, the coefficient of (Cronbach's alpha) was used, where the reliability coefficient of the resolution reached (84.8), which is a very good stability coefficient for conducting this study and adopting this tool as an appropriate tool for this study, and Table (5) shows the reliability coefficients for the fields of study.

Table 5

The reliability of study instruments

N.	Variables	No. of items	Cronbach's alpha
1	psychological stress scale	40	89.2
2	Resilience scale	10	88.1
3	Burnout scale	12	76.9

2.8 Data Collection

Using google forms, questionnaires were collected from health care workers in Occupied Palestine.

2.9 Data analysis

To answer the study's questions and examine its hypotheses, the researcher used the Statistical Packages for Social Sciences (SPSS) program by using the following:

- Means, and standard deviations to answer the first question.
- Validate the study instruments using the "Pearson" correlation coefficients.
- Reliability of study instruments using Cronbach's alpha equation.
- One- Way ANOVA analysis to determine the differences in psychological distress, resilience, and burnout according to all independent variables.
- Scheffe post- hoc test was used the post comparisons between means.

2.10 Ethical Considerations

Ethical approval was obtained from Al-Najah National University institutional review board, Participants confidentiality and privacy was kept safely, as the study questionnaires did not demand any personal information from the participants.

2.11 Study Variables

First: independent variables: psychological distress, resilience.

Second: Dependent variables: The study includes a dependent variable represented in the burnout scale

Third: demographic variables

The study included Demographic variables:

Gender: Male, Female.

Age:

* Monthly income

* Years of Experience

*Employment

Chapter Three

Study Results

The purpose of this study was to shed insight on the causes of psychological stress and its associations with resilience and burnout in a sample of occupied Palestinian healthcare workers.

3.1 Results of first question

What is the level of (psychological distress, resilience, and burnout) among health care workers in occupied Palestine?

To answer to this question, means and standard deviations were calculated for the total score of each scale as presented in table (6).

Table 6

Means, standard deviations and the level of (Psychological distress, Resilience, Burnout) among health care workers in occupied Palestine

N	Variables	Mean	SD	Level
1	Psychological distress	3.41	0.43	High
2	Resilience	4.10	0.61	Very High
3	Burnout	3.17	0.71	Medium

The results shown in table (6) were as the following:

the level of psychological distress among health care workers in occupied Palestine was high, as the mean of response for the total score was (3.41).

The level of resilience among health care workers in occupied Palestine was very high, as the mean of response for the total score was (4.10).

The level of burnout among health care workers in occupied Palestine was high, as the mean of response for the total score was (3.17).

3.2 Results of the second question

What is the relationship between (psychological distress, resilience, and burnout) among health care workers in occupied Palestine?

To answer to this question, Pearson correlation coefficient was used as shown in table (7).

Correlation among the study variables:

Table 7

The relationship between Resilience, psychological distress, and burnout among health care workers in occupied Palestine(n=153)

Scales	Distress	Resilience	Burnout
Psychological Distress		0.322	0.232
Resilience			0.849

The first hypothesis: Is there a relationship between psychological destress and burnout of health care providers in occupied Palestine؟

Table 8

Simple Linear Regression Between the variable (psychological stress) and (burnout)

Variable	(β)	Std. Error	t Value	Sig	R	R Square	Adjusted R Square
constant variable	2.417	0.287	8.413	0.000	0.3680	0.1360	0.1310
Psychological distress	0.402	0.072	5.571	0.000			

* Statistically significant at the significance level (0.05)

It was found from Table No. (8), that the value of the significance level is 0.000, which is statistically significant at the significance level (α=0.05), and the value of the coefficient of determination is (13.6%), which confirms that the explanatory power of the simple linear regression model is good, and therefore it can be said that the psychological distress has a 13.6% effect on burnout, and therefore the previous hypothesis is accepted.

The second hypothesis, which states: Is there a relationship between resilience and burnout for health care providers in occupied Palestine?

In order to check the validity of the hypothesis, a simple linear regression model was used, and the results of the regression model were as shown in Table No. (9).

Table 9

Simple Linear Regression Between the variable (resilience) and (burnout)

Variables	(β)	Std. Error	t Value	Sig	R	R Square	Adjusted R Square
constant variable	2.092	0.248	8.447	0.000	0.4850	0.2350	0.2310
Resilience	0.470	0.060	7.800	0.000			

* Statistically significant at the significance level (0.05)

It was found from Table No. (9) that the value of the significance level is 0.000, which is statistically significant at the significance level (α = 0.05), and that the value of the coefficient of determination is (23.5%), which confirms that the explanatory power of the simple linear regression model is strong, and therefore it can be said that the burnout affects 23.5% of the resilience, and therefore the previous hypothesis is accepted.

3.3 Results of hypothesis according to the demographic variables

The first hypothesis: (there are no statistically significant differences in the level of psychological distress, burnout and resilience for health care providers in occupied Palestine due to the gender variable).

The following table presents the results of this test, which involved comparing the two arithmetic means for two independent samples in order to extract the arithmetic means, standard deviations, the calculated t-value, degrees of freedom, and the value of statistical significance.

Table 10

Results of the independent sample t-test for the comparison between two arithmetic means for two independent samples, according to the gender variable

Variables	gender	No.	Mean	S.D	D.F	t	Sig*
psychological distress scale	Male	67	3.3507	39891.	151	-1.617-	0.108
	Female	86	3.4660	46482.			
resilience scale	Male	67	4.1134	62593.	151	236.	0.814
	Female	86	4.0895	61759.			
Burnout scale	Male	67	3.0970	70428.	151	-1.211-	0.228
	Female	86	3.2376	71863.			
Total field	Male	67	3.5204	35311.	151	-1.360-	0.167
	Female	86	3.5977	34540.			

* Statistically significant at the level (0.05).

It is clear from the previous table that there are no statistically significant differences at the significance level (0.05 = α) in the level of psychological distress, burnout and resilience for health care providers in occupied Palestine due to the gender variable due to the gender variable on all fields of study and on the aggregate, where the significance level of the field reached Total (0.167), which is a value higherthan the imposed value, and therefore the null hypothesis related to the gender variable is accepted.

The second hypothesis: which states: (There are no statistically significant differences in the level of psychological distress, burnout and resilience of health care providers in occupied Palestine due to the age variable)

A one-way ANOVA test was run to extract the values of the arithmetic means, standard deviations, degrees of freedom, calculated (F) values, and values of the level of statistical significance of the responses of the study sample to the study areas and to the overall tool of the study in order to confirm the validity of the previous null hypothesis. The results of this test are shown in the following tables.As seen in table 11 in appendix E

It is clear from the previous table that there are statistically significant differences in the level of psychological distress, burnout and resilience for health care providers in occupied Palestine due to the age variable on most fields of study and on the total field of study where the significance level for the total field reached (0.000), which is a value lower than the imposed value Therefore, the hypothesis related to the age variable is rejected.

The third hypothesis: which states: (There are no statistically significant differences in the level of psychological distress, burnout and resilience of health care providers in occupied Palestine due to the variable monthly income)

In order to extract the values of the arithmetic means, standard deviations, degrees of freedom, calculated (F) values, and values of the level of statistical significance of the responses of the study sample to the study areas and to the overall tool of the study, a one-way ANOVA test was conducted. The results are shown in the following tables.As seen in table 12 in appendix E

It is clear from the previous table that there are statistically significant differences in the level of psychological distress, burnout and resilience for health care providers in occupied Palestine due to the variable monthly income in most fields of study and on the total field of study where the significance level for the total field reached (0.001) which is a value lower than the value imposed, and therefore rejects the hypothesis related to the variable monthly income.

The fourth hypothesis: which states: (There are no statistically significant differences in the level of psychological distress, burnout and hardness of health care providers in occupied Palestine due to the variable years of experience)

In order to verify the validity of the previous null hypothesis, a one-way ANOVA test was conducted to extract the values of the arithmetic means, standard deviations, degrees of freedom, calculated (F) values, and values of the level of statistical significance of the study sample's responses to the study areas and to the study's overall tool. The following tables display the test's findings.As seen in table 13 in appendix E

level of psychological distress, burnout and resilience of health care providers in occupied Palestine due to the variable years of experience in most fields of study and on the total field of study where the level of significance for the total field reached (0.000),

which is a value lower than the value imposed, and therefore rejects the hypothesis related to the variable years of experience.

The fifth hypothesis: which states: (There are no statistically significant differences in the level of psychological distress, burnout, and resilience of health care providers in occupied Palestine due to the variable of the field of work)

A one-way ANOVA test was run to extract the values of the arithmetic means, standard deviations, degrees of freedom, calculated (F) values, and values of the level of statistical significance of the responses of the study sample to the study areas and to the overall tool of the study in order to confirm the validity of the previous null hypothesis. The results of this test are shown in the following tables. As seen in table 14 in appendix E.

It is clear from the previous table that there are statistically significant differences in the level of psychological distress, burnout and resilience of health care providers in occupied Palestine due to the variable of the field of work on most fields of study and on the total field of study where the level of significance for the total field reached (0.043), which is a value lower than the value imposed, and therefore rejects the hypothesis related to the variable field of work .

Chapter Four

Discussions and Conclusions

This chapter should include the discussion of questions and hypotheses ofthe study. At the end of this section, limitations, conclusions and recommendations need to be added.

4.1 Discussions

This descriptive and correlational study aimed to Investigate the level of (psychological distress, resilience, burnout) among health care workers in occupied Palestine, to determine the relationship between psychological distress, resilience and burnout among health care workers, and to determine the deference's psychological distress, resilience, burnout among health care workers in occupied Palestine according to the variables of (Gender, age, monthly income, years of experience, and employment).

The results related to the psychological distress scale indicated that the arithmetic average of the total domain reached (3.41), with an average psychological distress response degree. From the researcher's point of view, there are a number of sources of psychological distress that health service providers may be exposed to, such as stressors related to the physical work environment: such as stressors resulting from certain factors such as noise, heat, air pollution and others, or individual human stressors: such as stressors resulting from role conflict and ambiguity, excessive workload and the nature of work. The profession, and these psychological stressors are all related to the profession, as well as social stressors: represented in the weakness of the social relationship with colleagues at work, subordinates and the manager, in addition to stressors related to personal characteristics represented in: mental, emotional and physical qualities (personal style, control center, capabilities and needs of the individual) as well as demographic characteristics and characteristics that affect the individual interaction with psychological distress factors.

By reviewing the previous studies of the research, it was found that this result is consistent with the study of Firth and Br Med J (1986) it was found that the sources of psychological stress generally focus on dealing with mental patients and their influence. On the lives of students, the heavy consumption of alcohol, the impact of dealing with the cases they face in the hospital, in addition to the deaths. These results did not differ with any of the previous studies.

From the researcher's point of view, there are a number of pressures that health service providers may be exposed to, such as psychological ditress that are related to individual human pressures: such as pressures resulting from role conflict, marital status and its ambiguity, and excessive workload in terms of the number of hours and the nature of the profession. Social: It is represented in the weakness of the social relationship with colleagues at work, subordinates, and the manager, in addition to the pressures related to the personal characteristics represented in: mental, emotional and physical characteristics (personality style, the center of control, the capabilities and needs of the individual), as well as the demographic characteristics and characteristics that affect the interaction of the individual with the factors of psychological stress, In addition to the racist factors, the Arabs are present within mixed institutions in terms of race.

The level of resilience among health care workers in occupied Palestine was very high, as the mean of response for the total score was (4.10).

From the researcher's point of view, the importance of resilience lies in the fact that it works to resist the psychological distress and adversities that the individual is exposed to in his daily life, as it stands as an impenetrable dam to protect these psychological distress and situations that he faces in various aspects of life to transform them into useful situations and experiences and make him an individual capable of facing challenges and difficulties. and more ability and control to avoid its negative effects. Resilience is also useful for resisting stress and psychological exhaustion, as it modifies the individual's perception of events and makes them less effective, thus gaining the individual a degree of flexibility, so resilience increases the individual's abilities to face various pressures, as well as prevention of burnout.

These findings are consistent with the Dyrbye, Thomas, Power & Massie (2008) study that resilient students were less likely to develop depression, had higher quality of life, experienced fewer stressful life events, reported higher levels of social support, and perceived a special learning climate. students more positively.

The results related to the Burnout Scale indicated that the arithmetic average for this axis reached. (3.17), with a response degree a few times a month

The researcher believes that in many cases, a job with intense work or professions that require time and effort beyond a person's energy cause burnout, and the situation is also exposed to people who feel that they are doing work that is beyond their capacity and is

given an unfair appreciation for what they do, whether they are employees or managers who have not been able to do so. They have the opportunity to take a vacation or get upgrades after a long time. Even mothers, the housewife in charge of taking care of three children, in addition to her household chores and responsibility for her aging father, are also vulnerable to burnout. Work-related burnout can be caused by a sense of loss of control over work, lack of recognition or rewards for a job well done, unclear or exaggerated job expectations, monotony and routine, as well as working in a chaotic or high-pressure environment. As for the lifestyle that may cause combustion, it may be continuous work without providing times for relaxation and social life, taking on a lot of responsibilities without adequate help from others, not getting enough sleep, in addition to not having close supportive relationships at work. or family.

These results are in agreement with the study of Guiyuan, Xiuying, Xiaohong, Chunqin, Guopeng, Linghua and Ping (2015).

The results indicated a positive relationship between the dimensions of psychological distress and burnout. As for psychological inertia, it was negatively related to the dimensions of emotional exhaustion, depersonalization, and psychological disturbance. Signs did not differ with age. The cross-correlation between combustion dimensions was positively correlated. But emotional exhaustion was not related to personal achievement. However, there is a positive relationship between depersonalization and psychological distress and emotional exhaustion and stress was not related to resilience, Resilience mediates the association between burnout and psychological distress.

This result is consistent with a study on Guiyuan, Xiuying, Xiaohong, Chunqin, Guopeng, Linghua, and Ping (2015) results that indicated a positive relationship between the dimensions of psychological distress and burnout. As for psychological inertia, it was negatively related to the dimensions of emotional exhaustion, depersonalization and psychological disturbance. Signs did not differ with age. The cross-correlation between combustion dimensions was positively correlated. But burnout was not related to personal achievement. However, there is a positive relationship between depersonalization and psychological distress and burnout Stress was not related to resilience. Resilience mediates the association between burnout and psychological distress.

It was found that there is a relationship between resilience and psychological burnout of health care providers in occupied Palestine. This result did not agree with any of the previous studies.

This result agrees with the study of Thomas, Power & Massie (2008) and the results showed that there were no differences between the resilient and non-resilient students with regard to the subject of gender, and the study of AI Lala, Sturzu, Grama and Bobirnac (2016) and the results showed that there are no statistically significant differences between sex.

That there are statistically significant differences in the level of psychological distress, burnout and resilience for health care providers in occupied Palestine due to the age variable

The older age group, the higher the level of resilience, the same applies to burnout. As for psychological distress, there were no differences. Where the significance level for the total field reached (0.000), which is a value lower than the imposed value the differences here were in favor of the older age group, this finding is consistent with the study of (Sull, A., Harland, N. & Moore, 2018) A. which showed that older employees have a higher level of resilience.

There are statistically significant differences in the level of psychological distress, burnout and resilience of health care providers in occupied Palestine due to the monthly income variable on most fields of study and on the total field of study where the significance level for the total field reached (0.001), which is a value lower than the imposed value. This result did not agree with any of the previous studies.The researcher believes that those whose incomes are low have resilience and burnout is higher than Others whose monthly income was significantly high, and the reason for this could be the obligations incurred by these employees with insufficient monthly income for them. This result did not agree with any of the previous studies.

It was found that there are statistically significant differences in the level of psychological distress, burnout, and resilience of health care providers in occupied Palestine due to the variable years of experience in most fields of study and on the total field of study, where the significance level for the total field reached (0.000), which is a value lower than the imposed value, this result did not agree with any of the previous studies.

The researcher believes that the more years of experience at work, the less the psychological hardness of the two scholars, and thus the psychological burnout for them increases. The researcher believes that the reason for this is the employees dealing on a daily basis with large numbers of auditors, which causes psychological pressure over the years at work and thus increases their psychological burnout in the job.

4.2 Recommendations

Based on the previous results, the researcher had to include some recommendations that would contribute to the development of the performance of medical service providers. These recommendations were as follows:

- Attempting to understand the professional stressors experienced by medical service providers and help them overcome them in order to perform their job as required.
- Increasing the hours of counseling by specialists with the aim of psychological discharge for health care providers
- Encouraging healthcare providers andAppreciate their work.
- Work to reduce the shift system for health service providers, as it had an impact on increasing their psychological distress.
- Increasing the hours of their break time.

Suggestion

Conducting a study entitled:

- Conducting a study to find out the relationship between burnout and job satisfaction for medical service providers
- Conducting a study entitled: Perception of psychological distress and its relationship to some personality traits and some demographic variables among a sample of medical service providers in the occupied Palestine.
- Conducting a study entitled: burnout and its sources among a sample of medical service providers.

List of Abbreviations

Abbreviation	Meaning
APA	American psychological association
WHO	World health organization
HCWs	Health care workers

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Appendix

Appendix A

Questioners

		Always	often	sometimes	rearly	Never
1	Talking to companions of frustrated patients (family members, friends)					
2	Poor organization of work.					
3	Effect of hours of work in my family and personal life.					
4	Fear of reactions of them					
5	Patients are demanding					
6	Dealing with patient cases					
7	Lack of time to do the whole task.					
8	personal shift system.					
9	problems in relationships with colleagues					
10	unacceptable demands for patients.					
11	Experience a violence or threats					
12	Impact of work on my personal life					
13	Lack of sleep.					
14	Coordination within the team.					
15	Disagreements with troublemakers.					
16	Dealing the patient with his disease, which was diagnosed as advanced.					
17	Shortage of nuclear materials					
18	Lack of time for research.					
19	The conflict between nurses and technicians.					
20	Dealing with high and unrealistic customer expectations.					
21	Expect a call from patients for help					
22	The patient refused treatment methods					
23	Divide time between work and private matters					
24	Conflict between new doctors					
25	Fear of contagion from an infectious disease.					
26	The need for continuous learning					

27	Lack of support from colleagues.					
28	Realistic high expectations of colleagues.					
29	Inability to provide appropriate treatment.					
30	Performing administrative tasks.					
31	professional isolation.					
32	Lack of research data, information about the research					
33	Too much responsibility.					
34	Positive media advertising.					
35	Sensation and weakness of effectiveness at work.					
36	Dealing with emergency accidents in unsuitable circumstances.					
37	Dealing with a rare and unknown disease.					
38	Anticipate urgent and unexpected situations.					
39	Poor working conditions.					
40	recommendations from the Ministry of Health					

الفقرة		دائما	غالبا	احيانا	نادرا	ابدا
1	التحدث الى مرافقي المرضى المحبطين (افراد الأسرة، الأصدقاء)					
2	سوء تنظيم العمل عندما يكون هنالك الكثير من المرضى في الانتظار.					
3	ساعات العمل تؤثر في عائلتي وحياتي الشخصية.					
4	الخوف من القرارات غير المناسبة وردود الفعل عليها.					
5	المرضى كثيرو المطالب.					
6	التعامل مع حالات المريض.					
7	قلة الوقت لأداء المهمة بأكلمها.					
8	نظام المناوبات يؤثر في عائلتي وحياتي الشخصية.					
9	مشاكل في العلاقات مع الزملاء.					
10	المطالب غير الملائمة للمرضى.					
11	التعرض للتعنيف او التهديد.					

12	تأثير العمل في حياتي الشخصية.					
13	قلة النوم.					
14	تنسيق القرارات داخل الفريق.					
15	الخلافات مع المرضى مثيري المشاكل.					
16	تعامل المريض مع مرضه الذي تم تشخيصه بانه متقدم.					
17	نقص في الأجهزة و المواد الضرورية.					
18	قلة الوقت للقيام بالأبحاث.					
19	الصراع بين الممرضين و التقنيين.					
20	التعامل مع توقعات المرضى العالية والغير واقعية.					
21	توقع اتصال من المرضى لطلب المساعدة					
22	رفض المريض للطرق العلاجية المقترحة.					
23	تقسيم الوقت بين العمل و الأمور الخاصة.					
24	الصراع بين الأطباء الجدد و القديمين.					
25	الخوف من العدوى من مرض معد.					
26	الحاجة الى التعلم المستمر.					
27	غياب الدعم من الزملاء.					
28	التوقعات العالية وغير الواقعية من الزملاء.					
29	عدم القدرة على توفيرالعلاج المناسب.					
30	اداء المهمات الادارية.					
31	العزلة المهنية.					
32	عدم وجود بيانات ذات صلة لاتخاذ القرارات المناسبة حول التشخيص و العلاج.					
33	قدر كبير من المسؤولية.					
34	الدعاية السلبية في وسائل الاعلام.					
35	الاحساس بضعف الفاعلية في العمل.					
36	التعامل مع الحوادث الطارئة في اماكن و ظروف غير مناسبة.					
37	التعامل مع مرض نادر و غير معروف.					
38	توقع حالات عاجلة وغير متوقعة.					
39	.ظروف العمل السيئة.					
40	توصيات محددة من وزارة الصحة.					

Appendix B

Resilience Scale

		Strongly Agree	agree	Not sure	Dissent	Strongly Dissent
1	I have the ability to adapt to changes in life					
2	I have the ability to deal with anything that happens to me.					
3	I see the funny side of bad things.					
4	Adapting to different pressures makes me stronger.					
5	I benefit from my illness and the calamities that befall me.					
6	I achieve the goals I set.					
7	- Focus and think clearly under different pressures.					
8	I don't get discouraged when I fail.					
9	I think of myself as a strong person.					
10	I can deal with my bad and painful feelings.					

مقياس الصلابة النفسية

الفقرة		موافق بشدة	موافق	غير متأكد	معارض	معارض بشدة
1	لدي القدرة للتكيف مع التغيرات في الحياة					
2	لدي القدرة على التعامل مع أي شيء يحدث لي .					
3	ارى الجانب المضحك من الاشياء السيئة.					
4	التأقلم مع الضغوط المختلفة يقويني					

	الفقرة	موافق بشدة	موافق	غير متأكد	معارض	معارض بشدة
	اكثر.					
5	استفيد من مرضي والمصائب التي تحل بي.					
6	احقق الأهداف التي اضعها.					
7	اركز و افكر بوضوح تحت الضغوط المختلفة.					
8	لا احبط عندما افشل.					
9	افكر في نفسي كشخص قوي.					
10	أستطيع أن أتعامل مع أحاسيسي السيئة و المؤلمة.					

Appendix C

Burnout scale

		Every day	A few times a week	Once a week	A few times a month	A few times a year	Once a year	Not once
1	I feel emotionally drained due to my work							
2	I feel exhausted at the end of the day at work.							
3	I feel tired when I wake up in the morning to face another work day.							
4	I feel that dealing with people all day causes me stress.							
5	I deal with high efficiency with work and colleagues problems.							
6	I feel internally burned because of my work.							
7	I feel through my work that I contribute positively to the lives of others.							
8	I have become less interested in my job since I started this job.							
9	I feel less enthusiastic about my work.							
10	In my opinion, I am good at my job.							
11	I feel joy when I accomplish something at work							
12	You have accomplished many noteworthy things in this job.							
13	I just want to do my job and it annoys me otherwise.							
14	I have become more pessimistic about whether my work contributes to anything.							
15	I doubt the importance of my work.							
16	In my work, I feel confident that I am effective at getting things done.							

Appendix D

مقياس الاحتراق النفسي / عربي

الفقرة		كل يوم	مرات قليلة بالأسبوع	مرة كل اسبوع	مرات قليلة بالشهر	مرات قليلة بالسنة	مرة بالسنة	ولا مرة
1-	أشعر بأنني استنزفت عاطفيا (انفعاليا) بسبب عملي							
2-	أشعر باستنفاذ كامل طاقتي في نهاية اليوم الذي أقضيه في عملي							
3-	أشعر بالإرهاق حينما أصحو في الصباح لمواجهة يوم عمل أخر.							
4-	أشعر أن التعامل مع الناس طوال اليوم يسبب لي التوتر.							
5-	أتعامل بكفاءة عالية مع مشاكل العمل والزملاء.							
6-	أشعر بأنني احترق داخليا بسبب عملي.							
7-	أشعر من خلال عملي انني اسهم ايجابيا في حياة الآخرين.							
8-	أصبحت أقل اهتمامًا بعملي منذ أن بدأت هذه الوظيفة.							
9-	أصبحت اشعر انني أقل حماسة تجاه عملي.							
10-	في رأيي ، أنا جيد في عملي.							
11-	أشعر بالبهجة عندما أنجز شيئًا في العمل.							
12-	قد أنجزت العديد من الأشياء الجديرة بالاهتمام في هذه الوظيفة.							

13-	أريد فقط أن أقوم بعملي ويزعجني عكس ذلك.							
14-	لقد أصبحت أكثر تشاؤمًا بشأن ما إذا كان عملي يساهم في أي شيء.							
15-	أشك في أهمية عملي.							
16-	في عملي، أشعر بالثقة في أنني فعال في إنجاز الأمور.							

Appendix E

Tables

Table 11

One-way ANOVA results by age variable

Domain	between groups			within groups			F. value	Indication level
	sum of squares	Mean squares	D.F	sum of squares	Mean squares	D.F		
Psychological distress scale	0.303	.076	4	29.064	1960.	148	3860.	0.818-
resilience scale	17.516	4.379	4	40.784	2760.	148	15.891	*0.000
burnout scale	7.990	1.998	4	69.388	4690.	148	4.261	*0.003
Total field	2.999	.750	4	15.597	1050.	148	7.114	*0.000

* Statistically significant at the level (0.05).

Table 12

Results of the One Way ANOVA test by monthly income variable

Domain	Between groups			within groups			F. Value	Indication level
	Sum square	Mean square	D.F	Sum square	Mean square	D.F		
Psychological distress scale	2.382	596.	4	26.985	1820.	148	3.266	*0.013
Resilience scale	6370.	159.	4	57.663	3900.	148	4090.	*0.802
Burnout scale	16.361	4.090	4	61.018	4120.	148	9.921	*0.00
Total field	2.135	534.	4	16.460	1110.	148	4.800	*0.001

* Statistically significant at the level (0.05).

Table 13

Results of the One Way ANOVA test by years of experience variable

Domain	Between groups			Within groups			F. Value	Indication level
	Sum square	Mean square	Degrees of freedom	Sum square	Mean square	D.F		
Psychological distress scale	5080.	0.127	4	28.860	1950.	148	6510.	.6270
Resilience scale	16.394	4.099	4	41.906	2830.	148	14.475	*000.
Burnout scale	8.656	2.164	4	68.723	4640.	148	4.660	.1000*
Total field	2.961	0.740	4	15.635	1060.	148	7.007	.0000*

Table 14

Results of the one-way ANOVA test by field of work variable

Domain	Between groups			Within groups			F.Value	Indication level
	Sum square	Mean square	Degrees of freedom	Sum square	Mean square	Degrees of freedom		
Psychological distress scale	1.044	1740.	6	28.323	1940.	146	897.	0.4990
Resilience Scale	4.819	8030.	6	53.481	3660.	146	2.193	.*0470
Burnout Scale	4.555	7590.	6	72.824	4990.	146	1.522	.1750
Total field	1.566	2610.	6	17.029	1170.	146	2.237	*043.

*Statistically significant at the level (0.05)

جـامعـــة النجاح الوطنية

كليـــة الدراســـات العليـــا

مصادر الضغوط النفسية وعلاقتها بالصلابة النفسية والاحتراق النفسي لدى مقدمي الرعاية الصحية في فلسطين

إعداد

فاتنة محاميد

إشراف

د. شادي ابو الكباش

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجه الماجستير في علم النفس الإكلينيكي، من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس– فلسطين.

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اعداد

فاتنة محاميد

إشراف

د .شادي خليل أبو الكباش

الملخص

هدفت هذه الدراسة إلى معرفة المستوى والعلاقة بين الضغوط النفسية، الصلابة النفسية والاحتراق النفسي بين العاملين في مجال الرعاية الصحية في فلسطين المحتلة. كما حاولت الدراسة اكتشاف آثار بعض المتغيرات الديموغرافية) الجنس، والعمر، والدخل الشهري، وسنوات الخبرة والتوظيف على الضغوط النفسية، الصلابة النفسية، والاحتراق النفسي، وأجريت الدراسة على عينة من 153 عاملاً في مجال الرعاية الصحية في المراكز الطبية والمستشفيات وأقسام الطوارئ في فلسطين المحتلة 34.8٪ من المستجيبين ذكور و56.2٪ إناث و17٪ من مقدمي الرعاية الصحية 25 سنة فأقل. تم استخدام مقياس الصلابة النفسية ومقياس الاحتراف النفسي Maslachومقياس الضغط النفسي في هذه الدراسة، وتم التأكد من صحتها وموثوقيتها.

أظهرت نتائج الدراسة أن مستوى الضغوط النفسية، والصلابة النفسية لدى العاملين في مجال الرعاية الصحية في فلسطين المحتلة كان مرتفعاً. وتبين ان الضغوط النفسية لها تأثير على الاحتراق النفسي بنسبة 13.6%، بالإضافة الى ان الصلابة النفسية تؤثر على الاحتراق النفسي بنسبة 23.5%، كما أشارت النتائج إلى عدم وجود فروق ذات دلالة إحصائية في الدرجة الكلية للضغوط النفسية والصلابة النفسية والاحتراق النفسي بين العاملين في مجال الرعاية الصحية حسب متغير الجنس، وكانت هناك فروق ذات دلالة إحصائية في مجموع درجات الصلابة النفسية والاحتراق النفسي بين العاملين في مجال

الرعاية الصحية حسب متغير العمر لصالح 50+ ، من كان بعمر +50 كان يعاني من احتراق نفسي وعدم صلابة نفسية. اما بالنسبة للضغوط النفسية لم تعزى أية فروق بالنسبة للعمر، وهناك فروق ذات دلالة في الدرجة الكلية الضغط النفسي والاحتراق النفسي حسب متغير الشهر الدخل بين أقل من (3000 و (5000-3000) لصالح أقل من (3000)، كما أظهرت النتائج وجود فروق ذات دلالة إحصائية للصلابة النفسية لدى العاملين في مجال الرعاية الصحية حسب متغير سنوات الخبرة لصالح أقل من0.5 ، توجد فروق ذات دلالة في مجموع درجات الصلابة النفسية لدى العاملين في مجال الرعاية الصحية تعزى إلى متغير التوظيف بين الطب العام، والفروق لصالح التخصصات الأخرى. وأخيرًا توصي الدراسة بمحاولة فهم الضغوطات المهنية التي يعاني منها مقدمو الخدمات الطبية ومساعدتهم على التغلب عليها لأداء عملهم بالشكل المطلوب وعقد دورات تثقيفية وتأهيلية بشكل مستمر لمقدمي الخدمات الطبية حتى يكونوا على دراية بها . آخر المستجدات في العمل مما يشجعهم ويساعدهم على أداء عملهم بشكل أكثر إيجابية.

الكلمات المفتاحية: الضغوط النفسية، الصلابة النفسية، الاحتراق النفسي.