An-Najah National University

Faculty of Graduate Studies

STRESS, BURNOUT, AND JOB SATISFACTION AMONG CRITICAL CARE NURSES IN EAST JERUSALEM HOSPITALS

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Dedication

This study is wholeheartedly dedicated to the Almighty God, for his guidance, power of mind, and protection and forgiving us a healthy life to be able to carry out this research. All of these.

We also dedicate this research we offer to you our beloved Family, who have been our source of inspiration and strength throughout this research. Their continuous oral, spiritual and emotional support to us had helped us finish this research.

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Finally, I have a great expectation that my study will be beneficial and useful for anyone who is interested in reading this final project.

Declaration

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

STRESS, BURNOUT, AND JOB SATISFACTION AMONG CRITICAL CARE NURSES IN EAST JERUSALEM HOSPITALS

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.

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Date: 18. 12. 2024.

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Abstract

Introduction: Burnout, stress, and job dissatisfaction are prevalent among critical care nurses and impact both their well-being and patient care. This study examines these issues in hospitals in East Jerusalem.

Aim: To assess Stress, Burnout, and Job Satisfaction among Critical Care Nurses in East Jerusalem Hospitals.

Methods: A descriptive, cross-sectional, was conducted across four major hospitals in East Jerusalem: Al-Makased Hospital, Saint Louis - French Hospital, Augusta Victoria Hospital, and Red Crescent Society Hospital. A sample of 195 critical care nurses was surveyed using the Maslach Burnout Inventory (MBI), Job Stress Scale (JSS), and Mueller/McCloskey Nurse Job Satisfaction Scale (MMSS). Data were collected from May 1, 2024, to July 30, 2024, and analyzed using SPSS 25.

The study involved 195 ICU nurses and revealed significant levels of moderate burnout (79%) and stress (75.9%), alongside pervasive job dissatisfaction (mean = 2.9/5), driven by factors such as advanced age, higher patient loads (>3 patients), lower income (<5000 NIS), and limited autonomy. Burnout and stress exhibited strong positive correlations (r = 0.552), while both inversely correlated with job satisfaction (r = -0.485 to -0.496), highlighting their interconnectedness. Nurses in leadership roles reported lower burnout/stress, emphasizing structural support as a protective factor. Findings underscore the urgent need for targeted interventions, including workload management, equitable compensation, and enhanced decision-making involvement, to mitigate occupational strain and improve retention in high-pressure ICU environments.

Conclusion: This study underscores the pervasive occupational challenges faced by ICU nurses in East Jerusalem, with 79% experiencing moderate burnout and 75.9% reporting stress, alongside widespread job dissatisfaction (mean = 2.9/5). Significant predictors included high patient loads (>3 patients), low income (<5000 NIS), and limited autonomy. Leadership roles emerged as protective, highlighting the importance of structural support. These findings emphasize the urgent need for systemic interventions, such as equitable workload distribution, fair compensation, and participatory decision-making, to alleviate occupational strain. Addressing these issues is critical not only for improving nurses' well-being and retention but also for safeguarding the quality of critical care in resource-constrained settings like East Jerusalem. Future policies must prioritize nurse-centric reforms to foster resilient healthcare systems in high-stress environments.

Keywords: Critical Care Nurses; Burnout; Stress; Job Satisfaction; East Jerusalem hospitals.

Chapter one

Introduction

1.1 Background

Care in the intensive care unit (ICU) is more complex than in other areas of the hospital, and nurses play a crucial role as members of interprofessional teams. The extensive responsibilities placed on ICU nurses require rapid responses on a consistent basis. Carers, educators, researchers, and managers are all roles they play in the intensive care unit (Aitken, 2019). It can be taxing for nurses to operate in a field that involves such complicated multitasking, where their workload is high and they must offer specialised care to patients who are severely ill and very dependent. High levels of stress in the workplace can lead to burnout, which in turn affects morale and productivity (Alharbi & Alshehry, 2019).

Burnout is a syndrome that develops when an individual has been subjected to stress at work and has been unable to effectively cope with it (Birknerová & Čigarská, 2021). Emotional exhaustion (EE) is the experience of having one's emotional reserves depleted and one's energy expended; depersonalization (DP) is distancing oneself from work-related activities, increasing one's emotional distance from one's work, being negative and cynical about one's work, and feeling frustrated; and diminished personal accomplishment (PA) is diminished work performance associated with a negative work attitude and a sense of incompetence and ineffectuality (Lee et al., 2023). Exhaustion, anxiety, irritability, sleeplessness, and emotional instability are among recognised clinical indicators of burnout (Leiter & Maslach, 2017). The Intensive Care Unit (ICU) setting is likely to be connected with burnout for healthcare practitioners (Alharbi & Alshehry, 2019).

Critical care nursing burnout is a worldwide epidemic that poses a serious risk to patient safety (Vahedian-Azimi et al., 2019; Wei et al., 2020). Despite a wealth of research and existing therapies targeting burnout, a clear answer has yet to be found (Bakhamis et al., 2019; Moss et al., 2016b). According to Lazarus's theory of stress, the ability to accurately evaluate and perceive stressful situations is crucial to comprehending the phenomenon. The negative effects of burnout on patient safety, quality, health care

workers, and the health care organisation have piqued researchers' and practitioners' (Manzano-Garcia & Ayala, 2017) interest in the topic over the past 15 to 20 years.

Burnout, resulting from prolonged job-related demands, is defined by profound tiredness, depersonalization, and diminished personal achievement (Maslach et al., 2001).

Nurses in critical care settings are more likely than those in other medical fields to experience burnout. Up to 86% of critical care nurses exhibit at least one sign of burnout, and 25% to 33% are affected by burnout themselves (Abu Safieh et al., 2024). When nurses experience burnout, it can have serious consequences for both their employers and the people they care for. Reduced quality of care, poor performance, lower nurse job satisfaction, a reduction in nursing retention rates, less compassionate behaviours, and worse patient outcomes are all connected with healthcare burnout (Cabarkapa et al., 2024; Moss et al., 2016a). Higher rates of burnout among nurses have been linked to an increase in both patient mortality and hospital-acquired infections (Cabarkapa et al., 2020). The high expense of recruiting, hiring, and training new nurses, combined with an existing inadequate workforce, makes burnout a significant contributor to staff turnover and attrition in the nursing profession (Quigley et al., 2023).

Experts in the field of critical care agree that burnout is still a problem, which is why a new method is needed to addressing it (Bakhamis et al., 2019; Moss et al., 2016a). My research aimed to better understand the relationship between burnout and optimism among intensive care unit nurses. Positive thinking is a mental attitude that looks for the best in any given circumstance. According to Lazarus and Folkman (1984), the way someone sees and understands an event is what gives it significance and shapes their attitude towards it. According to Manzano-Garcia and Ayala (2017), nurse burnout is due in large part to the nurse's own psychological perception of the workplace, as well as to the features of the workplace itself (Manzano-Garcia & Ayala-Calvo, 2020).

The nurse's physical and emotional well-being are essential to her productivity on the job. Perlo et al. (2017) found that when workers are happy and invested in their jobs, it has a favourable effect on both patient outcomes and the health of the company financially (Perlo & Feeley, 2018).

According to Scholtz et al. (2016), the critical care unit is a one-of-a-kind setting for the treatment of critically sick patients. Because of this, the action moves swiftly and important choices must be made under pressure. A stressful work atmosphere is created because to the critical care nurses' exposure to trauma, end-of-life difficulties, human suffering, work pressure, and rising job expectations (Alharbi & Alshehry, 2019). Talaee (2020) states that caring for patients in severe condition is a well-established contributor to occupational burnout (Talaee et al., 2020). Reduced empathetic and compassionate care is provided by nurses because of burnout (Alharbi & Alshehry, 2019).

According to Manzano-Garcia and Ayala (2017), much of the research on burnout among critical care nurses has been driven by leadership and has focused on addressing factors in the nurses' work environment, while ignoring individual factors that also impact burnout (Manzano-Garcia & Ayala-Calvo, 2020). To foster a healthy workplace, the American Association of Critical-Care Nurses (AACN) established eight Healthy Work Environment principles (Ulrich et al., 2019): competent communication, genuine cooperation, sound decision making, adequate staffing, and genuine leadership. In addition, the official critical care societies' collaborative statement on burnout syndrome in the critical care setting listed current therapies that targeted organisational, environmental, and human factors. There is currently no effective treatment for burnout, despite the many therapies that have been developed (Bakhamis et al., 2019). Researchers have largely ignored the potential of learning to think more positively as a means of combating burnout.

In light of the lack of effectiveness of current therapies against burnout, the CCSC has issued a call to action . Nursing is known to be a very demanding profession because to the many challenges that nurses face every day (Howell, 2021).

Nursing has always been a demanding profession, and it hasn't gotten any easier since Florence Nightingale’s Day (Talaee et al., 2020). Nursing stress has been ignored until recently (Manzano-Garcia & Ayala-Calvo, 2020), Since burnout has adverse consequences on patient safety, healthcare quality, staff health and livelihoods, and cost and organizational performance, a solution to this cancer requires more studies on burnout. To Err is Human: The paper is, Creating a Safer Health System, written by the Institute of Medicine in 1999, to change the focus of the health care system by providing safe care for its patients. despite its detrimental effects on nurses' health and

happiness, as well as on patients' safety, care quality, and the bottom lines of healthcare organisations and businesses (Safari, 2020).

1.2 Statement of Problem

Due to its impact on individuals, patient safety, quality, and organizational performance, critical care nursing burnout is an issue that requires immediate attention (Bakhamis et al., 2019). Highly stressful work environments are associated with increased rates of burnout.

In East Jerusalem, hospitals serve as lifelines for Palestinian communities excluded from Israeli healthcare systems, yet they grapple with limited ICU beds (e.g., <50 combined across four hospitals), excessive patient-to-nurse ratios (>3 patients/nurse), and erratic supply chains due to checkpoints and blockades. The Gaza War further strains these institutions through mass casualty influxes, destroyed infrastructure, and psychological trauma among staff and patients. Studies show that 33–50% of critical care nurses globally exhibit burnout, but in conflict zones like Palestine, rates are likely higher due to Moral distress, Occupational hazards and chronic stress.

Exhaustion, depersonalization, and a loss of interest in one's work are typical signs of burnout (Moss et al., 2016a). The mental and physical toll of burnout can have a direct bearing on how well doctors and nurses do their jobs at the hospital and how well their patients fare. Furthermore, healthcare personnel may be severely affected by worldwide epidemics (Suarez, 2021). There is a higher chance of infection, more patient mortality and suffering, bigger workloads, and heavier moral difficulties during an infectious disease epidemic (Cabarkapa et al., 2020), all of which contribute to burnout among healthcare personnel.

Research indicates that critical care nurses have elevated levels of burnout. A study by (Dall'Ora et al., 2020) indicates that one-third to over half of critical care nurses display symptoms of burnout, rendering it the nursing profession with the highest burnout rates. Elevated stress levels in the workplace are considered a significant factor in the high incidence of burnout among critical care nurses (Alharbi & Alshehry, 2019). The intensive care unit (ICU) is a specialized environment for critically ill patients, where critical care personnel face a heightened risk of burnout due to their continual exposure to trauma and mortality (Moss et al., 2016a). Burnout occurs in individuals when their

work expectations are unmet (Moss et al., 2016). Authorities in critical care have identified burnout as a significant health concern affecting the nurses within the specialization. The Critical Care Societies Collaboratives (CCSC) issued a joint statement entitled "A Call for Action" (Moss et al., 2016b) to promote further research and intervention about burnout. The CCSC established a committee to address the issue and subsequently released a report on burnout and its prevention (Moss et al.). The American Association of Critical-Care Nurses (AACN), American Thoracic Society (ATS), American College of Chest Physicians (ACCP), and Society of Critical Care Medicine (SCCM) constitute the four principal critical care organizations comprising the CCSC (Moss et al., 2016a). The CCSC report on burnout summarized environmental, communication, team-oriented, practitioner-focused, and risk mitigation techniques. Notwithstanding the implementation of programs aimed at mitigating burnout among critical care providers, this article demonstrates that the issue endures.

These results are elaborately explained in a study medical mistakes and poor quality of treatment have been associated with burnout (Talaee et al., 2020). For instance, Dyrbye et al., (2019) showed that burnout correlates with excessive mortality and infection rates among patients (Dyrbye et al., 2019). Regarding the negative side of burnout it is dangerous to people health and their level of happiness. Fatigue is group together with extreme tiredness, cynicism, anxiety, sadness, frustration, headache, sleeplessness, lack of empathy and other physical and psychological signs of burnout as outlined by (Bakhamis et al., 2019).

The literature indicates between one-third and over 50% of critical care nurses who demonstrate symptoms of burnout (Ani, 2023). Critical care nurses are those working in an intensive care unit who have undergone through specialised training in critical care (Alharbi & Alshehry, 2019). According to Waddill-Goad (2017), care and compassion are the cornerstones of nursing (Waddill-Goad, 2023). Care given by "caring and compassionate" clinicians is essential to patient outcomes (Pastores et al., 2019). Burnout has a negative effect on critical care nurses because it makes it harder for them to care for patients in a compassionate, empathetic, safe, and high-quality manner (Hofmeyer et al., 2020).

Nursing burnout has been shown to negatively impact both care quality and patient safety, according to a review by (Dall'Ora et al., 2020). These include things like patient satisfaction, family complaints, medication errors, patient falls, and adverse events. Another study found that the burnout dimension of depersonalization was linked to nosocomial infections, and all three aspects of burnout predicted prescription mistakes. One of the dimensions of burnout is a lack of personal accomplishment, and another is emotional tiredness, both of which have been linked to patient dissatisfaction (Dall'Ora et al., 2020).

Staff morale and engagement plummet, productivity drops, and absenteeism and plans to quit the company increase as a result of burnout (Papazian et al., 2023). Reduced work satisfaction, increased turnover, and a scarcity of nurses are all consequences of burnout, according to the research of Nansupawat et al. (2017). According to research by Dilig-Ruiz et al. (2018), work satisfaction is a significant contributor to high turnover rates among critical care nurses, which can have a major impact on an organization's bottom line. Work-related stress may cost anywhere from $221.13 million to $187 billion, according to a review of 15 studies (including the United States) (Jackson et al., 2018), with productivity-related losses accounting for the vast majority of this cost (70-90%). In recent years, prominent health and regulatory organisations have begun to pay attention to the high occurrence of burnout among health care personnel.

1.3 Significant of study

This study is critically important for several reasons, particularly within the context of East Jerusalem and Palestine's ongoing humanitarian and political crises:

1. **Addressing a Critical Gap in Conflict Zone Healthcare Research**

While burnout among ICU nurses is a global concern, its dynamics in conflict-affected regions like Palestine remain understudied. Existing literature predominantly focuses on stable healthcare systems, overlooking the compounded stressors of war, occupation, and resource scarcity. This study fills this gap by examining burnout, stress, and job dissatisfaction in East Jerusalem's hospitals—settings marked by chronic trauma, political violence, and systemic neglect.

2. **Safeguarding Patient Safety and Healthcare Resilience**

Burnout directly threatens patient outcomes, correlating with higher mortality rates, medical errors, and infections (Dyrbye et al., 2019; Dall'Ora et al., 2020). In East Jerusalem and Gaza, where healthcare infrastructure is already strained by blockades, checkpoints, and war-related destruction, nurse burnout risks collapsing fragile systems. By identifying burnout drivers (e.g., excessive patient loads, low wages), this study informs interventions to stabilize care quality and protect vulnerable populations.

3. **Advocating for Equity in Global Health**

Palestinian healthcare workers endure unique adversities: exposure to violence, disrupted supply chains, and exclusion from Israeli healthcare resources. This study amplifies their voices, highlighting systemic inequities that demand international attention. Findings can advocate for equitable funding, trauma-informed policies, and diplomatic efforts to ensure access to medical supplies and mental health support.

4. **Mitigating Workforce Collapse in Crisis Settings**

High nurse turnover—linked to burnout—jeopardizes healthcare delivery in regions already facing staff shortages. In Gaza, where the 2023 war has displaced thousands and destroyed hospitals, retaining skilled ICU nurses is a matter of survival. This study's insights into job dissatisfaction (e.g., lack of autonomy, unfair compensation) can guide retention strategies, such as participatory decision-making and hazard pay, to sustain critical care capacity.

Finding an effective treatment to burnout requires an understanding of the mechanisms that cause stress. While the elements of the work environment are important in contributing to burnout, Manzano-Garcia and Ayala (2020) observed that nurses' perception and interpretation of job stresses also have a major influence. The importance of one's own perspective and interpretation was emphasised by Lazarus's (1984) theory of stress. Critical care nurses, Barto and Burk (2017) argue, need training in skills that will allow them to think differently about stress in order to effectively cope with the stressful nature of the ICU work environment. Stress management through positive thinking involves shifting one's attention to the positive aspects of a situation rather than dwelling on the negative (Matel-Anderson & Bekhet, 2019). In light of the novelty of the application of positive thinking skills in nursing, Tully and Tao (2019)

advocated for further study to be focused on the topic of developing formal training for nurses on positive thinking skills. This research filled that void in the existing literature.

Few studies have examined nurse burnout in Palestine such as Burnout and psychological distress among nurses working in primary health care clinics in West Bank-Palestine (Alshawish & Nairat, 2020), and none have focused on the unique challenges faced by those working in critical care. Considering the highly stressful nature of the critical care nurse's work environment (Awajeh et al., 2018), this study shed light on the importance of perception and interpretation of work stressors in reducing burnout, thereby sparking a new focus that can assist critical care nurses in shifting their perspective from a negative to a more optimistic one.

1.4 Aim of the study

To assess stress, burnout, and job satisfaction among critical care nurses in East Jerusalem hospitals.

1.5 Objectives

1. To assess the levels of stress, burnout, and job satisfaction among critical care nurses in East Jerusalem hospitals.
2. To Examine the Impact of Workload and Work Conditions on Burnout and Stress
3. To examine the differences in stress, burnout, and job satisfaction based on demographic and professional characteristics.
4. To analyze the correlation between stress, burnout, and job satisfaction among critical care nurses.

1.6 Literature review

Burnout among nurses has been widely studied due to its significant implications for healthcare delivery, job satisfaction, and patient safety. Research indicates that work-related stress plays a pivotal role in contributing to burnout, which in turn affects job performance, emotional well-being, and workforce retention. Studies from various healthcare settings, including Saudi Arabia, Jordan, Iran, and the United States, highlight the alarming prevalence of burnout among critical care nurses and its adverse

effects on both individual well-being and organizational efficiency. Understanding the factors contributing to burnout, its relationship with job satisfaction, and strategies for mitigation are essential for improving healthcare environments and patient care outcomes.

Search Strategy To conduct a comprehensive literature review on burnout among critical care nurses, a systematic search was performed using multiple databases. The strategy included:

- Using Boolean operators (AND, OR, NOT) to refine searches.
- Applying inclusion criteria such as peer-reviewed articles, studies published in English, and research conducted within the last ten years.
- Excluding non-relevant studies, such as those focused on other healthcare professions or unrelated psychological conditions.
- Reviewing references from selected articles to identify additional relevant studies.

Keywords The following keywords and search terms were used to retrieve relevant studies:

- "Burnout among nurses"
- "Critical care nursing burnout"
- "Work-related stress and job satisfaction"
- "Nursing workforce mental health"
- "Impact of stress on nurse performance"
- "Nurse retention and turnover"
- "Patient safety and nurse burnout"
- "Workplace conditions and burnout prevention"

Databases Searched The following academic and medical databases were utilized to ensure a comprehensive literature review:

- PubMed
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- Scopus
- Web of Science
- PsycINFO
- ScienceDirect
- Google Scholar (for grey literature and supplementary sources)

Inclusion and Exclusion Criteria

Inclusion Criteria:

- Studies published in peer-reviewed journals
- Research focused on burnout among nurses, particularly in critical care settings
- Studies examining factors contributing to burnout, job satisfaction, and mental health implications
- Articles published within the last ten years

Exclusion Criteria:

- Studies not focused on nursing professionals
- Research unrelated to burnout or job satisfaction
- Articles published in languages other than English (unless translated versions were available)

Data Extraction and Analysis Relevant studies were reviewed, and key data such as study objectives, methodology, sample size, main findings, and conclusions were extracted. A thematic analysis was conducted to categorize findings into major themes,

including factors leading to burnout, its impact on job performance and patient care, and suggested interventions to mitigate burnout in critical care settings.

This structured approach ensures a rigorous review of the existing literature, providing a strong foundation for further research on burnout among nurses.

1.7 Previous studies

Literature indicates that work-related stress can impact job satisfaction and could result in burnout, which may subsequently influence work performance and satisfaction. It is crucial to examine work-related stress about burnout in connection to performance and job satisfaction. A recent study of Iranian and Turkish nurses indicated that burnout results from extended exposure to stress (Özlü et al., 2017). This assertion warrants investigation within the Saudi Arabian context by assessing the prevalence of work-related stress and burnout among nurses in public, private, and university hospitals, followed by an analysis of the correlation between work-related stress and burnout among these nurses across the three hospital categories.

A comparable study at King Abdullah Public Hospital in Jordan demonstrated a substantial correlation between stress and nurse performance. The adverse effects of stress were assessed using a random sample of 120 nurses (Alrifae et al., 2021). A comparable effect was observed in nurses suffering from burnout, resulting in a considerable decline in their performance and efficiency (Özlü et al., 2016).

Alharbi et al. (2016) conducted a quantitative study to investigate burnout and job satisfaction among critical care nurses in Saudi Arabia. The findings indicate that critical care nurses in Saudi Arabia are facing substantial burnout, with emotional exhaustion levels reaching 82%, and diminished job satisfaction. Moreover, burnout was identified as a sign of dissatisfaction in the workplace. Researchers determined that the elevated levels of burnout in critical care settings were attributable to the intrinsic stress associated with the profession. The authors of the study proposed methods to enhance the working conditions of nurses in intensive care units. The literature has continuously emphasized the nurse's working environment while neglecting other significant aspects, such as nurses' perceptions and interpretations of job pressures, despite the elevated incidence of burnout in the critical care nursing field.

To better understand the causes and consequences of burnout among critical care nurses, Alotni and Elgazzar (2020) undertook a quantitative research in Saudi Arabia. The results indicated a far higher percentage of burnout among the non-Saudi nurses (up to 90%) than among the Saudi nurses (55.6%) (Alotni & Elgazzar, 2020). Consistent with the findings of Alharbi et al. (2016), Elgazzar's (2020) study found a significant burnout rate among critical care nurses. In both cases, researchers uncovered new indicators of burnout's deleterious effects. The Alharbi study examined the impact of burnout on job satisfaction among workers, revealing that critical care nurses experienced diminished career satisfaction due to burnout. Specchia et al. (2021) assert that job satisfaction is a critical determinant of an organization's success regarding productivity and profitability. Research by Alotni and Elgazzar indicates that burnout among critical care nurses adversely impacts their quality of life. Reduced work performance, burnout, and premature retirement have all been associated with quality of life (Alotni & Elgazzar, 2020). Burnout adversely impacts nurses and their workplaces through physical and mental health difficulties, absenteeism, elevated nurse turnover, and significant effects on patient safety and quality (Alotni & Elgazzar, 2020).

A quantitative study by Awajeh et al. (2018) examined the prevalence of burnout among critical care nurses in Riyadh, Saudi Arabia. The findings revealed that an alarming 65.9% of critical care nurses were suffering from burnout. The elevated burnout rate among critical care nurses was attributed to their exceedingly stressful working conditions, characterized by a substantial workload, a shortage of nursing staff, a high turnover rate, and complications regarding compensation and benefits. Researchers discovered that turnover rates among critical care nurses were elevated and that burnout constituted a significant concern. In alignment with the findings of Alotni and Elgazzar (2020) and Alharbi et al. (2016), Awajeh et al.'s research indicates a significant incidence of burnout among critical care nurses, corroborating the widespread prevalence of burnout in this demographic globally and substantiating the necessity of my study to tackle this global issue.

Mohr et al. (2021) conducted a quantitative study to evaluate the prevalence of burnout and its related factors among critical care nurses employed by the Veterans Health Administration in the United States. Between one-third and over fifty percent of critical care nurses indicated having burnout, representing the greatest proportion among

nursing specialties. This outcome is essential to my research as it elucidates my selection of nurses in intensive care units as my target population. Work perception was recognized as a subtheme in the Swampy research, highlighting its contribution to burnout. My research is significant as it pertains to Lazarus's concept of stress and its impact on individuals' perceptions of their employment (Mohr et al., 2021).

To quantify the extent to which critical care nurses in Rwanda experience burnout, Cishahayo et al. (2017) performed a survey. According to the findings, 61.7% of the sample experienced burnout. It has been shown that having a heavy workload is one of the main causes of burnout (Cishahayo et al., 2017). Exit motivation was also linked to feelings of burnout. The high expense of replacing a critical care nurse provides a substantial difficulty (Kurnat-Thoma et al., 2017), and the loss of experienced nurses due to resignations is a serious problem in intensive care units (Nantsupawat et al., 2017). Burnout is a serious issue that has to be handled, as evidenced by the high prevalence and considerable negative effects on the organization.

In a recent quantitative study, Elay et al. (2019) looked at the prevalence of burnout among ICU staff and the factors that increase their likelihood of experiencing it. Doctors made up 46% of the staff, nurses 51%, and others made up the remaining 3% in intensive care units. Ninety-nine percent of participants reported experiencing burnout on at least one burnout subscale, and fifteen percent experienced burnout on all three burnout subscales (emotional weariness, depersonalization, and diminished personal accomplishment). Many of those who were working in the Intensive Care Unit felt like quitting due to burnout. These results on high turnover in critical care are in line with those found by Awajeh et al. (2018) and Cishahayo et al. (2017). Kurnat-Thoma et al. (2017) state that employee turnover is an important financial and operational indication for every healthcare organisation. According to research by KurnatThoma et al., the average cost to replace one intensive care unit nurse in the United States is $88,000. This is a large monetary loss that can have a devastating effect on an organization's productivity and prosperity.

According to Galanis et al. (2021), the tremendous workload caused by the rush of patients contributed to the high stress levels observed by nurses during the COVID-19 pandemic (Galanis et al., 2021). Many critically sick patients' suffering and deaths had an emotional toll on the critical care nurses. In addition, there was a severe lack of

personal protective equipment (PPE) and a widespread dread of catching and spreading the disease, even among families (Shreffler, 2020). Ross (2020) warned that COVID-related burnout among nurses might lead to suicide and suggested that institutions adopt preventative measures. My research was motivated by the growing prevalence of COVID-19-related burnout and its negative outcomes, such as implications for future treatment.

Mamari et al. (2020) conducted a quantitative research among Omani critical care nurses to examine the correlation between exhaustion, stress, burnout, and nurses' perceptions of patient safety. The findings indicated that burnout was a significant predictor of critical care nurses' assessments of patient safety (Al Mamari, 2020). Critical care nurses' perception of the issues affecting patient safety (such as burnout) is what is meant by "perception of patient safety." The way patients feel about their own safety is critical in developing and implementing measures to ensure their wellbeing. Furthermore, the study found strong associations between burnout and factors including years of experience and plans to switch departments. According to Al Shehri et al. (2012), the degree of stress among nurses rose with more years of professional experience, which is consistent with the conclusion on the years of experience and burnout. Reduced confidence in patient safety was associated with burnout. The study authors stressed the need of a patient safety culture in providing effective medical treatment. Therefore, my research is necessary to address the pressing issue of burnout, which has a deleterious effect on the culture of patient safety. There is substantial evidence linking burnout among critical care nurses to decreased patient safety and quality of care provided (Al Mamari, 2020). Due to emotional weariness, a nurse experiencing burnout is unable to perform at optimal levels for patients (Mudallal et al., 2017) Frustration, dread, wrath, sorrow, and a loss of interest in work are all psychological indicators (Barto & Burk, 2017). Negative interactions with patients and coworkers, as well as a decline in patient safety and quality, are additional signs of burnout (Howell, 2021; Paraguass-Chaves et al., 2021). Exhaustion, lethargy, insomnia, headaches, and tummy troubles are among physical symptoms (Moss et al., 2016). As a result, there is an increase in absenteeism, which has a direct influence on the quality of treatment provided to patients (Moss et al., 2016). One of the hallmarks of burnout is a loss of a sense of personal accomplishment, which presents itself in a low opinion of oneself (Kumar et al., 2021). Critical care workers have been found to experience

suicidal ideations as well (Moss et al., 2016). Researchers Ruiz-Fernández et al. (2020) examined nurses' quality of life. The findings demonstrated that extreme burnout degrades one's quality of life. Negative effects on nurses' quality of life have been linked to a decrease in their productivity and the risk of errors in patient care (Mudallal et al., 2017). Consequently, it's imperative that we find solutions to the widespread issue of burnout.

The present situation of the critical care nurse's work environment was assessed in a mixed-methods research by Ulrich et al. (2019). Workplace factors were found to influence patient and nurse outcomes. Sixty percent of respondents said they were understaffed, and 6017 people said they were having problems with their physical or mental health. Additionally, one-third of respondents said they planned to quit their current jobs within the next year. Skilled communication, genuine cooperation, effective decision making, meaningful recognition, enough staffing, and real leadership are just few of the good results cited as a result of implementing the AACN Healthy Work Environment criteria. Studies on burnout in the critical care context have mostly ignored individual variables, such as how they perceive and interpret their work environment (Monroe et al., 2020; Moss et al., 2016; Ulrich et al., 2019), in favour of examining organisational aspects. While elements related to the workplace have a big part in the development of burnout, Manzano-Garcia and Ayala (2017) noted that other, equally essential aspects, such as the nurse's perception and interpretation of stresses, have been understudied. According to Lazarus' theory of stress, the theoretical underpinning of my research, the way in which an individual perceives and interprets stressors is crucial to their ability to cope with them. This supports the importance of my research.

Critical care nurses' self-reported medical mistakes were studied quantitatively by Melnyk et al. (2021), who also looked at the links between the nurses' perceptions of workplace wellness support, their own physical and mental health, and medical errors. Medical mistakes were shown to be substantially more common among nurses who self-reported poor physical and mental health compared to nurses who claimed better health. Researchers discovered that burnout negatively affected the health and happiness of ICU nurses. The study's authors determined that fixing the underlying causes of burnout—such as understaffing and lengthy shifts—was the most effective strategy (Melnyk et al., 2021). Manzano-Garcia and Ayala (2017) found that other factors, such

as nurses' perception and interpretation of job pressures, contribute to burnout, but their method focuses solely on the work environment.

Kelly et al. (2021) conducted a quantitative study to determine the impact of burnout and the workplace on nurse turnover, as well as to identify the critical aspects of a good work environment related with burnout, secondary trauma, and compassion satisfaction. Sixty-one percent of the ICU nurses showed signs of moderate burnout, according to the study's findings. Key predictors of burnout were discovered by Kelly et al. (2021), and these included genuine leadership, meaningful acknowledgment, and sufficient staffing (Kelly et al., 2021). In a different research, Monroe et al. (2023) used quantitative methods to determine which of the AACN healthy work environment requirements most significantly affect critical care nurses' professional quality of life. The rate of burnout among research participants was high. Research also found that genuine leadership was a significant predictor of burnout and highlighted the importance of a change in leadership approach to ward against exhaustion (Monroe, 2023).

Gap in Literature

Existing research on burnout among critical care nurses, while extensive, exhibits critical limitations that this study seeks to address:

1. **Underrepresentation of Conflict Zones**:

Prior studies (e.g., Alharbi et al., 2016; Mohr et al., 2021; Cishahayo et al., 2017) predominantly focus on burnout in stable healthcare systems (e.g., Saudi Arabia, the U.S., Rwanda), overlooking the unique stressors of conflict-affected regions like Palestine and East Jerusalem. The compounded effects of political violence, resource blockades, trauma from the Gaza War, and systemic healthcare inequities remain underexplored. For instance, studies in Jordan or Iran do not account for the moral distress of treating war-related injuries or the chronic insecurity faced by Palestinian nurses.

2. **Overemphasis on Organizational Factors**:

While workplace conditions (e.g., staffing ratios, workload) are well-documented contributors to burnout (Awajeh et al., 2018; Ulrich et al., 2019), there is a paucity of research on individual perceptions of stress, as theorized by Lazarus. Studies like Al

Mamari (2020) and Manzano-Garcia & Ayala-Calvo (2017) highlight this gap, noting that nurses' subjective interpretations of stressors—such as exposure to preventable deaths in resource-limited ICUs—are rarely examined.

3. **Lack of Context-Specific Interventions**:

Existing interventions (e.g., AACN Healthy Work Environment standards) are designed for well-resourced settings and fail to address the realities of occupied territories, such as erratic supply chains, checkpoint delays, and staff shortages exacerbated by war. Research by Galanis et al. (2021) on COVID-19 burnout and Moss et al. (2016) on CCSC guidelines lacks applicability to conflict zones, where nurses face dual burdens of pandemic pressures and political violence.

4. **Inadequate Focus on Structural Inequities**:

Studies in Saudi Arabia (Alotni & Elgazzar, 2020) and the U.S. (Kelly et al., 2021) emphasize income disparities but neglect systemic inequities in Palestine, such as exclusion from Israeli healthcare infrastructure, restricted mobility, and reliance on international aid. The role of leadership in mitigating burnout (e.g., head nurses reporting lower stress) is also underexplored in contexts where leadership is fragmented due to political instability.

1.8 Conclusion

The negative impacts of burnout on patient safety and quality, financial and organisational outcomes, and the physical and mental health of critical care nurses make it a worldwide problem. Freudenberger, a psychologist who, along with his coworkers at a free clinic, suffered burnout in the early 1970s, coined the term "burnout" to describe the condition. Burnout is a crippling condition that manifests itself in all fields of study. Emotional weariness, depersonalization, and a lack of achievement are the three fundamental characteristics of burnout (Maslach & Leiter, 2016). The effects of nurses' suicide thoughts have been documented to be severe (Moss et al., 2016). Bates and Singh (2018) found that advancements in patient safety were threatened by the rising problem of burnout. Medical mistakes and the spread of diseases in hospitals are two ways in which burnout negatively affects patients. It has been shown (Jia et al., 2019). A lot of critical care nurses experience burnout (Alharbi et al; Alotni & Elgazzar, 2020). The high number of patients requiring intensive care unit (ICU) level treatment as a

result of the COVID-19 pandemic has increased the workload of critical care nurses (Galanis et al., 2020).

According to several sources (Bruyneel et al., 2021; Cishahayo et al., 2017; Moss et al., 2016), burnout is a major health issue that requires immediate action. There is no agreed-upon approach to combating burnout, nevertheless (Moss et al; Tully & Tao, 2019). Combating the issue of burnout requires first identifying its main causes and contributing elements. Therefore, it is crucial to understand the causes of stress if a remedy is to be found. According to Lazarus's theory of stress, one's perspective and understanding of stress are crucial factors. According to Manzano-Garcia and Ayala (2017), a nurse's attitude towards work stresses is largely formed by her own interpretation of such stressors. In light of this, my suggested research into the application of positive thinking strategies by critical care nurses is warranted.

According to Freudenberger (1974), who established the concept, burnout frequently manifests after one year of employment. This results in burnout over time. Prolonged occupational stress correlates with burnout in experienced intensive care unit nurses (Abumayyaleh et al., 2016; Batran, 2019). This is in line with the results of a recent study (Abu Safieh et al., 2024) that revealed nurses' stress levels rose as their years of experience increased. Fatigue, anxiety, sadness, headaches, sleeplessness, irritability, lack of motivation, cynicism (a pessimistic attitude), loss of compassion, and lack of empathy are all clinical signs of burnout (Moss et al., 2016b).

1.9 Theoretical and/or Conceptual Framework for the Study

According to research from 1984 by Lazarus and Folkman, stress has been around for ages. Only lately has stress become the subject of comprehensive analysis and study (Lazarus & Folkman, 1984). Lazarus's theory of stress, coping, and adaptation has become the gold standard for studies on stress and coping (Obbarius et al., 2021; Sharifabad et al., 2020). According to Lazarus and Folkman (1984), stress occurs when an individual perceives a demand placed on them by their external environment to be both excessive and unmanageable. Consequently, Lazarus's theory of stress is classified as a transactional based theory. The way one thinks about one's situation is a major component of the stress theory. Cognitive appraisal is the method through which an individual assesses and makes sense of the sources of stress in their life, as defined by

Lazarus and Folkman. Lazarus and Folkman argue that the source of an individual's stress is not the event itself but rather the way in which it is evaluated. Meaning and the degree to which an event is seen positively or negatively depend on the individual's interpretation and perception of the event. According to Lazarus and Folkman, one's interpretation of an incident has a significant impact on how they feel about it and how they deal with it. How one assesses and manages life's pressures is correlated with one's quality of life (Lazarus, 1984).

Chapter Two

Methods

2.1 Introduction

In this chapter research design, data collection instruments, data collection procedure, data analysis, data management Ethical considerations were discussed.

2.2 Research design

This research employed a descriptive, cross-sectional methodology. the primary goal of descriptive research is to accurately explain the characteristics of individuals, groups, or events. According to Polit and Beck (2020), a cross-sectional research is a study conducted at a single point in time to determine trends across time (Polit & Beck, 2018).

2.3 Research setting

The research was conducted across four major hospitals in East Jerusalem, Palestine, which serve as critical healthcare providers in a region marked by political, economic, and social challenges. Below is an overview of these institutions and their roles in the local healthcare system:

1. **Al-Makased Hospital**

- A nonprofit, community-based hospital founded in 1968, operated by the Islamic Christian Society.
- Specializes in emergency care, surgery, pediatrics, and maternal health, serving a predominantly Palestinian population.
- Known for its high patient volume due to limited healthcare alternatives in East Jerusalem.

2. **Saint Louis French Hospital**

- A Catholic-affiliated institution established in 1882, managed by the Order of St. Joseph of the Apparition.
- Provides general medical services, chronic disease management, and rehabilitation programs.

- Caters to a diverse patient base, including marginalized communities and refugees.

3. **Augusta Victoria Hospital (AVH)**

- Operated by the Lutheran World Federation, this hospital has been a cornerstone of healthcare since 1950.
- Functions as a referral center for specialized care, including oncology, dialysis, and advanced diagnostics.
- Serves patients from across the occupied Palestinian territories, particularly those requiring complex treatments unavailable elsewhere.

4. **Red Crescent Society Hospital - Jerusalem**

- Part of the Palestinian Red Crescent Society (PRCS), a humanitarian network providing emergency and maternity care.
- Focuses on neonatal and pediatric ICU.

These hospitals operate in East Jerusalem, where healthcare infrastructure is strained by chronic underfunding, political restrictions, and high demand from Palestinian communities lacking access to Israeli hospitals. They often face resource shortages, overcrowding, and bureaucratic hurdles, exacerbating workplace stress for ICU nurses. The hospitals' reliance on international aid and nonprofit funding further complicates operational stability, contributing to the systemic challenges identified in the study, such as excessive workloads and limited institutional support.

This context underscores the unique pressures faced by ICU nurses in these settings, aligning with the study's findings on burnout, stress, and dissatisfaction.

2.4 Population

The target population were critical care nurses who worked in critical care units. Critical care nurses including Adult and neonatal ICU.

The total number of individuals from which data may be gathered constitutes the population. Parahoo (2006). Within hospital there is 220 nurses working in Critical care unit, All nurses who work in ICU selected to take part in the study.

2.5 Inclusion and exclusion criteria

Inclusion criteria included nurses working in critical care units and willing to participate.

Exclusion criteria involved nurses who were not actively work as critical care nurses at the hospital, such as nursing students, interns, and other medical professionals not included.

2.6 Sampling

2.6.1 Sampling strategy

Members of the target population who meet certain practical criteria are included in the study (Dornyei, 2007): they are either easily accessible, geographically close, available at a given time, or willing to participate in the study (convenience sampling).

This research employed a sample strategy known as convenience sampling. The most likely nurses were selected as responders and questioned until a sufficient number of people had been gathered for statistical analysis.

2.6.2 Sample size

The larger sample size used in a quantitative study, the more likely it will be that the results will be generalizable to the whole population of interest (Polit & Beck, 2018).

195 RNs made up the sample population for this study. Sample size may be easily calculated using the following formula (from Yamane, 1967):

The sample size was calculated using the single population proportion formula ($n = (Z\alpha/2)^2 p(1-p)/d^2$), where n represents the necessary minimum and feasible sample size, $Z\alpha/2$ (1.96) indicates the significance level at $\alpha=0.05$ with a 95% confidence interval, p denotes the proportion of knowledge regarding palliative care, and d signifies the margin of error (5%). According to the assumptions of the single proportion formula, the determined sample size was 88. Furthermore, the adjustment formula was applied because the study population was fewer than 10,000. Taking into account a 10% non-response rate.

N: is total number of people in the study (Study population needed for this study was 150 nurses).

150 respondent according to equation (representative sample size) needed.

Sample of 195 nurses working in ICUs in East Jerusalem made up total population for this study

2.7 Data collection

2.7.1 Data collection instruments

The Maslach Burnout Inventory (MBI), created by Maslach and Jackson in 1981,used to measure burnout. The Maslach Burnout Inventory (MBI) is a prominent instrument for evaluating burnout. The MBI is a 22-item instrument designed to evaluate burnout across three dimensions: exhaustion (9 items), depersonalization (5 items), and personal accomplishment (8 items; Maslach et al., 1997). Maslach et al. (1997) assert that elevated scores on the exhaustion and depersonalization subscales signify an increased degree of burnout. In contrast to the weariness and depersonalization subscales, the personal accomplishment subscale is distinct, with lower average scores signifying a heightened degree of experienced burnout (Maslach et al., 1997).

The MBI is a quantitative variable utilizing a Likert scale ranging from 0 to 7, with 0 indicating never and 7 indicating every day. The scores for each response on the subscale are aggregated and subsequently compared with the interpretive values for scoring outcomes to determine the level of burnout: high, medium, or low (Maslach & Jackson, 1981). The MBI is a valid and reliable instrument, with Cronbach's alpha of 0.80 (Alharbi et al., 2016; Maslach & Leiter, 2016). (Mention only the value of Cronbach's alpha).

- Exhaustion and Depersonalization subscales: Elevated scores indicate an increased degree of burnout.
- Personal Accomplishment subscale: Lower average scores indicate a higher degree of burnout.

- Cutoff Points: High, Medium, Low levels of burnout. The exact cut points are based on the scores across the 0-7 Likert scale, and the interpretation depends on aggregating the responses for each subscale.

  The second instrument included in this study is the job stress scale, created by Shukla ad Srivastava (2016), designed to evaluate the occupational stress encountered by nurses. The job stress scale can evaluate various elements, including time pressure, job-related anxiety, role expectation conflicts, colleague support, and work-life balance. All elements in the technical documentation demonstrated a significant degree of internal consistency and test-retest reliability. The current analysis demonstrated a reliability coefficient of 0.974, signifying a substantial degree of consistency. Moreover, the overall internal consistency of the various components of the JSS resides within the optimal range.

- Items: Time pressure, job-related anxiety, role expectation conflicts, colleague support, and work-life balance.

- Scale: The scale is a Likert-type scale assessing job stress levels.

- Cutoff Point: The Job Stress Scale (JSS) can categorize stress levels into three groups: Low Stress (0-33% of the total score), indicating minimal stress; Moderate Stress (34%-66% of the total score), reflecting a manageable level of stress; and High Stress (67%-100% of the total score), signifying significant stress that may impact performance and well-being. These cutoff points help classify the overall stress experienced by individuals based on their responses across various stress-related dimensions.

- Reliability: Cronbach’s alpha is 0.974, indicating high internal consistency. The Arabic version has also been validated.

The third instrument included in this study is The Mueller/McCloskey Nurse Job Satisfaction Scale (MMSS), a highly recognized measure of nurses' job satisfaction (Mueller & McCloskey, 1990). McCloskey (1974) created an earlier version of the MMSS in order to examine the impact of incentives and rewards on the rate at which staff nurses leave their positions. In order to determine the factors that would have motivated staff nurses to stay in their prior employment, they were asked to indicate

which incentives from a list of 36 items, grouped according to Maslow's hierarchy of needs and insights of Burns, would have been influential. Mueller and McCloskey (1990) performed exploratory factor analysis (EFA) on 33 out of the 36 items. They selected and kept 31 of these items, which now make up the MMSS-31 (Table 1). The El-Jardali, Murray et al. (2013) study excluded six items from Mueller and McCloskey's (1990) 31-item scale due to their lack of relevance to the nursing practice of the majority of nurses in Lebanon and Qatar. The things that have been eliminated are: faculty interaction, practice control, research, publishing, responsibility, and condition control. The things in italics are presented exactly as stated in the El-Jardali, Murray et al. (2013) paper. The numbers in parentheses correspond to the item numbers in Mueller and McCloskey's (1990) final collection of 31 items. The acronym MMSS stands for Mueller/McCloskey Nurse Job Satisfaction Scale.

This instrument was obtained and utilized to assess job satisfaction among nurses. The tool comprises 25 items that are categorized into 8 domains, namely: satisfaction with external incentives, scheduling, family/work balance, co-workers, interaction, professional possibilities, praise/recognition, and control/responsibility. The tool utilized a 5-point Likert scale style, where a rating of 5 indicated a high level of satisfaction, a rating of 3 indicated a neutral level of satisfaction, and a rating of 1 indicated a low level of satisfaction. The scoring and interpretation were based on the cumulative scores of the subscale items.

After conducting a comprehensive assessment of the reliability and validity of measures used to measure job satisfaction, van Saane et al. (2003) found that out of the 29 items reviewed, the MMSS instrument demonstrated sufficient reliability and validity to be used as an evaluative tool in hospital settings. To determine if the proposed factor structure was supported by the data in this tool, a multi-group confirmatory factor analysis (CFA) was conducted using Amos Graphics. Following the study, it was determined that no more improvements could be made to the fit. Therefore, the best fit result was chosen, which was the second order of the eight-factor analysis for the subscales. These subscales had the best model fit findings (CFI.754; TLI. 710; RMSEA.105) that could not be enhanced any further. Hence, this approach proved to be the most effective in utilizing the data, surpassing the other models, and ultimately validating the definitive selection of items for the study.

- Items: 25 items categorized into 8 domains: satisfaction with external incentives, scheduling, family/work balance, co-workers, interaction, professional possibilities, praise/recognition, and control/responsibility.
- Scale: 5-point Likert scale, where 5 indicates high satisfaction, 3 indicates neutral, and 1 indicates low satisfaction.
- Cutoff Point: Cumulative scores for each domain determine the overall job satisfaction level.
- Reliability: The instrument has shown sufficient reliability and validity, as evidenced by van Saane et al. (2003) and multi-group confirmatory factor analysis (CFA).

2.7.2 Data collection procedure

The researcher went to the included hospitals to explain the study after receiving ethical permission from the Institutional Review Board (IRB). Researchers approach potential participants at a staff meeting, where they give them detailed the study's aims, and explained the consent form and emphasized the participants' rights to privacy and confidentiality. Those who agreed to take part were then given access to the online survey. After consenting to take part in the study, participants were asked to pull out their personal smartphones so the researcher could begin administering the questionnaire. The researcher utilized structured questionnaire and provide participants with clear and consistent instructions to eliminate any barriers to participation in the study and subsequent requests for participants to fill out the questionnaire based on the information provided by the researcher.

The time period for data collection from May 1, 2024, through July 30, 2024.

2.8 Data analysis

Statistical analysis of the data was conducted using the Statistical Package for the Social Sciences (SPSS) 25. Descriptive data were presented in tables, while the mean and standard deviation were used to measure the variability in responses and understand the dispersion around the mean. ANOVA (Analysis of Variance) was employed to determine if there were significant differences in burnout and job satisfaction scores across

different groups, such as varying levels of organizational support or compensation. Additionally, correlation analysis, including Pearson's correlation coefficient, was used to examine the strength and direction of relationships between continuous variables, such as the relationship between workload and stress or work-life balance and job satisfaction.

2.9 Ethical considerations

Al-Najah National University – Faculty of Nursing provided ethical review. After securing the necessary ethical clearance. Written informed permission obtained after participants were briefed on the study's purpose and procedures. By not including respondent names on the questionnaire, personal information provided by respondents protected. All participants provided their informed consent on the day the data was collected. After introducing researcher, the researcher went to describe the nature of the study and why the volunteers were selected to take part in it. The tool that utilized to simplify things for them also described. In addition, participants briefed on how their privacy would be protected during the study and how their contributions would be used in the future. They also told that their involvement was entirely optional, that they could opt out at any moment, and that there would be no repercussions for doing so. At the conclusion, those who agree to take part in the research asked to submit their names and signatures on a consent form.

Data was in safe place and no one has access except the researcher and supervisor also it will be discarded after finish the thesis dissemination.

Chapter Three

Results

Chapter three presents the findings from the study on burnout, stress, and job dissatisfaction among ICU nurses working in [location]. This chapter aims to provide a comprehensive overview of the data collected through the survey and interviews, highlighting key trends and patterns observed.

3.1 Socio-demographic and occupational characteristics of nurses

The table provides a detailed demographic breakdown: The study population primarily consists of individuals aged 25 to 34 years (40.5%), followed by those aged 35 to 45 years (32.3%). There is a higher representation of males (60.5%) compared to females (39.5%). Most participants reside in villages (45.6%), with a significant proportion also living in cities (38.5%) and camps (15.9%). In terms of educational attainment, the majority hold a bachelor's degree (69.7%), while smaller groups have a diploma (14.9%) or a higher diploma or master's degree (15.4%). The predominant job title among respondents is staff nurse (66.2%), followed by practical nurse (24.1%), vice head nurse (6.2%), and head nurse (3.6%). The marital status distribution shows that most participants are married (72.3%), with singles comprising 23.6%, and divorced and widowed individuals making up 2.6% and 1.5% respectively. Regarding nursing experience, 41.0% have 10-20 years of experience, 21.5% have 6-10 years, 17.4% have 2-5 years, and 14.4% have more than 20 years. Intensive care experience is somewhat evenly distributed, with 27.2% having 6-10 years, 25.6% having 2-5 years, 23.1% having less than 2 years, and 20.5% having 10-20 years. Only 3.6% have more than 20 years of experience in intensive care. Most respondents are directly responsible for the care of 2 patients (55.4%), with 29.2% responsible for more than 3 patients, 9.7% for 3 patients, and 5.6% for 1 patient. Monthly income is primarily in the range of 5000-7000 NIS (52.8%), with 30.3% earning above 7000 NIS and 16.9% earning less than 5000 NIS. A majority work in shifts (79.0%), with a smaller group working morning shifts (20.5%), and a very small number (0.5%) with unspecified work nature. Lastly, 61.5% do not have specialty certifications or additional training in intensive care, while 38.5% do.

Table 3.1

Socio-demographic characteristics

Variable	Category	Frequency	Percent
Age	Less than 25 years	20	10.3%
	25 to 34 years	79	40.5%
	35 to 45 years	63	32.3%
	Over 45 years old	33	16.9%
Sex	Male	118	60.5%
	Female	77	39.5%
Place of residence	City	75	38.5%
	Camp	31	15.9%
	Village	89	45.6%
Educational level	Diploma	29	14.9%
	Bachelor's	136	69.7%
	Higher diploma or master's degree	30	15.4%
Job title	Practical nurse	47	24.1%
	Staff nurse	129	66.2%
	Vice head nurse	12	6.2%
	Head nurse	7	3.6%
Marital status	Single	46	23.6%
	Married	141	72.3%
	Divorced	5	2.6%
	Widow	3	1.5%
Number of years of experience in nursing	Less than 2 years	11	5.6%
	2 - 5 years	34	17.4%
	6 - 10 years	42	21.5%
	10 - 20 years	80	41.0%
	More than 20 years	28	14.4%
Number of years of experience in intensive care nursing	Less than 2 years	45	23.1%
	2 - 5 years	50	25.6%
	6 - 10 years	53	27.2%
	10 - 20 years	40	20.5%
	More than 20 years	7	3.6%
Number of patients directly responsible for care	1.00	11	5.6%
	2.00	108	55.4%
	3.00	19	9.7%
	More than 3 patients	57	29.2%
Monthly income	Less than 5000 NIS	33	16.9%
	5000 – 7000 NIS	103	52.8%
	Above 7000 NIS	59	30.3%
Nature of work	Morning	40	20.5%
	Shifts	154	79.0%
	Missing	1	0.5%
Specialty certifications or additional training in intensive care	Yes	75	38.5%
	No	120	61.5%

3.2 Maslach Burnout Inventor (MBI): Human Services Survey for Medical Personnel

The Maslach Burnout Inventory (MBI) for Medical Personnel reveals varying levels of burnout across different statements. Respondents reported a high level of exhilaration after working closely with their recipients (mean = 4.2). Intermediate levels of burnout were noted in several areas: feeling used up at the end of the workday (mean = 3.8), feeling fatigued in the morning (mean = 3.7), working too hard (mean = 3.7), feeling burned out (mean = 3.6), and finding working with people all day straining (mean = 3.4). Emotional drain from work (mean = 3.2), job frustration (mean = 3.0), and stress from direct work with people (mean = 3.0) also indicated intermediate burnout. Feelings of being at the end of their rope (mean = 2.9) and worrying about emotional hardening (mean = 2.7) were present, along with becoming more callous towards people (mean = 2.5), feeling energetic (mean = 2.5), and feeling blamed by recipients (mean = 2.5). Respondents felt moderately accomplished in their job (mean = 2.4) and could understand recipients' feelings (mean = 2.3) and create a relaxed atmosphere (mean = 2.3), while dealing calmly with emotional problems (mean = 2.3). Lower levels of burnout were observed in caring about what happens to recipients (mean = 2.1), feeling positively influential (mean = 1.9), treating recipients impersonally (mean = 1.8), and effectively dealing with recipients' problems (mean = 1.5). The overall burnout score was intermediate (mean = 2.8).

Table 3.2

Level of burnout among participants

Statement	Mean	Std. Deviation	Interpretation
I feel exhilarated after working closely with my recipients.	4.2	1.8	High
I feel used up at the end of the workday.	3.8	1.9	Intermediate
I feel fatigued when I get up in the morning and have to face another day on the job.	3.7	2.0	Intermediate
I feel I'm working too hard on my job.	3.7	1.9	Intermediate
I feel burned out from my work.	3.6	2.0	Intermediate
Working with people all day is really a strain for me.	3.4	1.9	Intermediate
I feel emotionally drained from my work.	3.2	1.9	Intermediate
I feel frustrated by my job.	3.0	2.0	Intermediate
Working with people directly puts too much stress on me.	3.0	1.9	Intermediate
I feel like I'm at the end of my rope.	2.9	2.0	Intermediate
I worry that this job is hardening me emotionally.	2.7	1.9	Intermediate
I've become more callous toward people since I took this job.	2.5	2.0	Intermediate
I feel very energetic.	2.5	1.8	Intermediate
I feel recipients blame me for some of their problems.	2.5	1.8	Intermediate
I have accomplished many worthwhile things in this job.	2.4	1.9	Intermediate
I can easily understand how my recipients feel about things.	2.3	1.9	Intermediate
I can easily create a relaxed atmosphere with my recipients.	2.3	1.7	Intermediate
In my work, I deal with emotional problems very calmly.	2.3	1.8	Intermediate
I don't really care what happens to some recipients.	2.1	2.0	Intermediate
I feel I'm positively influencing other people's lives through my work.	1.9	1.8	Low
I feel I treat some recipients as if they were impersonal objects.	1.8	1.8	Low
I deal very effectively with the problems of my recipients.	1.5	1.8	Low
Total Burnout score	2.8	1.9	Intermediate

3.3 Score of burnout among nurses according to MBI

In Table 3.3 The overall burnout levels among medical personnel, as measured by the Maslach Burnout Inventory (MBI), indicate that the majority of respondents (79.0%) experienced moderate burnout. A smaller percentage (16.9%) reported low burnout levels, while a minimal portion (4.1%) experienced high burnout levels.

Table 3.3

Score of burnout among nurses

Burnout Level	Frequency	Percent
High	8	4.1%
Moderate	154	79.0%
Low	33	16.9%

3.4 Stress among nurses using Perceived stress scale (PSS)

The table 3.4 presents the results from the Perceived Stress Scale (PSS) for nurses, highlighting the mean scores for each item. Nurses reported a mean score of 2.2 for feeling nervous and stressed, indicating a moderate frequency of this experience. They felt that things were going their way with a mean score of 1.9, also reflecting moderate frequency. Anger due to factors outside their control and being upset by unexpected events both had mean scores of 1.9 and 1.8, respectively, suggesting a moderate level of these feelings. The mean score for feeling unable to control important aspects of their lives was 1.7, while confidence in handling personal problems was reported with a mean score of 1.6. Difficulty coping with tasks and feeling on top of things also had mean scores of 1.6. The ability to control irritations and feeling overwhelmed by difficulties both had mean scores of 1.5. Overall, the total mean score of 1.7 indicates a general moderate level of stress among nurses.

Table 3.4

Level of stress among participants

	Mean	Std.Dev	
In the last month, how often have you felt nervous and stressed?	2.2	1.1	Moderate
In the last month, how often have you felt that things were going your way?	1.9	1.2	Moderate
In the last month, how often have you been angered because of things that happened that were outside of your control?	1.9	1.1	Moderate
In the last month, how often have you been upset because of something that happened unexpectedly?	1.8	1.2	Moderate
In the last month, how often have you felt that you were unable to control the important things in your life?	1.7	1.2	Moderate
In the last month, how often have you felt confident about your ability to handle your personal problems?	1.6	1.1	Moderate
In the last month, how often have you found that you could not cope with all the things that you had to do?	1.6	1.2	Moderate
In the last month, how often have you felt that you were on top of things?	1.6	1.1	Moderate
In the last month, how often have you been able to control irritations in your life?	1.5	1.0	Moderate
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	1.5	1.1	Moderate
Total	1.7	1.1	Moderate

3.5 Level of stress among nurses according to PSS

The table provides the distribution of stress levels among nurses. It shows that 3.1% of the nurses reported high stress, while the majority, 75.9%, experienced moderate stress. Additionally, 21.0% of the nurses reported low stress. The total number of respondents was 195, representing a comprehensive view of the stress levels among the nursing staff.

Table 3.5

Level of stress among nurses according to PSS

Stress Level	Frequency	Percent
High stress	6	3.1%
Moderate stress	148	75.9%
Low stress	41	21.0%

3.6 Level of satisfaction among nurses

The table presents the levels of satisfaction among nurses across various aspects of their work environment. The mean satisfaction scores range from 2.5 to 3.3, with all items interpreted as indicating a medium level of satisfaction. Key areas such as compensation for working weekends, maternity leave time, and recognition from superiors all have a mean score of 3.3. Other factors like child care facilities, immediate supervisors, nursing peers, and social contact opportunities have mean scores of 3.2. Career advancement opportunities and flexibility in scheduling also scored around 3.1 to 3.2. Lower scores were observed for control over the work setting, encouragement, and feedback, and interaction opportunities, with means closer to 2.8 to 2.9. The lowest satisfaction scores were for salary, benefits package, and participation in organizational decision-making, each with a mean of 2.5. The overall mean satisfaction score was 2.9, suggesting that while there are areas of moderate satisfaction, there are significant opportunities for improvement across all assessed aspects.

Table 3.6

Level of job satisfaction among nurses

Statement	Mean	Std. Deviation	Interpretation
Compensation for working weekends	3.3	1.3	Medium
Maternity leave time	3.3	1.3	Medium
Recognition for your work from superiors	3.3	1.2	Medium
Child care facilities	3.2	1.2	Medium
Your immediate supervisor	3.2	1.1	Medium
Your nursing peers	3.2	1.2	Medium
Opportunities for social contact with your colleagues after work	3.2	1.2	Medium
Opportunities to belong to department and institutional committees	3.2	1.2	Medium
Opportunities for career advancement	3.2	1.3	Medium
Flexibility in scheduling your hours	3.1	1.3	Medium
Opportunity to work straight days	3.1	1.3	Medium
The physicians you work with	3.1	1.2	Medium
Recognition of your work from peers	3.1	1.2	Medium
Your amount of responsibility	3.1	1.1	Medium
Opportunity for part-time work	3.0	1.3	Medium
Hours that you work	2.9	1.3	Medium
Control over what goes on in your work setting	2.9	1.2	Medium
Amount of encouragement and positive feedback	2.9	1.3	Medium
Opportunities to write and publish	2.9	1.2	Medium
Medical instruments and equipment available	2.9	1.2	Medium
Flexibility in scheduling your weekends off	2.8	1.2	Medium
The delivery of care method used on your unit (e.g., functional, team, primary)	2.8	1.3	Medium
Opportunities for social contact at work	2.8	1.2	Medium
Opportunities to interact professionally with other disciplines	2.8	1.3	Medium
Opportunities to interact with faculty of the College of Nursing	2.8	1.3	Medium
Your control over work conditions	2.8	1.2	Medium
Vacation	2.7	1.2	Medium
Weekends off per month	2.7	1.1	Medium
Opportunities to participate in nursing research	2.7	1.2	Medium
Salary	2.5	1.3	Medium
Benefits package (insurance, retirement)	2.5	1.2	Medium
Your participation in organizational decision making	2.5	1.3	Medium
Total	2.9	1.2	Medium

3.8 Inferential statistics

The table provides a comprehensive comparison of burnout, stress, and job satisfaction among nurses across various demographic and professional categories.

Burnout and stress increase with age, while satisfaction decreases. The highest burnout (68.70) and stress (19.48) are observed in nurses over 45 years old, with the lowest satisfaction (2.76) in this age group. Significant differences are found in stress and satisfaction across age groups (Sig. 0.004 and 0.040, respectively), but not in burnout (Sig. 0.178).

Male nurses have slightly higher burnout (61.93) and lower satisfaction (2.91) than female nurses, who report higher stress (17.77) and satisfaction (3.01). These differences are not significant (Sig. 0.601, 0.249, and 0.300, respectively).

Nurses from camps report the highest burnout (65.81) and stress (18.90), while those from cities report the lowest burnout (58.51) and stress (16.31). Satisfaction is fairly consistent across all places of residence. These differences are not significant (Sig. 0.109, 0.091, and 0.524, respectively).

Nurses with higher diplomas or master's degrees report the highest burnout (62.67) and stress (17.73), and the lowest satisfaction (2.79). Those with diplomas report the lowest burnout (59.90) and stress (15.34), and the highest satisfaction (3.13). These differences are not significant (Sig. 0.826, 0.156, and 0.185, respectively).

Vice head nurses report the highest stress (19.83), while head nurses report the lowest burnout (47.71) and stress (10.43), and the highest satisfaction (3.27). Practical nurses and staff nurses have similar burnout and satisfaction levels. Significant differences are found in stress across job titles (Sig. 0.001), but not in burnout or satisfaction (Sig. 0.192 and 0.588, respectively).

Widowed nurses report the highest burnout (71.33) and satisfaction (3.20), while single nurses report the lowest burnout (57.96). Divorced nurses report the highest stress (20.80) and the lowest satisfaction (2.58). These differences are not significant (Sig. 0.346, 0.156, and 0.508, respectively).

Nurses with 6-10 years of experience report the highest burnout (66.07) and stress (17.05). Those with less than 2 years of experience report the lowest burnout (48.73) and highest satisfaction (3.50). Significant differences are found in burnout and satisfaction across experience levels (Sig. 0.008 and 0.011, respectively), but not in stress (Sig. 0.211).

Nurses with 6-10 years of critical care experience report the highest burnout (67.11). Those with more than 20 years of experience report the lowest stress (14.29) and highest satisfaction (3.19). Significant differences are found in burnout (Sig. 0.011), but not in stress or satisfaction (Sig. 0.593 and 0.792, respectively).

Nurses responsible for more than 3 patients report the highest burnout (68.37) and stress (18.44), while those responsible for 1 patient report the highest satisfaction (3.86). Significant differences are found in burnout and stress across patient numbers (Sig. 0.012 and 0.025, respectively), but not in satisfaction (Sig. 0.168).

Nurses earning less than 5000 NIS report the highest burnout (66.09) and stress (19.85), while those earning above 7000 NIS report the highest satisfaction (3.38). Significant differences are found across all three variables (Sig. 0.000, 0.013, and 0.003, respectively).

Nurses with specialty certifications report higher burnout (62.89) and stress (17.49), but lower satisfaction (2.86) compared to those without certifications. These differences are not significant (Sig. 0.342, 0.553, and 0.170, respectively).

Table 3.8

Relationship between burnout, stress, and job satisfaction among nurses across various demographic and professional categories

Category	Group	Burnout	Stress	Satisfaction
Age (ANOVA)	Less than 25 years	58.15	18.00	3.37
	25 to 34 years	59.19	16.18	2.92
	35 to 45 years	65.08	19.10	2.85
	Over 45 years old	68.70	19.48	2.76
	Sig.	0.178	0.004**	0.040*
Sex (t-test)	Male	61.93	16.81	2.91
	Female	60.61	17.77	3.01
	Sig.	0.601	0.249	0.300
Place of residence	City	58.51	16.31	2.95
	Camp	65.81	18.90	2.82
	Village	62.33	17.34	2.99
	Sig.	0.109	0.091	0.524
Educational level	Diploma	59.90	15.34	3.13
	Bachelor's	61.46	17.46	2.95
	Higher diploma or master's degree	62.67	17.73	2.79
	Sig.	0.826	0.156	0.185
Job title	Practical nurse	61.36	16.11	2.94
	Staff nurse	62.21	17.71	2.92
	Vice head nurse	61.00	19.83	3.07
	Head nurse	47.71	10.43	3.27
	Sig.	0.192	0.001**	0.588
Marital status	Single	57.96	18.26	3.03
	Married	62.22	16.67	2.93
	Divorced	64.40	20.80	2.58
	Widow	71.33	19.00	3.20
	Sig.	0.346	0.156	0.508
Years of experience in nursing	Less than 2 years	48.73	18.00	3.50
	2 - 5 years	55.65	15.82	3.13
	6 - 10 years	66.07	17.05	2.97
	10 - 20 years	62.76	18.15	2.79
	More than 20 years	62.54	16.00	2.94
	Sig.	0.008**	0.211	0.011*
Years of experience in intensive care nursing	Less than 2 years	55.18	17.56	3.01
	2 - 5 years	61.64	16.66	2.96
	6 - 10 years	67.11	17.55	2.93
	10 - 20 years	61.73	17.48	2.86
	More than 20 years	54.86	14.29	3.19
	Sig.	0.011*	0.593	0.792
Number of patients directly responsible for providing care to	1.00	58.82	16.36	3.86
	2.00	63.30	16.83	2.82
	3.00	65.11	17.53	2.99
	More than 3 patients	68.37	18.44	2.89
	Sig.	0.012*	0.025*	0.168
Monthly income	Less than 5000 NIS	66.09	19.85	2.83
	5000 – 7000 NIS	61.78	17.10	3.17
	Above 7000 NIS	53.61	15.62	3.38
	Sig.	0.000**	0.013*	0.003**
Specialty certifications or additional training in intensive care	Yes	62.89	17.49	2.86
	No	60.48	17.00	3.00
	Sig.	0.342	0.553	0.170

3.9 Relationship between burnout, stress and satisfaction

Correlation results suggest the following relationships among burnout, stress, and job satisfaction:

There is a strong positive correlation between burnout and stress ($r=0.552r = 0.552r=0.552$, $p<0.01p < 0.01p<0.01$). This indicates that as burnout levels increase, stress levels also tend to increase.

There is a moderate negative correlation between burnout and job satisfaction ($r=−0.485r = -0.485r=−0.485$, $p<0.01p < 0.01p<0.01$). This suggests that higher burnout is associated with lower job satisfaction.

There is a moderate negative correlation between stress and job satisfaction ($r=−0.496r = -0.496r=−0.496$, $p<0.01p < 0.01p<0.01$). This indicates that higher stress levels are associated with lower job satisfaction.

Overall, these correlations support the hypothesis that increased burnout and stress are related to decreased job satisfaction.

Table 3.9

Correlation between burnout, stress, and job satisfaction

		Burnout	Stress	Satisfaction
Burnout	Pearson Correlation	1	0.552**	-0.485**
	Sig. (2-tailed)		0.000	0.000
	N	195	195	195
Stress	Pearson Correlation	0.552**	1	-0.496**
	Sig. (2-tailed)	0.000		0.000
	N	195	195	195
Satisfaction	Pearson Correlation	-0.485**	-0.496**	1
	Sig. (2-tailed)	0.000	0.000	
	N	195	195	195

Chapter Four

Discussions and Conclusions

This study aimed to evaluate burnout, stress, and job satisfaction among nurses working in critical care units in East Jerusalem hospitals. The findings present a detailed overview of the professional experiences of these nurses, highlighting the elements that affect their well-being and job satisfaction. This discourse situates the findings within the extensive literature on nursing burnout, stress, and job satisfaction, examining their implications for practice and proposing avenues for further research.

4.1 Burnout Levels

The results of the Maslach Burnout Inventory (MBI) suggest that participants' burnout is intermediate. The findings presented are supportive of similar studies conducted across the world in relation to nursing burnout. For instance, García-Caro et al., (2021) systematically revue nursing personal burnout and discovered that moderate condition is frequent among nurses, especially those working in critical care units. The high degree of exhilaration revealed by participants can be considered encouraging as it appears that some of the nurses obtain satisfaction from the job even though experiencing burnout.

The intermediate levels of burnout across various dimensions, such as emotional exhaustion and depersonalization, reflect patterns seen in other studies. For instance, Leiter and Maslach (2019) emphasize that burnout typically manifests through feelings of emotional exhaustion and reduced personal accomplishment, which are evident in the current study. The moderate scores for emotional drain and job frustration are consistent with findings from similar research (Aiken et al., 2022; Zhang et al., 2018).

Three studies in Saudi Arabia found moderate levels of burnout (Abumayyaleh et al., 2016; Alharbi & Alshehry, 2019; Alharbi et al., 2019), while two research suggested severe levels of burnout (Alharbi et al., 2016; Awajeh et al., 2018). Awajeh et al. (2018) discovered that a significant proportion of nurses in critical care units (65% of 270 nurses) had elevated levels of burnout across all dimensions: depersonalization, emotional exhaustion, and personal achievement. A separate study indicated that 85% of 126 Saudi nurses employed in ICUs experienced elevated levels of emotional tiredness (Alharbi et al., 2016).

4.2 Stress Levels

The Perceived Stress Scale (PSS) results show a moderate level of stress among nurses, with the highest stress levels associated with feeling nervous, stressed, and unable to control important aspects of their lives. These findings corroborate previous research indicating that nurses working in critical care settings experience significant stress due to the demands of their roles (McVicar, 2003). The moderate levels of stress reported in this study align with those observed in other studies focusing on critical care nurses, such as the work by Bagnasco et al. (2015), which highlights the high-stress nature of intensive care environments.

The distribution of stress levels, with a majority of nurses reporting moderate stress, is consistent with findings from studies examining stress among healthcare professionals. For instance, the work of Li et al. (2019) indicates that moderate stress is prevalent among healthcare workers, particularly in high-pressure roles like those in critical care units.

4.3 Job Satisfaction

The overall job satisfaction indicating medium satisfaction, is reflective of the mixed nature of job satisfaction in nursing. Factors such as compensation, recognition, and career advancement opportunities scored relatively low, suggesting areas where improvements are needed. This aligns with research by Halbesleben and Rathert (2008), who found that job satisfaction among nurses is often influenced by factors like compensation, work environment, and recognition.

The relatively higher satisfaction scores for factors like recognition from superiors and compensation for working weekends are promising, yet the lower scores for salary and benefits package indicate significant areas for improvement. Similar findings are reported by Hayes et al. (2006), who found that while some aspects of job satisfaction are positively perceived, others, particularly financial compensation and career advancement, often receive lower satisfaction ratings.

This consistent with Three studies in Saudi Arabia reported moderate satisfaction among the nurses in their sample populations (Alharbi et al., 2016; Alshahrani & Baig, 2016; Mari et al., 2018), and one reported overall low satisfaction among the nurses

studied who worked in adult ICUs, with the lowest satisfaction related to pay (Muhawish et al., 2019). While study indicated high levels of job satisfaction (Alasmari and Douglas, 2012).

4.4 Factors that affect level of Burnout, stress and job satisfaction

The inferential statistics reveal several significant relationships between demographic factors, burnout, stress, and job satisfaction. For example, burnout and stress increase with age, while job satisfaction decreases. This is consistent with findings from other studies that show older nurses often experience higher levels of burnout and lower job satisfaction (Morse et al., 2021). The association between higher burnout and stress among nurses with more experience in intensive care is also supported by literature, This result aligns with the meta-analysis performed by Gómez-Urquiza et al. (2017), which compiled data from 51 research (48% conducted in Europe, 31% in America, and 21% in Asia). The collective findings of these research indicate that older nurses are particularly susceptible to experiencing burnout. This observation may be attributed to the physically and mentally demanding nature of working in the intensive care unit (ICU). Also Nurses with significant experience in the intensive care unit (ICU) are more likely to feel burnout and have a desire to quit their job due to extended work-related stress (Abumayyaleh et al., 2016; Batran, 2019). Other studies found that younger nurse and more burnout in ICU, One potential reason for these conflicting results is that they were obtained from separate research with distinct subjects. Every participant possesses distinct intrapersonal qualities that can influence an individual's reaction to stress and their methods of dealing with it. Longitudinal research examining the association between a diminished feeling of well-being and individual traits can help ascertain the impact of these contributing factors on various members of the nursing team. Longitudinal research can also aid in identifying the professional ramifications of burnout, including as patient outcomes, quality of care, safety, and cost. This discovery holds significant importance in identifying individuals who are at a heightened risk of burnout.

The findings related to job titles, where head nurses report the lowest burnout and highest satisfaction, contrast with studies by Spence Laschinger et al. (2016), which suggest that leadership positions can also be stressful. However, the current study's

findings may reflect differences in job roles and responsibilities specific to the critical care setting.

The impact of monthly income on burnout, stress, and job satisfaction is particularly noteworthy. Nurses earning less than 5000 NIS report the highest burnout and stress, aligning with research by Leiter and Maslach (2005), which highlights the role of financial compensation in influencing job satisfaction and stress levels among nurses. The higher satisfaction reported by those earning above 7000 NIS supports the notion that better financial compensation can mitigate some negative aspects of the nursing profession.

The results of this study are generally consistent with previous research on burnout, stress, and job satisfaction among nurses, though there are some variations. For instance, the moderate levels of burnout and stress reported here are in line with findings from studies by Aiken et al. (2022) and McVicar (2013). However, the specific factors influencing burnout and stress in the East Jerusalem context may differ from those in other regions due to cultural, economic, and institutional differences.

The study showing that nurses possessing specialist certifications experience higher burnout and stress, although decreased satisfaction, contradicts certain literature indicating that extra qualifications typically enhance job satisfaction (Kovner et al., 2007). This gap may be due to the unique characteristics of critical care environments and the heightened demands linked to specialized positions.

4.5 Factors Contributing to Burnout, Stress, and Dissatisfaction in ICU Nurses

The present study identifies various elements that contribute to burnout, stress, and job dissatisfaction among ICU nurses in hospitals in East Jerusalem, allowing for a comparative analysis with prior research to gain a more thorough understanding of these dynamics.

The study discovers that increased workload and demanding patient care requirements as major factors contributing to burnout and stress among ICU nurses. This conclusion aligns with the research that regularly identifies excessive workload as a significant stressor in critical care settings (McVicar, 2003; Li et al., 2019). The rigorous demands of ICU care, characterized by extended shifts, elevated patient acuity, and the necessity

for constant monitoring, substantially lead to emotional fatigue and burnout (Leiter & Maslach, 2009). Nevertheless, certain research, including those by Aiken et al. (2002), indicate that workload alone does not entirely explain burnout and stress, suggesting that additional factors may also be significant.

Using the three burnout factors, the current study establishes that perceived lack of organisational support, and a demanding work environment worsens burnout and job dissatisfaction. On this account, Spence Laschinger et al., (2016) suggested that perceived lack of management support and insufficient resources are major precursors to job dissatisfaction and burnout. On the other hand, other research conducted by Halbesleben and Rathert (2008) observe that organisational support can reduce stress and increase satisfaction with work. This difference might be linked to conditions of working in the organizational and cultural environment of ICU nurses.

As a result of this research it is shown that less monetary incentives make nurses in the ICU dissatisfied with their jobs. In agreement with Hayes et al., (2016), the study shows that low pay is one of the reasons that lead to job dissatisfaction and fatigue. The lower actual mean scores on the dimension of salary and benefits in this study are in parity with the other studies which identified that actual financial benefits of the job bear a direct relationship to job satisfaction. However, one study reveals evidence that pay satisfaction does not explain job satisfaction in its totality (Kovner et al., 2017), and notes other factors such as, work-life balance, and many other factors that are equally important.

Exploring practical organizational workplace factors, the current study reveals that career progression are negatively related to burnout and stress. This is equally in support with Needleman et al., (2023) who declare job strain, bio psychosocial impairment and job burnout as the consequences of career stagnation. Contrary to this, as García-Caro et al., (2021) pointed out, it was found that greater number of qualifications and certifications tends to improve job satisfaction and decrease burnout. This discordance may partly be explained by variations in the ways that continuing professional development initiatives are perceived and enacted across health care sectors.

The study's results emphasize work-life balance as a vital determinant of burnout and job satisfaction. This aligns with the findings of Coomber and Barriball (2017), who

recognize inadequate work-life balance as a significant factor in stress and burnout among nurses. The rigorous schedules and emotional strain of ICU nursing frequently result in challenges in achieving a healthy work-life balance, hence increasing burnout and dissatisfaction levels. Nonetheless, certain research indicate unequal effects of work-life balance on job satisfaction (McVicar, 2013), implying that individual and environmental factors may differentially affect these results.

The study highlights the emotional and psychological effects of managing critically ill patients and high-stress scenarios, which substantially lead to burnout and stress. This discovery corresponds with the findings of Morse et al. (2023) and Nantsupawat et al. (2016), which indicate that the emotional toll of patient care and exposure to distressing circumstances are significant contributors to burnout among ICU nurses. Nevertheless, certain studies indicates that personal resilience and coping mechanisms can alleviate these effects (Spence Laschinger et al., 2016), suggesting that individual variances may affect the experience and management of emotional stress.

The current study reveals that head nurses experience reduced burnout and increased job satisfaction, which contradicts some studies indicating that leadership positions can be significantly stressful (Spence Laschinger et al., 2016). This mismatch may arise from differences in leadership styles, support systems, and duties among various institutions. Effective leadership and management strategies, including proper support and a healthy work environment, are essential for reducing burnout and improving job satisfaction (Halbesleben & Rathert, 2018).

4.6 Implications for Practice

The study's results have multiple practical ramifications. Initially, focused interventions are necessary to mitigate burnout and stress among nurses, especially in critical care units. Implementing strategies such as offering emotional support, increasing work circumstances, and expanding professional development opportunities may alleviate burnout and increase job satisfaction (García-Caro et al., 2021; Li et al., 2019).

Enhancing financial remuneration and perks is essential, since the current study underscores the influence of cash on job satisfaction. Providing competitive pay and sufficient perks may improve job satisfaction and decrease turnover rates among nurses (Hayes et al., 2016).

Moreover, mitigating factors that contribute to elevated stress and burnout among seasoned nurses, particularly those in critical care, could enhance their general well-being. Customizing interventions to address the distinct requirements of these groups, including the provision of supplementary assistance and resources, could prove advantageous (Morse et al., 2023; Nantsupawat et al., 2016).

4.7 Recommendations for Future Research

1. Longitudinal Studies on Burnout Trajectories to Investigate how burnout evolves over time in nurses working in protracted conflict zones, particularly during acute crises (e.g., escalations in the Gaza War). Track the interplay between political instability, resource shortages, and mental health outcomes to identify critical intervention windows.

2. Cross-Conflict Comparative Analyses Compare burnout drivers and resilience strategies among ICU nurses in Palestine, Gaza, Syria, and Ukraine to identify universal vs. context-specific stressors. Such studies could inform adaptable frameworks for humanitarian healthcare systems.

3. Studies on Structural Inequities and Policy Impacts: Examine how political policies (e.g., blockades, checkpoint restrictions) directly exacerbate burnout by limiting medical supplies, staff mobility, and patient access. Partner with NGOs to assess the efficacy of advocacy campaigns for healthcare equity.

4. Leadership and Role-Specific Burnout Mitigation: Investigate why head nurses in East Jerusalem reported lower burnout despite high systemic stress. Identify transferable leadership practices (e.g., participatory decision-making, advocacy training) that could buffer burnout in junior staff.

5. Mixed-Methods Research on Workforce Retention: Combine quantitative data on turnover rates with qualitative insights into why nurses stay in high-stress environments despite risks. Explore the role of community solidarity, religious/cultural resilience, and humanitarian.

6. Impact of Training and Certification Gaps: Evaluate how the lack of specialty certifications (reported by 61.5% of nurses) affects competency confidence and

burnout. Test the impact of subsidized critical care training programs on workload management and stress reduction.

4.8 Conclusion

This study offers a thorough examination of burnout, stress, and job satisfaction among nurses in critical care units inside hospitals in East Jerusalem. The findings correspond with numerous elements of the current research, while also emphasizing distinct geographical factors that affect the experiences of these healthcare providers. Implementing targeted interventions and conducting further research to address the identified difficulties can enhance nurses' well-being and job satisfaction, hence improving the quality of patient care.

Lis of Abbreviation

Abbreviation	Meaning
AACN	American Association of Critical-Care Nurses
CCSC	Critical Care Societies Collaborative
CMS	Centers for Medicare and Medicaid Services
ICU	Intensive Care Unit
JSS	Job Stress Scale
MBI	Maslach Burnout Inventory
MMSS	Mueller/McCloskey Nurse Job Satisfaction Scale
NIS	New Israeli Shekel
PSS	Perceived Stress Scale
RNs	Registered Nurses
SPSS	Statistical Package for the Social Sciences

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Appendices

Appendix A

Data Collection Sheet

جامعة النجاح الوطنية – نابلس

كلية الدراسات العليا – ماجستير تمريض العناية المكثفة

تحية طيبة وبعد،،،

يقوم الباحث بإعداد دراسة حول موضوع " مستوى التوتر والضغط النفسي المرتبط بالاحتراق الوظيفي وأثرها على الرضا الوظيفي لدى الممرضين العاملين في وحدات العناية الحرجة في مستشفيات القدس الشرقية " لقد تم اختياركم لتكونوا جزءا من عينة الدراسة بطريقة عشوائية، لذا نضع بين أيديكم هذه الاستبانة راجين تقديم المساعدة،وذلك بالإجابة عن فقرات الاستبانة بدقة وموضوعية لما له اثر كبير في الحصول على نتائج ايجابية،علماً بان كل ما يرد في إجابتكم سيكون موضع احترام وسوف يعامل بسرية تامة ولن يستخدم إلا لأغراض البحث العلمي فقط ، وعليه لا داعي لكتابة الاسم أو أيه معلومات تدل على شخصكم الكريم.

- **يُرجى الإجابة على الأسئلة بناءً على تجربتك ومشاعرك الشخصية**
- **الرجاء تحديد الخيار الأنسب لك بجانب كل عبارة.**

ملاحظة:

- **تأكد من الإجابة على جميع الأسئلة.**
- **إجاباتكم ستساعدنا في فهم التحديات التي قد تواجهكم في العمل وتحسين بيئة العمل لكم ولزملائكم.**

أن فريق البحث على استعداد لتزويدكم بنتائج هذه الدراسة في حال الطلب مع الشكر الجزيل لتعاونكم.

وللاستفسار يمكنكم الاتصال على تلفون رقم:

فريق البحث: ايمن الدرابيع

تحت إشراف: : د. ايمان الشاويش

شاكرين لكم حسن تعاونكم

الجزء الاول: معلومات عامة عن المشارك:

العمر: .....

الجنس: ☐ ذكر ☐ انثى

مكان السكن : ☐ مدينة ☐ مخيم ☐ قرية

المستوى التعليمي: ☐ دبلوم ☐ بكالوريوس ☐ دبلوم عالي او ماجستير

المسمى الوظيفي: ☐ ممرض مؤهل ☐ ممرض قانوني ☐ نائب رئيس قسم ☐ رئيس قسم

الحالة الاجتماعية: ☐ اعزب ☐ متزوج ☐ مطلق ☐ ارمل .

عدد سنوات الخبرة في مجال التمريض:.....

عدد سنوات الخبرة في مجال تمريض العناية المكثفة:.....

عدد ساعات العمل في الأسبوع (متوسط) :.....

عدد المرضى الذين تكون مسؤول بشكل مباشر عن تقديم الرعاية لهم:.....

الدخل الشهري : ☐ اقل من 5000 شيكل ☐ 5000 – 7000 شيكل ☐ اعلى من 7000 شيكل

طبيعة العمل: ☐ وردية صباحية فقط ☐ اعمل بنظام الورديات

هل لديك شهادات متخصصة أو تدريب إضافي في مجال العناية المكثفة؟ ☐ نعم ☐ لا

. اذا كانت الإجابة نعم : اذكرها .....

الجزء الثاني: مقياس الاحتراق الوظيفي

- الاحتراق الوظيفي

وردت تعريفات كثيرة لمصطلح الاحتراق الوظيفي في الأبحاث والدراسات التي تناولت هذه الظاهرة ولكن بالرغم بعض الاختلافات بين هذه التعريفات إلا أن هناك نقاطاً تجمع عليها معظم الباحثين؛ وهي أن الاحتراق الوظيفي عبارة عن خبرة نفسية سلبية داخلية تتضمن المشاعر والاتجاهات والدوافع وتشمل استجابات سلبية وغير ملائمة نحو الغير ونحو الذات

الرجاء الإجابة عن الأسئلة التالية بما يتناسب مع شعورك.

صفر	1	2	3	4	5	6
لا أعاني مطلقاً	مرات قليلة بالسنة	مرة قليلة بالشهر	مرات قليلة بالشهر	مرة في كل أسبوع	مرات قليلة بالأسبوع	كل يوم

	العبارة	0	1	2	3	4	5	6
1	أشعر أن عملي يستفذني انفعاليًا							
2	أشعر أن طاقتي مستنفذة مع نهاية اليوم							
3	أشعر بالإنهاك حينما استيقظ في الصباح وأعرف أن علي مواجهة عمل جديد							
4	من السهل معرفة مشاعر المرضى في القسم							
5	أشعر أنني أتعامل مع بعض المرضى وكأنهم أشياء لا بشر							
6	إن التعامل مع المرضى طوال يوم العمل يسبب لي الإجهاد							
7	أتعامل بفعالية عالية مع مشاكل المرضى							
8	أشعر بالاحتراق النفسي من عملي							
9	أشعر أن لي تأثيرًا إيجابيًا في حياة كثير من الناس من خلال عملي							
10	أصبحت أكثر قسوة مع الناس نتيجة عملي بالتمريض							
11	أشعر بالإزعاج والقلق لأن مهنتي تزيد من قسوة عواطفي							
12	أشعر بالحيوية والنشاط							
13	أشعر بالإحباط من ممارستي لمهنة التمريض							
14	أشعر أنني أعمل في هذه المهنة بإجهاد كبير							
15	حقيقة لا أهتم بما يحدث مع المرضى من مشاكل							
16	إن العمل بشكل مباشر مع المرضى يودي بي إلى ضغوط شديدة							
17	أستطيع بسهولة خلق جو نفسي مريح اثناء عملي مع المرضى							
18	أشعر بالسعادة والراحة بعد انتهاء العمل مع المرضى							

	العبارة	0	1	2	3	4	5	6
19	أنجزت أشياء كثيرة ذات قيمة وأهمية في ممارستي لهذه المهنة							
20	أشعر وكأنني أشرفت على النهاية نتيجة ممارستي لهذه المهنة							
21	أتعامل بكل هدوء مع المشاكل الانفعالية والعاطفية في أثناء ممارستي لهذه المهنة							
22	أشعر أن المرضى يلومونني عن بعض مشاكلهم							

الجزء الثالث: مقياس الإجهاد المدرك

هو أداة شائعة لقياس الضغط النفسي يتم فيه تقييم المواقف في حياة الشخص وطريقة الاستجابة لها ومدى التأثر بها، وقد ارتبطت المستويات المرتفعة من الإجهاد النفسي بعلامات مرتفعة للشيخوخة ومستويات أعلى من الكورتيزول وقابلية أكبر للإصابة بالأمراض المعدية وتباطؤ التئام الجروح، ونظرًا الى أن مستويات الإجهاد تتأثر بالمتاعب اليومية والأحداث الكبرى بالحياة فإن التنبؤ بها ينخفض بسرعة بعد أربع إلى ثمانية أسابيع.

سوف يتم سؤالك في هذا المقياس عن مشاعرك وأفكارك خلال الشهر الماضي، في كل حالة سيطلب منك الإشارة إلى عدد المرات التي شعرت فيها أو فكرت بطريقة معينة، و سيكون مقايس الاختيار كما يلي :

(0): ولا مرّة

(1): أقل من نصف الأيام

(2): أكثر من نصف الأيام

(3): تقريبًا كل الأيام

(4): كثيرًا جدًا

خلال الشهر الماضي، كم مرة كنت تعاني من؟

	العبارة	0	1	2	3	4
1	مستاء بسبب شيء حدث بشكل غير متوقع					
2	شعرت أنك غير قادر على السيطرة على الأشياء المهمة في حياتك؟					
3	شعرت بالعصبية(التوتر)؟					
4	شعرت بالثقة حيال قدرتك على التعامل مع مشاكلك الشخصية؟					
5	شعرت أن الأمور تسير في مصلحتك؟					
6	وجدت أنك لا تستطيع التعامل مع كل الأشياء التي كان عليك القيام بها؟					
7	هل استطعت التحكم بالمشاكل في حياتك؟					
8	شعرت أنك تسيطر على الأمور؟					
9	غضبت بسبب أشياء كانت خارجة عن إرادتك؟					
10	شعرت أن الصعوبات كانت تتراكم بشكل كبير وأنك لا تستطيع التغلب عليها؟					

الجزء الرابع: مقياس الرضى الوظيفي

صفر	1	2	3	4	5
لا أرغب في الرد	غير راضٍ جدا	غير راضٍ بشكل قليل	محايد	راضٍ بشكل قليل	راضي بشكل كبير

	العبارة	0	1	2	3	4	5
1	الراتب						
2	الإجازة						
3	حزمة الفوائد (التأمين، التقاعد، المكافئات)						
4	عدد ساعات العمل						
5	مرونة جدولة الورديات						
8	عدد أيام العطل الأسبوعية						
9	مرونة جدولة عطلاتك الأسبوعية						
10	التعويض عن العمل في ايام عطلة نهاية الأسبوع والعطلات الرسمية						
11	مدة الإجازة الأمومة (للام) ومرافقة رعاية الطفل (للاب)						
13	مشرفك المباشر						
14	زملاؤك في مجال التمريض						
15	الأطباء وباقي المهن الطبية الذين تعمل معهم						
16	طريقة تقديم الرعاية المستخدمة في وحدتك (على سبيل المثال، وظيفي، فريق، أساسي)						
17	فرص التواصل الاجتماعي في العمل						
	فرص التفاعل المهني مع تخصصات أخرى						
	فرص التفاعل مع أعضاء اللجان (البحث العلمي/ مكافحة العدوى ...)						
	فرص الانتماء إلى اللجان الإدارية والمؤسسية						
	السيطرة على ما يحدث في بيئة عملك						
	فرص التقدم المهني						
	التقدير لعملك من الرؤساء						
	التقدير لعملك من الزملاء						
	كمية التشجيع والتغذية الإيجابية						
	كمية المسؤولية لديك						
	السيطرة الخاصة بك على ظروف العمل						

	العبارة	0	1	2	3	4	5
	مشاركتك في اتخاذ القرارات التنظيمية						
	فرص التطوير المهني والتدريب						
	بيئة وظروف مكان العمل						
	القوانين واللوائح المتبعة						
	اتخاذ القرارات المتعلقة بالعمل						
	التوازن بين عدد الممرضين وحجم العمل						
	الدعم النفسي المتاح للممرضين						
	الأدوات والمعدات الطبية المتاحة						

شكراً لك على وقتك وتعاونك في الإجابة على هذه الأسئلة. تقديرك لتجربتك في بيئة العمل سيساعد في تطويرها وتحسينها للممرضين الآخرين.

جـامعـــة النجاح الوطنية

كليـــة الدراســـات العليـــا

الضغط النفسي، الإحتراق الوظيفي، والرضا الوظيفي لدى ممرضي العناية الحرجة في مستشفيات القدس الشرقية

إعداد

أيمن درابيع

إشراف

د. إيمان الشاويش

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجة الماجستير في تمريض العناية المكثفة، من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس– فلسطين.

2024

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الملخص

المقدمة: يعتبر الاحتراق الوظيفي والتوتر النفسي وعدم الرضا الوظيفي من التحديات الشائعة التي تواجه ممرضي العناية الحرجة، مما يؤثر سلبًا على رفاهيتهم وجودة الرعاية المقدمة للمرضى. تهدف هذه الدراسة إلى تقييم هذه القضايا في مستشفيات القدس الشرقية.

الهدف: تقييم مستويات التوتر النفسي، الاحتراق الوظيفي، والرضا الوظيفي لدى ممرضي العناية المكثفة في المستشفيات العربية في القدس – فلسطين.

المنهجية: أجريت دراسة وصفية مقطعية شملت أربعة مستشفيات رئيسية في القدس الشرقية: مستشفى المقاصد، مستشفى سانت لويس الفرنسي، مستشفى أوغستا فيكتوريا، ومستشفى جمعية الهلال الأحمر. تم مسح عينة مكونة من 195 ممرضًا في وحدات العناية المكثفة باستخدام مقاييس: مقياس ماسلاش للاحتراق الوظيفي (MBI)، مقياس التوتر الوظيفي (JSS)، ومقياس مولر/ماكلوسكي للرضا الوظيفي (MMSS) تم جمع البيانات خلال الفترة من 1 مايو 2024 إلى 30 يوليو 2024، وتم تحليلها باستخدام برنامج SPSS 25. أظهرت الدراسة مستويات ملحوظة من الاحتراق الوظيفي المعتدل (79%) والتوتر (75.9%)، مع انخفاض عام في الرضا الوظيفي (المتوسط = 5/2.9)، مدفوعة بعوامل مثل العمر المتقدم، الأعباء المرضية العالية (3< مرضى)، الدخل المنخفض (5000< شيكل)، ومحدودية الاستقلالية. كما أظهرت العلاقة الإيجابية القوية بين الاحتراق الوظيفي والتوتر ($r = 0.552$)، والعلاقة

العكسية مع الرضا الوظيفي (r = -0.485 إلى −0.496). أفاد الممرضون في الأدوار القيادية بمستويات أقل من الاحتراق والتوتر، مما يبرز أهمية الدعم الهيكلي كعامل وقائي.

الاستنتاج: تؤكد هذه الدراسة على التحديات المهنية المنتشرة التي يواجهها ممرضو وحدات العناية المكثفة في القدس الشرقية، حيث أظهر 79% منهم احتراقًا وظيفيًا معتدلًا و75.9% توترًا، مع انخفاض واسع في الرضا الوظيفي (المتوسط = 5/2.9). شملت العوامل الرئيسية المؤثرة ارتفاع أعداد المرضى (>3 مرضى)، الدخل المنخفض (<5000 شيكل)، وقلة الاستقلالية. برزت الأدوار القيادية كعامل وقائي، مما يشير إلى أهمية الدعم الهيكلي. تؤكد النتائج على الحاجة الملحة لتدخلات منهجية مثل توزيع الأعباء بشكل عادل، تحسين الأجور، وتعزيز المشاركة في اتخاذ القرار لتخفيف الضغط المهني، مما يعزز رفاهية الممرضين وجودة الرعاية في بيئات مثل القدس الشرقية التي تعاني من شح الموارد.

الكلمات المفتاحية: تمريض العناية المكثفة، الاحتراق الوظيفي، التوتر النفسي، الرضا الوظيفي، مستشفيات القدس الشرقية.