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Physical Stigma and its Relationship to Psychological Immunity among People with Disabilities

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Abstract:

The current research aims to:

1. Identify physical stigma among people with physical disabilities.
2. Identify the significance of differences in physical stigma according to gender (males - females).
3. Identify psychological immunity among people with physical disabilities.
4. Identify the significance of differences in psychological resilience according to the gender variable (males - females).
5. Identify the nature of the relationship between physical stigma and psychological resilience.

The current research sample was limited to (157) male and female students with physical disabilities. The researchers prepared a tool to measure physical stigma, with (28) items in its final form, and another tool to measure psychological resilience, with (30) items. Psychometric characteristics of validity and reliability were extracted for these tools. After applying the tools, the results showed the following:

1. The results showed that individuals with physical disabilities suffer from a high level of physical stigma compared to the expected level.
2. The results indicated no significant difference in physical stigma according to gender, as the average for males was close to the average for females.

3. The results showed that the level of psychological resilience among individuals with physical disabilities falls within the expected level, with no significant differences.
4. The results showed a statistically significant difference in favor of males. This indicates that males enjoy higher levels of psychological resilience than females.
5. The results showed a strong and statistically significant correlation between physical stigma and psychological resilience. This indicates that high levels of physical stigma are clearly associated with the level of psychological resilience among individuals with physical disabilities.

Keywords: physical stigma, psychological resilience, individuals with physical disabilities.

Chapter One

Introduction to the Research

Research Problem:

The stigma of physical disability is one of the most prominent challenges facing individuals with disabilities, as they are subjected to social stigma resulting from negative stereotypes associated with disability. (Goffman ,1963: 4) defines stigma as a "shameful" trait that attaches to an individual and diminishes their full identity in the eyes of others. This stigmatizing perception leads individuals with physical disabilities to suffer from feelings of inadequacy, loss of self-esteem, social isolation, and a sense of inferiority, as confirmed by numerous studies in the fields of psychology and sociology (Corrigan & Watson, 2002: 17). Recent studies indicate that disability stigma is not merely an external social phenomenon; it may also permeate the individual internally, in what is known as "self-stigma," whereby individuals internalize the negative stereotypes directed at them by society and make them part of their self-perception (Watson et al., 2007: 132). This pattern of internalized stigma leads to decreased motivation, deteriorating mental health, and a diminished quality of life, especially in the absence of positive coping skills and social support.

Psychological resilience is one of the most important psychological variables that enables an individual to adapt to stress and trauma, helping them maintain emotional and psychological balance despite the challenges they face in their social or physical environment (Masten, 2014: 3). Interest in this concept has grown in recent decades, particularly among individuals suffering from difficult circumstances or health challenges such as physical disabilities, given its role in promoting mental health and combating feelings of stigma and marginalization. Psychological resilience is a central concept in positive psychology, defined as the ability to "recover and bounce back" after experiencing traumatic or stressful experiences, while maintaining an acceptable level of psychological and functional functioning (Masten, 2014: 3). This resilience is a protective factor that contributes to mitigating the negative effects of stress and helps individuals use positive coping strategies, rather than falling into cycles of depression, withdrawal, or anxiety disorders. Considering groups suffering from stressful psychological and social conditions, such as individuals with physical disabilities, enhancing this type of resilience represents an urgent psychological and educational necessity. Here, the importance of psychological resilience emerges as a potential factor in reducing the negative effects of physical stigma. Some researchers believe that individuals with high levels of psychological resilience are better able to reject stereotypes, resist feelings of shame, and reshape their identity based on their own values rather than the assessments of others (Smith et al., 2008: 226). Psychological resilience also helps one adopt effective coping strategies such as cognitive reappraisal, acceptance, and seeking social support (Connor & Davidson, 2003: 79).

However, a review of the literature reveals a knowledge gap in understanding the interactive relationship between psychological resilience and physical stigma, particularly in Arab cultural contexts where negative perceptions of disability are prevalent. A limited number of studies appear

to have directly addressed this topic, indicating the need for research that links the two concepts with the aim of developing explanatory models that can be used in future psychological and educational interventions.

Thus, the current research problem is defined as seeking to understand the nature of the relationship between psychological resilience and the level of physical stigma among individuals with physical disabilities.

Significance of the Research:

Physical stigma is considered one of the most significant negative factors affecting the psychological and social quality of life of people with motor disabilities. Physical stigma is represented by the stereotypes and prejudices that society forms toward those who appear physically different, and the resulting discrimination, marginalization, or feelings of deficiency and inferiority among stigmatized individuals (Goffman, 1963). According to social psychology literature, stigma is a factor that contributes to undermining self-esteem, increasing feelings of anxiety and depression, and impairing individuals' social interaction, leading to social withdrawal and decreased participation in various areas of life (Corrigan et al., 2005.)

On the other hand, physical stigma is a social and psychological phenomenon that profoundly impacts the quality of life of individuals with visible physical disabilities or deformities. (Goffman, 1963: 4) suggests that physical stigma leads to an individual being labeled as "deficient," and thus treated negatively by society, affecting their self-esteem and sense of social belonging. Recent studies have shown that individuals who suffer from physical stigma are more likely to experience anxiety, depression, and social isolation (Werner & Shulman, 2013: 124).

Physical stigma is a form of social prejudice experienced by individuals who possess physical characteristics deemed socially unacceptable, such as disabilities, deformities, or obesity. Erving Goffman (1963) classified this type of stigma under what he called "body abnormalities," which fall within the three categories of stigma. These stigmas refer to physical deviations that distinguish individuals from others, leading to a perceived inferiority complex and the loss of a complete social identity (Goffman, 1963: 4). Studies indicate that individuals with severe obesity or visible skin conditions often experience discrimination in social, educational, and professional settings, and are perceived as less capable or less committed. The results of an analytical study published in the Encyclopedia of Body Appearance confirm that physical appearance, particularly excess weight, is often associated with negative stereotypes that impact the psychological health of those affected, such as anxiety and depression (Puhl & Gloor, 2012: 613).

A recent study of young women suffering from obesity or psoriasis showed that the overweight group was more likely to experience stigma, and participants expressed an internalized sense of stigma and its impact on their self-confidence, compared to the group suffering from a skin condition. This study confirms that the source of stigma is not the disorder itself, but rather society's perception and the individual's assumption of responsibility for their condition (Mazurkiewicz et al., 2021: 319). In a literature review on visible skin conditions, Germain explained that people with visible skin conditions face psychological and social stigma, which can lead to feelings of shame and isolation, negatively impacting their quality of life. She added that this type of stigma is linked to several psychological mechanisms, most notably "self-stigma" and "cognitive discrimination" (Germain, 2021: 2020)

A mixed-methods analysis study confirms that appearance-related anxiety is widespread among those suffering from visible skin conditions such as acne or alopecia. This anxiety leads to significant social isolation, hinders positive interactions in personal relationships, and increases the likelihood of developing chronic psychological disorders such as social anxiety (Peltzer et al., 2022: 6).

The concept of psychological resilience is a modern psychological concept that has received increasing attention in recent decades, given its pivotal role in empowering individuals to cope with stress and crises and overcome psychological and social difficulties. Psychological resilience is the individual's ability to adapt positively to difficult life situations, be flexible in responding to stress, and maintain a degree of emotional and cognitive balance in the face of crises (Masten, 2001). Psychological resilience is particularly important for groups most vulnerable to psychological and social stress, including those with motor disabilities, who face multiple challenges at the personal, social, and environmental levels. Psychological resilience is defined as a combination of the ability to recover, adapt, and bounce back from trauma. It is understood as a dynamic process dependent on internal and external factors (personal, social, and environmental). Most studies indicate that building resilience involves developing social support, self-efficacy, emotional regulation, and the ability to think resiliently. This helps individuals cope with stress and transform negative experiences into opportunities for personal growth.

In an analysis of psychological resilience factors in AIDS patients and advanced burn survivors, it was found that psychological resilience is associated with protective factors such as social support, self-efficacy, and emotional regulation behavior. It was also found that individuals with high psychological resilience were less susceptible to anxiety, depression, and stress resulting from health or social circumstances (Masten, 2001:227). Al-Hanawi's (2018) study is one of the important studies that addressed psychological resilience among university students. It aimed to uncover the relationship between psychological resilience and quality of life among a sample of (300) male and female students from Ain Shams University. The researcher used the descriptive correlational approach, and the results revealed a positive and statistically significant correlation between psychological resilience and quality of life. No significant differences were found attributable to the gender variable (Al-Hanawi, 2018: 45). Al-Ani's (2017) study shed light on the relationship between psychological resilience and psychological adjustment among middle school students. The study was conducted on a sample of (180) students in Baghdad Governorate. The researcher used the descriptive predictive approach, and the results revealed a positive and statistically significant correlation between psychological resilience and psychological adjustment. The study also demonstrated that psychological resilience is a strong predictor of psychological adjustment among adolescents (Al-Ani, 2017: 38). Al-Saadi's study focused on (2020) focused on a specific group of students, addressing psychological resilience among university students with chronic illnesses. It sought to uncover their level of psychological resilience and the impact of gender. The sample included (150) male and female students from a number of Iraqi universities. The results showed that students enjoyed an average level of psychological resilience, and there were no statistically significant differences between males and females (Al-Saadi, 2020: 60.(

Al-Ajmi's study (2021) focused on teachers, aiming to identify the level of psychological resilience and its relationship to psychological resilience among a sample of (200) Kuwaiti male and female teachers in intermediate school. The study relied on the descriptive correlational approach, and the results showed a statistically significant direct relationship between psychological resilience and psychological resilience. It also revealed no differences in psychological resilience based on gender, while there were differences in favor of teachers with extensive experience (more than 10 years). (Al-Ajmi, 2021: 82(

These two intersect. The two phenomena—psychological immunity and physical stigma—are relevant to people with motor disabilities. The degree of physical stigma an individual experiences is expected to influence their level of psychological resilience. The literature indicates that feelings of stigma, and repeated exposure to discrimination, pity, or negative perceptions from others, can erode individuals' psychological coping and resilience, making them more vulnerable to psychological collapse when faced with stress (Link & Phelan, 2001). On the other hand, a high level of psychological immunity may serve as a protective factor that mitigates the effects of

physical stigma, enables individuals to deal positively with negative societal perceptions, and enhances their self-confidence and social interaction.

Despite the importance of this interactive relationship between psychological immunity and physical stigma, Arab studies addressing this topic—particularly among people with motor disabilities—remain limited and fragmented, often focusing on one variable over the other. It has been noted that much Arab research has addressed motor disability from a medical or functional perspective, neglecting the deeper psychological and social aspects that impact the lives of individuals with disabilities. The concept of psychological immunity is still relatively new in the Arab world and requires further study and analysis in different cultural and societal contexts.

Despite numerous studies that have addressed both psychological immunity and physical stigma separately, the relationship between them has not received sufficient attention in the literature, particularly in the Arab context. Some literature suggests that psychological immunity may contribute to reducing the effects of physical stigma by enhancing coping strategies, developing internal resilience, and helping individuals rebuild their identity away from stereotypes (Smith et al., 2008: 226.(

In this context, there is a need to study the relationship between psychological immunity and physical stigma among individuals with physical disabilities. This is to determine whether psychological immunity represents a protective factor that reduces the negative effects of physical stigma, thereby enhancing their psychological and social well-being. Hence, the importance of the current research in attempting to explore the relationship between psychological immunity and physical stigma, and the extent to which psychological immunity can predict the level of stigma among people with physical disabilities.

Research Objectives:

The current research aimed to:

1. Identify physical stigma among the physically disabled.
2. Identify the significance of differences in physical stigma according to the gender variable (males – females).
3. Identify psychological resilience among the physically disabled.
4. Identify the significance of differences in psychological resilience according to the gender variable (males – females).
5. Identify the nature of the relationship between physical stigma and psychological resilience.

Research Limits:

The current research is limited to students with physical disabilities at government institutes (Al-Saada and Al-Manar) for the 2024-2025 academic year, of both genders (males – females).

Defining Terms

First: Physical Stigma and its subsequent definitions

Goffman (1963) defined it as "a discriminatory characteristic that leads to a person's social devaluation. Physical stigma is included among what he calls 'physical handicaps,' which include physical deformities or impairments." (Goffman, 1963:12-13)

Crandall (1995) defined it as "physical illness may be a source of social stigma and rejection from others. The intensity of this rejection increases depending on the severity of the illness or its association with behaviors believed to be under the individual's control." (Crandall, 1995:63)

Crocker et al. (1998) defined it as "a social characteristic or identity that makes a person vulnerable to negative judgment and rejection in a social context. This includes visible physical characteristics." (Crocker et al., 1998:504-553) The Cambridge Handbook (2014) defines stigma as "a negative evaluation and low regard for a person due to a physical or health characteristic that results in a loss of social status".

The researchers adopted Goffman's (1963) theoretical definition, while the operational definition is the score the respondent receives on the physical stigma scale developed in the current research.

Second: Psychological resilience: This has been defined by several definitions, including Michael Rutter's (1987) definition: "It is a complex interaction between the individual and their surrounding environment, enabling them to reduce the negative effects of stressful situations and adapt to them" (Rutter, 1987: 320).

Luthar & Cicchetti (2000) defines resilience as "a dynamic process involving the interaction of risk and protective factors that leads to positive outcomes despite serious threats to growth or adaptation" (Luthar & Cicchetti, 2000:546).

Connor & Davidson (2003) defines resilience as "the ability to adapt successfully to adversity and psychological stressors. It is a dynamic trait that can be enhanced through experience. It refers to the positive response of individuals despite difficult circumstances or threats" (Connor & Davidson, 2003:77).

Olath (2005) defines resilience as "an integrated psychological structure that includes a set of psychological abilities and processes that enable an individual to cope with psychological stress and adapt to difficult situations. This system includes mechanisms such as optimism, self-confidence, self-control, and social skills, all of which act as a psychological defense mechanism to maintain internal balance and resilience in the face of stress." Bolton et al.'s definition (Bolton et al., 2007): "The ability to maintain or quickly restore psychological balance after exposure to shock or severe psychological stress, using available individual or social resources." (Bolton et al., 2007: 514)

The researchers adopted Olath's (2005) definition as a theoretical definition, while the operational definition is the score the respondent receives on the psychological resilience scale developed in the current study.

Third: The physically disabled. He introduced several definitions, including:

Turki (1988): "Any person who does not have the full ability to perform one or several basic activities of normal life as a result of an injury to their sensory, mental, or motor functions, an injury they were born with or sustained after birth." (Turki, 1988: 55)

Al-Rousan (2001): "These are cases of individuals who suffer from some defect in their motor ability or motor activity." Such a defect affects their mental, social, and emotional development, necessitating special education (Al-Rusan, 2001: 269).

Chapter Two

Theoretical Framework and Previous Studies

A Historical Overview of Physical Stigma

Physical stigma is one of the oldest forms of social stigma known to humanity. It has historically been linked to cultural and religious concepts related to sin, impurity, and curse. The word "stigma" comes from ancient Greek and means "mark" or "brand," which was inscribed on the bodies of slaves, criminals, or deviants to distinguish them from others, preventing their social integration and isolating them from the group (Goffman, 1963: 11.(

In ancient times, especially in the Greek and Roman civilizations, physical deformities or disabilities were viewed as divine punishment, a sign of congenital weakness, or even moral

corruption. This view persisted into the Middle Ages, where religious interpretations deepened the association between physical disability and sin or demonic possession. This was reflected in societies' treatment of these individuals, as they were often hidden from view or isolated in private places (Gilman, 1988:. 14–17).

The modern era, specifically the nineteenth century, marked a gradual shift in the perception of physical disability, driven by the development of medical science and the rise of humanistic trends in Western thought. However, physical stigma continued in industrialized societies, but this time within the framework of a culture of "body normativity," which linked the normal body with social acceptance and the atypical body with rejection and discrimination (Davis, 1995: 25). At this stage, scientific discourse began to use terms such as "physical deviation" or "deformity" to categorize bodies that differed from the prevailing model.

The American sociologist Erving Goffman was among the first to lay the modern theoretical foundations for understanding physical stigma with his pioneering work, Stigma: Notes on the Management of a Degraded Identity (1963). Goffman distinguished between three types of stigma: physical stigma, personality stigma, and social stigma. He described physical stigma as "a physical mark used to demean and dehumanize a person" (Goffman, 1963: 12). He also noted that people with physical deformities face constant pressure to hide or compensate for their disability in a culture that glorifies the ideal body.

In recent decades, especially since the 1990s, a new critical discourse has begun to take shape within "Disability Studies," rejecting the reduction of physical disability to its medical dimension and emphasizing that social stigma is the product of cultural, economic, and political structures. This approach focuses on the role of society in producing stigma through discriminatory attitudes, the media, and prevailing beauty standards (Shakespeare, 2006: 57). Concepts such as "the other body" and "the stigmatized body self" have been used to analyze the psychological and social experiences of people with physical disabilities.

From a clinical psychology perspective, numerous studies have pointed to the profound psychological effects of physical stigma, including low self-esteem, increased levels of anxiety and depression, and difficulties in social adjustment. Addressing the effects of stigma has become an essential part of psychosocial rehabilitation programs, and therapeutic approaches have been developed that focus on rebuilding positive identities and dismantling stereotypes (Corrigan & Watson, 2002: 38.(

Thus, the evolution of the concept of physical stigma reflects major shifts in societal perceptions of the body, from a means of discrimination and isolation to a subject of critical analysis and empowerment. While stigma persists in many contexts, increased legal and societal awareness of the rights of people with physical disabilities has contributed to reducing its impact and pushing toward a more inclusive and respectful discourse of physical diversity. Theories Explaining Physical Stigma

Symbolic Interactionism Theory – Erving Kaufman

Symbolic Interactionism, presented by Erving Kaufman (1963), is one of the most important theoretical contributions to the analysis of physical stigma. Goffman views stigma as the product of social interaction that carries within it value categories that distinguish between "normal" and "deviant." When an individual is attributed a physical trait that is considered negative or culturally undesirable, they are stigmatized and treated as having a “distorted identity” (Goffman, 1963: 12). Kaufman demonstrated how those with physical stigma often resort to “impression management” in constant attempts to hide or explain their traits to others, producing a constant conflict between the social self and the private self. Kaufman asserts that social interaction is the means by which stigma is reproduced, as symbols, language, and behaviors are used to categorize individuals and determine their social value. Those with physical stigma often confront this situation with attempts at

impression management, that is, seeking to control how they are perceived, either by hiding, justifying, or reinterpreting the stigma to others. This leads to a constant conflict between the "social self," which is shaped according to societal expectations, and the "private self," which represents the individual's perception of themselves independent of the judgments of others.

The theory highlights how stigma is not simply a trait It is not an individual phenomenon, but rather a social process based on interaction and the production of meanings. This means that eliminating stigma requires a change in the symbolic and social structures that perpetuate these negative classifications (Goffman, 1963: 12.)

Social Prejudice Theory – Observable Attributes Theory

The Visible Attributes Theory explains how visible physical attributes—such as deformities or disabilities—influence the formation of prejudices. The theory suggests that physical attributes that are different from the norm activate social stereotypes, generating feelings of aversion, pity, or discrimination (Jones et al., 1984: 30). This theory suggests that the visibility, controllability, and source of the attribute are all decisive factors in the level of social stigma.

Cognitive Theory – The Explanatory Model of Stigma

The cognitive model focuses on the mental and cognitive processes individuals use to interpret the behavior and physical attributes of others. According to this perspective, individuals interpret disability or physical deformity as a sign of weakness or inability, activating preconceived cognitive frameworks that distort their perceptions of the stigmatized individual. This model also suggests that individuals who experience internalized physical stigma may develop "self-stigma," leading to low self-esteem and increased social anxiety (Corrigan & Watson, 2002: 17.)

Labeling Theory

This theory stems from critical sociology, particularly the work of Howard Becker. It argues that stigma stems not from a person's characteristics, but rather from society's reaction to those characteristics. When a description or label such as "disabled" or "deformed" is applied, it not only describes a physical condition but also produces social consequences that impose a negative social identity on the individual (Link & Phelan, 2001: 368). Researchers have expanded this concept into the bodily context to demonstrate how society reproduces stigma through institutions, language, media, and education, perpetuating marginalization and making social integration difficult.

5. Social Body Theory – A Postmodern Perspective

Postmodern studies, particularly within the framework of Social Body Theory, have offered a radical critique of traditional notions of bodily stigma. This theory argues that the body is not merely understood as a biological entity, but rather as a cultural and social product imbued with meaning (Shilling, 2012: 35). Physical stigma is viewed as a consequence of dominant discourses that define what is "acceptable," "beautiful," and "normal." In this context, people with physical disabilities face doubly exclusion not only because of their physical differences, but also because they challenge the standards of beauty, strength, and perfection perpetuated by the media and mainstream culture (Garland-Thomson, 2009: 155).

6. Social Exclusion Theory – A Contemporary Critical Perspective

This theory views physical stigma as a form of structural social exclusion, practiced through public policies, the labor market, and service sectors, and reproducing class and cultural inequalities. According to this approach, stigma is not merely an individual or psychological phenomenon, but rather part of relations of power and domination that control the distribution of resources and social recognition (Parker & Aggleton, 2003: 18). A Historical Overview of Psychological Immunity

The concept of psychological immunity is a relatively new concept in psychology. However, its roots extend back to earlier uses in physics and medicine, where the word referred to the ability of materials to recover their original form after being exposed to stress or tension. From here, the concept spread to psychological sciences to describe individuals' ability to adapt positively despite adversity and hardship (Masten, 2001: 227.(

Organized scientific interest in psychological immunity emerged in the 1950s through childhood research, particularly that which studied children raised in environments fraught with economic and social risks. Perhaps the most prominent of these studies was that presented by researcher Amy Werner in her longitudinal project on the island of Kauai, Hawaii, which extended from 1955 to the 1970s. The study followed the development of 698 children and concluded that one-third of them, despite experiencing environmental and health challenges, demonstrated a pattern of healthy adjustment and positive development, later known as the "resilient child" (Werner & Smith, 1982, pp. 8–10).

In the 1980s and 1990s, the concept expanded beyond children to encompass multiple age groups, and the focus shifted from individual traits to the dynamic interactions between the individual and their environment. Researcher Ann Masten played a central role in this shift by describing resilience not as a rare quality, but rather as a "habitual charm" that emerges from basic human adaptive systems (Masten, 2001: 235). Several explanatory theories have emerged, most notably: the protective model, which assumes the presence of factors that protect the individual from negative influences; the reactive model, which emphasizes the reciprocal interaction between risk and protection; and the compensatory model, which argues that certain factors compensate for the effects of risk (Garmezy, Masten, & Tellegen, 1984: 98).

At the beginning of the twenty-first century, psychological resilience began to be viewed as a dynamic process involving positive adaptation to adversity, rather than simply a fixed personality trait. This understanding has also evolved to include post-traumatic growth, redefining resilience as an individual's ability not only to survive, but also to rebuild and grow psychologically after adversity (Southwick & Charney, 2012, pp. 19–21). The concept of resilience has also become linked to neuroplasticity and social support, as well as to the possession of interpersonal and cognitive skills. This conceptual expansion was followed by the development of psychological measurement tools for the concept of resilience, most notably the Connor and Davidson Resilience Scale for Psychological Resilience (CD-RISC), which was designed to assess the ability to cope with psychological stress and restore psychological balance (Connor & Davidson, 2003: 78). This scale has contributed to the strengthening of quantitative research on psychological resilience in various fields such as mental health, counseling, education, and work with marginalized groups. Thus, psychological resilience has evolved from a simple concept referring to "surviving adversity" to a complex psychosocial construct reflecting an individual's ability to grow and thrive despite difficult circumstances. This development has contributed to directing psychological research toward a deeper understanding of coping mechanisms, making psychological resilience a central focus of positive psychology, therapeutic psychology, and human development.

Theories Explaining Psychological Resilience

The Protective Model

This model argues that psychological resilience arises through the presence of protective factors that mitigate the impact of risk factors on the individual. These factors may be internal (such as self-efficacy or positive thinking) or external (such as family support or positive relationships). This model assumes that protective factors act as a "psychological buffer" that reduces the chances of developing psychological disorders in individuals exposed to stress (Rutter, 1987: 317).

The Compensatory Model

This model assumes that certain factors can compensate for the impact of risk factors even if these factors are not directly related to the risk. For example, an individual may experience difficult family circumstances, but having a supportive teacher or regular creative activities can independently enhance their psychological resilience (Garmezy et al., 1984: 98). This model views resilience as the outcome of a balance between negative and positive forces in an individual's life. 3. Dynamic Process Model

Unlike previous models that focused on fixed traits or factors, this model emphasizes that psychological resilience is an ongoing process, not a permanent trait. This process is based on the ongoing interaction between the individual and their environment and may change depending on age, social, and societal circumstances. Researcher Ann Masten believes that resilience is the result of the activation of "natural adaptive systems" in humans, such as family bonding, cognitive functions, and self-regulation, describing it as "ordinary magic" (Masten, 2001: 235).

Cognitive Behavioral Theory

This theory explains psychological resilience as being related to how an individual thinks and responds to stressful events. Individuals with high resilience tend to use rational and positive thinking styles and adopt effective coping strategies such as cognitive reappraisal, planning, and problem-solving. Research shows that cognitive-behavioral skills training can enhance psychological resilience in children and adults (Reivich & Shatté, 2002: 42).

Social Support Theory

This theory highlights the role of social support—whether from family, friends, or the community—in enhancing individuals' ability to adapt to challenges. Support strengthens belonging and identity, and provides emotional and moral resources, which leads to reduced levels of anxiety and depression in crises (Cohen & Wills, 1985: 312). According to this theory, psychological resilience stems not only from the individual, but also from their social environment.

Social Learning Theory

According to Albert Bandura, psychological resilience is enhanced through observation, imitation, and modeling. When individuals see positive role models coping effectively with adversity, they, in turn, gain self-efficacy, which drives them to believe in their ability to overcome difficulties. This self-efficacy is considered one of the essential determinants of psychological resilience (Bandura, 1997: 39)

Olath's Psychological Resilience Theory (2005)

Describes psychological resilience as an interactive and dynamic process (a process, not just an individual trait) that includes an individual's ability to adapt positively and cope with psychological stress and trauma. It aims to achieve a "functional balance" in psychological and emotional performance despite challenges.

Among the factors that stimulate psychological resilience are:

Promotive factors: such as optimism, a sense of self-efficacy, social skills, and social support.

Protective factors: such as family or community support that reduce the impact of risk factors. These factors interact to strengthen an individual's ability to withstand and overcome challenges.

Resilience is not fixed; rather, it develops through the individual's encounter with difficult or stressful situations. Controlled exposure to difficulties contributes to building coping and learning skills, within the framework of the "Challenge Model." This means that when people face obstacles, confronting these pressures can enhance their ability to adapt and develop psychologically.

The most important components of the model, according to Olath, are:

Self-efficacy: An individual's belief in their ability to overcome difficulties is considered a fundamental asset for psychological resilience.

Regulatory and emotional skills: such as self-control, decision-making, positive thinking, and transforming adverse situations into opportunities.

Environmental interaction: This includes social resources and support from family and community, which mitigate the impact of risk factors.

These components work together interactively to enable an individual to overcome psychological stress in a flexible and productive manner. Psychological resilience is not the complete absence of distress, but rather the ability to persist and adapt despite the presence of pressures or feelings of discomfort. In other words, it balances psychological achievement with coping with difficulties. The accumulation of positive factors (support, personal skills, a healthy environment) also enhances the growth of resilience over time through the concept of "resource caravans." According to Olath (2005), psychological resilience is an evolving process based on the interaction of risks and resources, where personal and environmental factors intersect to shape an individual's ability to psychologically adapt and cope with crises. This theory encourages the development of rehabilitation and training programs aimed at strengthening an individual's personal skills and supporting them with social resources to enhance their psychological health and ability to face challenges (Masten, 2014; Fergus & Zimmerman, 2005:17).

First: Studies that addressed physical stigma.

Smart's study (2001) aimed to conduct a comprehensive analysis of studies related to stigma associated with physical disabilities, focusing on its types, sources, and psychological and social impacts. The study did not include a field sample, as it was a systematic literature review that included the results of previous research. The researcher used an analytical approach to review studies published between 1980 and 2000. The results showed that physical stigma is one of the most prominent obstacles to the integration of people with disabilities into society, as it is associated with low self-esteem, increased social isolation, and difficulties in psychological and social adjustment. The study recommended the development of social awareness programs and psychological interventions that reduce stigma and support the integration of people with disabilities (Smart, 2001: 1-21).

Shumet et al.'s (2024) study aimed to explore the associations between perceived stigma and several factors, such as social support, inaccessible environment, and self-compassion, among people with mobility disabilities in Hong Kong. The study included 98 adult participants with physical disabilities from 10 non-governmental organizations in Hong Kong, with a mean age of 36.4 years (42.3% female). The study used the Perceived Stigma Questionnaire, the Inaccessible Environment Questionnaire, and the Self-Compassion Scale, along with activities of daily living. Statistical methods used were hierarchical multiple regression analysis. The results showed that inaccessible environment and negative empathy were positively associated with stigma, while positive self-compassion was negatively associated. The full model explained 53.9% of the variance in stigma (Shumet et al., 2024: 6).

Second: Studies that addressed immunity Psychology

Fergus & Zimmerman (2005)

The study aimed to present a theoretical framework that explains the factors contributing to the development of psychological resilience in adolescents and its relationship to coping strategies and mental health. The sample consisted of 350 American adolescents (13–18 years old) who were followed longitudinally for three years. The researchers used the Adolescent Psychological

Resilience Scale, the Coping Strategies Scale, and measures of depression and substance use indicators.

They relied on longitudinal growth analysis, ANOVA, and causal modeling. The results showed that psychological resilience was negatively associated with depression and substance use, and that adolescents with high resilience adopted positive coping strategies and were less vulnerable to risk. The study recommended the need to support psychological resilience across the family, school, and community. (Fergus & Zimmerman, 2005: 399-419)

Cassidy (2015)

The study aimed to explore the relationship between psychological resilience and academic success among college students, examining the role of emotional regulation as a mediator in this relationship. The sample consisted of 200 British students aged 18 to 24. The researcher used the Adult Resilience Scale (RSA), the Emotion Regulation Questionnaire (ERQ), and cumulative grade point average (GPA). Data were analyzed using Pearson's correlation coefficient, analysis of variance (ANOVA), and multiple regression. The results showed a significant positive relationship between resilience and academic success, and that emotional regulation, particularly cognitive reappraisal, was an important mediator of this relationship. The study recommended incorporating emotion regulation skills into resilience programs for students. (Cassidy, 2015: 4-6)

Arpaci et al.'s (2021) study aimed to examine the role of resilience in promoting psychological well-being and reducing anxiety and depression in older adults during the COVID-19 pandemic. The sample consisted of 160 participants over the age of 60 in Turkey. The study used the Brief Resilience Scale (BRS), the World Health Organization's Psychological Well-being Index (WHO 5), and the Anxiety and Depression Scale (HADS). Statistical methods were used: Pearson's correlation coefficient, regression analysis, and independent samples t-test. The results showed that individuals with high psychological resilience reported greater psychological well-being and less anxiety and depression. They emphasized the need to enhance psychological resilience among older adults during health crises. (Arpaci et al., 2021:2-4)

Discussion of the Studies

First: Objectives: The five studies combined aimed to explore topics related to physical stigma and psychological resilience from different perspectives. Smart (2001) focused on analyzing the literature on stigma associated with physical disabilities, while Shumet et al. (2024) sought to explore factors associated with perceived physical stigma, such as social support, inaccessible environments, and self-compassion among people with mobility disabilities. The other three studies focused on the topic of psychological resilience. Fergus and Zimmerman (2005) examined the factors influencing the development of psychological resilience among adolescents and its relationship to coping strategies and mental health, while Cassidy (2015) examined the relationship between psychological resilience and academic success and the role of emotional regulation as a mediator in this relationship. Arpaci et al. (2021) focused on the role of psychological resilience in promoting psychological well-being and reducing anxiety and depression among older adults during the COVID-19 pandemic.

Second: Sample: The study samples varied according to their objectives. Smart's study was a systematic literature review that did not include a field sample, while Shumet et al.'s (2024) study included a sample of 98 individuals with mobility disabilities in Hong Kong. Fergus and Zimmerman's (2005) study included 350 American adolescents who were followed longitudinally for three years, while Cassidy's (2015) study included 200 British university students, and Arpaci et al.'s (2021) study included 160 older participants in Turkey.

Third: Tools: The tools used varied between specialized scales and questionnaires; Shumet et al.'s (2024) study used questionnaires to measure stigma, disadvantaged environments, and self-

compassion, while studies on resilience have used measures such as the Adolescent Resilience Scale, the Coping Strategies Scale, depression and substance use indicators, the Adult Resilience Scale (RSA), the Emotion Regulation Questionnaire (ERQ), grade point average (GPA), the Brief Resilience Scale (BRS), the World Health Organization's Psychological Well-being Index (WHO-5), and the Anxiety and Depression Scale (HADS.(

Fourth: Statistical Methods: The statistical methods used varied depending on the nature of the data. Smart's (2001) study did not include statistical methods due to its literature review, while Shumet et al.'s (2024) study used hierarchical multiple regression analysis, and Fergus and Zimmerman's (2005) study used longitudinal growth analysis, analysis of variance (ANOVA), and causal modeling. Cassidy's (2015) study relied on Pearson's correlation coefficient, analysis of variance (ANOVA), and multiple regression, while Arpaci et al.'s (2021) study used Pearson's correlation coefficient, regression analysis, and an independent-samples t-test.

Fifth: Results: The main findings of these studies showed that physical stigma represents a major obstacle to the integration of individuals with disabilities and is associated with low self-esteem, increased isolation, and difficulties with psychosocial adjustment. Shumet et al.'s study also demonstrated that an unfavorable environment and negative empathy contribute to increased stigma, while positive self-compassion contributes to its reduction. Studies related to psychological resilience have shown that high psychological resilience is associated with lower levels of depression and substance abuse in adolescents, increased academic success among university students, and improved psychological well-being and reduced anxiety and depression in older adults.

Chapter Three

Research Methodology and Procedures

Research Procedures: This chapter defines the research methodology and procedures followed to achieve its objectives, starting with defining the research community and sample, selecting the research tool, and the statistical methods used in data analysis. These steps are presented below.

First: Research Methodology: In their current research, the researchers adopted the descriptive approach because it is more appropriate for achieving the research objectives. This approach not only collects and classifies data, but also interprets this data and its implications. Therefore, description is coupled with comparison by using measurement and interpretation methods to arrive at generalizations regarding the phenomenon.

Second: Research Community: Table (1) shows the numbers of physically disabled students at the Al-Saada Institute for Physical Disability and Al-Manar Institute, distributed by gender. It appears that the Al-Saada Institute includes 45 males and 40 females, for a total of 85 students, while the Al-Manar Institute includes 52 males and 48 females, for a total of 100 students. This brings the total number of students at the two institutes to 185, including 97 males and 88 females. These figures indicate that the number of males slightly exceeds that of females at both institutes, with males representing approximately 52% of the total student body, while females represent approximately 48%.

Table (1) The number of students with physical disabilities in Al-Saada Institute for Physical Disabilities and Al-Manar Institute, distributed by gender

Institute	Gender	Total
	Males	Females
Al-Saada	45	40
Al-Manar	52	48
Total	97	88

Third: The research sample consists of students with physical disabilities from Al-Saada Institute for Physical Disabilities and Al-Manar Institute for the academic year 2024–2025, with a total of (157) students, including (82) males and (75) females. Table (2) illustrates this.

Table (2) The number of students with physical disabilities in Al-Saada Institute for Physical Disabilities and Al-Manar Institute, distributed by gender

Institute	Gender	Total
	Males	Females
Al-Saada	38	35
Al-Manar	44	40
Total	82	75

Third: Research Instruments

First: Item Formulation:

To measure psychological immunity, the researchers constructed a Psychological Immunity Scale based on the theoretical definition derived from Olath's (2005) theory. According to this theoretical framework, the scale consisted of 30 items. For measuring physical stigma, the researchers developed a scale based on the theoretical definition of physical stigma, and the total number of items in this scale was 28 items.

Second: Item Validity: The initial versions of the Psychological Immunity Scale and the Physical Stigma Scale were presented to a panel of 10 experts specialized in educational and psychological sciences. The experts evaluated the suitability of the items, and an agreement rate of 80% or higher was set as the criterion for item acceptance. Based on the experts' feedback, all items were retained, as they achieved an agreement rate exceeding 80%, with some minor modifications applied to certain items.

Third: Indicators of Construct Validity:

Extreme Groups Method: To verify the discriminative power of the items, a random sample of 150 students was selected. The obtained scores were arranged in descending order (from the highest to the lowest). Then, the top 27% and bottom 27% of scores were chosen to represent the two extreme groups, resulting in 80 students in total, with 40 students in each group.

The researchers used the independent samples t-test to examine the differences between the high and low groups for each item. The calculated t-value was compared with the tabulated t-value (1.990) at a significance level of 0.05 and 78 degrees of freedom. The results showed that all items were discriminative, as their calculated t-values were higher than the tabulated value. Tables (3) and (4) present these results.

Table (3) ***t-values for the items of the Physical Stigma Scale using the Extreme Groups Method***

No.	Upper 27% Group		Lower 27% Group		Calculated t-value	No	Upper 27% Group		Lower 27% Group		Calculated t-value
	Mean	SD	Mean	SD			Mean	SD	Mean	SD	
1	2.9500	.31623	2.7000	.60764	2.308	**15**	2.7250	.67889	2.2500	.98058	2.519
2	2.9500	.22072	2.5750	.78078	2.923	**16**	2.7500	.54302	2.1000	1.00766	3.591
3	2.9500	.22072	2.3250	.85896	4.457	**17**	2.7750	.53048	2.0500	1.01147	4.015
4	2.9250	.26675	2.4500	.87560	3.282	**18**	2.7250	.55412	2.0000	1.01274	3.972
5	2.9250	.26675	2.2250	.61966	6.562	**19**	2.8000	.51640	1.9500	1.01147	4.734
6	2.9001	.37893	2.6250	.70484	2.173	**20**	2.8250	.50064	1.9000	1.00766	5.199
7	2.9000	.44144	2.4000	.84124	3.329	**21**	2.7250	.55412	1.8500	1.00128	4.836
8	2.8750	.33493	2.3500	.89299	3.481	**22**	2.7750	.53048	1.8000	.99228	5.480
9	2.8750	.40430	2.2000	.99228	3.984	**23**	2.8500	.48305	1.7500	.98058	6.364
10	2.8750	.33493	2.1500	1.00128	4.343	**24**	2.7500	.63043	1.7000	.96609	5.757
11	2.8500	.53349	2.1500	.89299	4.256	**25**	2.6750	.65584	1.6500	.94868	5.621
12	2.8500	.53349	2.1750	.87376	4.170	**26**	2.8000	.60764	1.5500	.90441	7.256
13	2.8250	.54948	2.1000	.87119	4.452	**27**	2.6000	.77790	1.4500	.84580	6.329
14	2.7000	.64847	2.3000	.96609	2.174	**28**	2.8000	.40510	2.3750	.58562	3.775

Table (4) T-values for the items of the Psychological Immunity Scale using the two-extreme sample method

No.	Upper 27% Group		Lower 27% Group		Calculated t-value	No.	Upper 27% Group		Lower 27% Group		Calculated t-value
	Mean	SD	Mean	SD			Mean	SD	Mean	SD	
1	2.8750	.33493	1.9000	1.00766	5.807	**16**	2.6250	.49029	1.9250	.76418	4.876
2	2.8500	.53349	1.1000	.30382	18.028	**17**	2.6000	.49614	2.0000	.00123	7.649
3	2.8250	.50064	1.2000	.40510	15.959	**18**	2.6000	.67178	1.2750	.45220	10.348
4	2.8000	.40510	1.4000	.81019	9.775	**19**	2.6000	.81019	1.9750	.99968	3.072
5	2.2750	.45220	1.8500	1.00128	2.447	**20**	2.6000	.70892	1.2000	.56387	9.775
6	2.7500	.66986	1.3250	.47434	10.980	**21**	2.5500	.84580	1.0500	.22072	10.853
7	2.7500	.66986	1.2750	.45220	11.542	**22**	2.5500	.50383	1.4500	.78283	7.473
8	2.7250	.45220	1.3500	.76962	9.742	**23**	2.4500	.90441	1.1000	.44144	8.484
9	2.7000	.46410	1.6250	.49029	10.071	**24**	2.4000	.90014	1.4250	.81296	5.084
10	2.7000	.64847	1.4000	.49614	10.070	**25**	2.3000	.46410	1.7500	.70711	4.113
11	2.7000	.72324	1.1500	.36162	12.123	**26**	2.2500	.98058	1.8500	.57957	2.221
12	2.6750	.47434	1.7750	.42290	8.957	**27**	2.1500	1.00128	1.4000	.49614	4.245
13	2.6500	.48305	1.2750	.45220	13.143	**28**	2.1000	1.00766	1.2000	.40510	5.241
14	2.6500	.76962	1.2000	.40510	10.544	**29**	2.0750	.99711	1.1000	.30382	5.916
15	2.6500	.76962	1.2250	.57679	9.371	**30**	2.0500	1.01147	1.1500	.36162	5.299

b- The Relationship Between the Item and the Total Score

The discrimination index of the items in the Psychological Immunity Scale and the Physical Stigma Scale was calculated using Pearson's correlation coefficient between the individual scores on each item and their total scores on the scale, based on 150 forms (the same forms that were analyzed using the extreme groups method). The results showed that all correlation coefficients were significant when compared to the tabulated correlation values. Table (5) and Table (6) illustrate these results.

Table (5) Correlation coefficients between each item of the Physical Stigma Scale and the total score on the scale

Item	Correlation	Item	Correlation	Item	Correlation	Item	Correlation	Item	Correlation
1	0.34	7	0.56	13	0.35	19	0.45	25	0.35
2	0.40	8	0.43	14	0.47	20	0.39	26	0.48
3	0.42	9	0.50	15	0.61	21	0.39	27	0.44
4	0.43	10	0.35	16	0.36	22	0.44	28	0.39
5	0.48	11	0.51	17	0.59	23	0.37		
6	0.42	12	0.44	18	0.54	24	0.49		

Table (6) ***Correlation coefficients between each item of the Psychological Immunity Scale and the total score on the scale***

Item	Correlation	Item	Correlation	Item	Correlation	Item	Correlation	Item	Correlation	Item	Correlation
1	0.55	6	0.40	11	0.43	16	0.41	21	0.30	26	0.47
2	0.33	7	0.54	12	0.32	17	0.52	22	0.56	27	0.38
3	0.43	8	0.38	13	0.38	18	0.50	23	0.39	28	0.35
4	0.47	9	0.38	14	0.48	19	0.39	24	0.34	29	0.39
5	0.48	10	0.35	15	0.39	20	0.54	25	0.55	30	0.37

Sixth: Reliability of the Scales: The researchers calculated the reliability of the scales using two methods:

1. **Test–retest method:** The scales were administered to a random sample of **40 students**. After two weeks, the scales were re-administered to the same participants. Pearson's correlation coefficient was then calculated between the two sets of scores. The correlation coefficient was **0.86** for the Psychological Immunity Scale and **0.84** for the Physical Stigma Scale, indicating that both scales have **high reliability.**
2. **Split-half method:** For the Physical Stigma Scale, the items were divided into odd and even items, and the correlation coefficient between the two halves was **0.76**. After applying the **Spearman–Brown correction formula**, the total test reliability coefficient was found to be **0.86.** For the Psychological Immunity Scale, the correlation between the two halves was **0.79**, and after applying the Spearman–Brown formula, the reliability coefficient was **0.88**.

Fourth: Scoring the Scales:The final version of the Psychological Immunity Scale consisted of **30 items,** each with three response options: *Always applies (3 points), Sometimes applies (2 points), Does not apply (1 point).* The final version of the Physical Stigma Scale consisted of **28 items,** each with the same three response options and scoring weights *(3, 2, 1).*

Fifth: Final Application: After finalizing the Psychological Immunity Scale and the Physical Stigma Scale (Appendix 4/5), they were administered to the research sample of 157 students with physical disabilities, who were randomly selected and distributed by gender.

Sixth: Statistical Methods: The following statistical methods were used:

1. Pearson's correlation coefficient to determine scale reliability and the relationship between variables.
2. One-sample t-test to compare the obtained mean with the theoretical mean of the Psychological Immunity and Physical Stigma Scales.
3. Independent samples t-test to examine item discrimination and to detect differences based on gender (males–females).

Chapter Four: Presentation and Discussion of Results

1. Identifying the level of physical stigma among students with physical disabilities

The results of the one-sample t-test in Table (7) showed that the mean score of physical stigma among students with physical disabilities (M = 57.80, SD = 6.62) was higher than the hypothetical mean (56). The calculated t-value was 3.407, which is greater than the tabulated t-value (1.960) at the 0.05 significance level with 156 degrees of freedom, indicating a statistically significant difference in favor of the sample mean.

Table (7) t-test results for the difference between the mean scores of physical stigma and the hypothetical mean of the sample

Sample Type	N	Mean	SD	Hypothetical Mean	Calculated t	Tabulated t	Sig. (0.05)
Students with physical disabilities	157	57.8025	6.62884	56	3.407	1.960	Significant

Since the calculated t-value (3.407) is greater than the tabulated t-value (1.960) at the 0.05 significance level, the difference between the sample mean and the hypothetical mean is statistically significant. This indicates that the level of physical stigma among students with physical disabilities is significantly higher than the hypothetical level (56), as the sample mean (57.80) exceeded the hypothetical mean. According to Kaufman, physical stigma arises when society holds stereotypes and prejudices against individuals with physical characteristics that differ from "socially accepted norms." He argues that such stigma leads to discrimination, social exclusion, and low self-esteem among stigmatized individuals.

Based on the results, it can be concluded that students with physical disabilities experience a higher level of physical stigma, which aligns with Kaufman's perspective that society still associates physical disability with negative attributes such as helplessness, weakness, or inability to participate fully in social life. This reflects that physical disability is treated as a source of difference leading to discrimination, which supports Kaufman's notion that stigma is constructed based on society's perception of physical differences as "deficiencies" or "flaws" that justify negative treatment or social exclusion.

2.Examining the Significance of Differences in Physical Stigma Based on the Gender Variable (Male – Female)

The results of the t-test revealed that the mean score for males was 58.48 with a standard deviation of 8.93, while the mean score for females was 57.05 with a standard deviation of 2.02. The calculated t-value was 1.358, whereas the critical t-value at the 0.05 significance level and appropriate degrees of freedom was 1.960. Comparing both values shows that the calculated t-value is less than the critical t-value, indicating that there is no statistically significant difference between the mean scores of males and females at the 0.05 level. This suggests that gender does not significantly influence the level of physical stigma. Table (8) presents these findings.

Table (8) T-test results for the significance of differences between the mean scores of physical stigma according to gender

Gender |	N	Mean	Standard Deviation(	Calculated t-value	Critical t-value	Significance Level (0.05(
Males	82	58.4878	8.93909	1.358	1.960	Not significant
Females	75	57.0533	2.01945			

From Covan's perspective, he believes that physical stigma is shaped by social interactions based on stereotypes and prejudices toward individuals who differ physically from the norm. According to Covan's view, the lack of significant differences reflects that stereotypes associated with physical stigma affect both sexes equally, as society adopts similar prejudices toward individuals with physical differences, regardless of their gender. This indicates that physical stigma, as a social product, is influenced less by an individual's gender than by the extent to which they conform to or differ from prevailing societal physical norms.

3. Identifying psychological resilience among the physically disabled.

Table (9) shows the results of a one-sample t-test, which aims to compare the average psychological resilience scores of physically disabled individuals with the hypothetical mean of 60. The table shows that the sample consisted of 157 individuals, and that the arithmetic mean of their scores was 59.63, with a standard deviation of 10.05. The calculated t-value was 0.453, which is lower than the tabular t-value of 1.960 at a significance level of 0.05. This indicates that the difference between the average psychological resilience scores of the sample and the hypothetical mean is not statistically significant. That is, the level of psychological resilience among physically disabled individuals is close to the expected level and does not show a significant difference. Table (9) illustrates this.

Table (9) T-test for the significance of differences between the average psychological resilience scores and the hypothetical mean of the sample

Sample Type	N	Mean	SD	Hypothetical Mean	Calculated t	Tabulated t	Sig. (0.05)
Students with physical disabilities	**157**	**59.6369**	**10.05125**	**60**	**0.453**	**1.960**	**Not significant**

Olath (2005) defines psychological resilience as an integrated psychological construct encompassing a set of psychological abilities and processes that enable an individual to cope with psychological stress and adapt to difficult situations. These include optimism, self-confidence, self-control, and social skills. According to this perspective, the lack of statistically significant differences between the sample's mean psychological resilience scores and the hypothetical mean indicates that individuals with motor disabilities possess an average level of psychological resilience that enables them to cope with stress and adapt to challenges to some extent. This level may be sufficient to maintain a degree of psychological balance, but it does not reflect a significant superiority or decline from the expected level.

4. Identifying the Significance of Differences in Psychological Resilience According to the Gender Variable (Males – Females)

Table (10) shows the results of a t-test for two independent samples, which aims to determine whether there is a difference in the average psychological resilience scores according to the gender variable. The table shows that the number of males was 82 individuals, with an arithmetic mean of 62.03 and a standard deviation of 12.22, while the number of females was 75 individuals, with an arithmetic mean of 57.01 and a standard deviation of 6.00. The calculated t-value was 3.220, which is greater than the tabular t-value of 1.960 at a significance level of 0.05, indicating a statistically significant difference between males and females in the level of psychological resilience. The results show that males enjoy a higher level of psychological resilience than females, as their average scores were significantly higher.

Table (10) T-test for the Significance of Differences between the Averages of Psychological Resilience Scores According to the Gender Variable

Gender |	N	Mean	Standard Deviation(	Calculated t-value	Critical t-value	Significance Level (0.05(
Males	82	62.0366	12.22368	3.220	1.960	significant
Females	75	57.0133	6.00561			

From the perspective of Olath (2005), who views psychological resilience as an integrated psychological construct consisting of abilities and processes that help an individual cope with stress and adapt to difficult situations through optimism, self-confidence, self-control, and social skills, the result can be explained by the fact that males in this sample may have higher levels of these psychological components than females. This may be due to social and cultural factors that provide males with greater opportunities to acquire coping skills and assume responsibility, which is reflected in their ability to face the challenges and pressures of motor disability to a greater extent than females.

5. To identify the nature of the relationship between physical stigma and psychological immunity.

To achieve this goal, the researchers used Pearson's correlation coefficient to identify the relationship between the variables of physical stigma and psychological immunity. The correlation coefficient reached 0.67. The result of the significance test of the correlation coefficient between physical stigma and psychological immunity, which reached r = 0.67, r = 0.67, indicates a strong correlation between the two variables. Using the t-test for the correlation coefficient, the calculated t value reached 11.23 with (155) degrees of freedom, which is greater than the table value of 1.960 at a significance level of 0.05. This indicates that the relationship between physical stigma and psychological immunity is statistically significant.

This means that a high level of physical stigma is clearly associated with an increase or decrease in the level of psychological immunity among individuals with physical disabilities, indicating a close relationship between negative societal perceptions of disability and an individual's ability to adapt psychologically and cope with stress.

Conclusions:

1. There was no statistically significant difference between the sample's mean psychological resilience and the hypothetical mean, indicating that the level of psychological resilience among individuals with physical disabilities is within the expected range.
2. A statistically significant difference was found in psychological resilience according to gender, with males scoring higher than females, indicating a greater capacity for psychological adaptation.
3. Regarding physical stigma, the mean was higher than the hypothetical mean, reflecting the high exposure of individuals with physical disabilities to physical stigma.
4. There was no significant difference in physical stigma according to gender, with the mean for males being close to the mean for females.
5. The correlation coefficient test revealed a strong and statistically significant relationship between physical stigma and psychological resilience, indicating that high stigma is associated with low levels of psychological adaptation.

Recommendations: Based on the research results, the researchers recommend the following:

1. The need to implement community awareness programs aimed at correcting negative stereotypes associated with physical disabilities to reduce physical stigma.
2. Providing psychological and social counseling programs for individuals with physical disabilities to enhance self-confidence and develop coping skills and psychological resilience.
3. Involving the media in positive campaigns that focus on highlighting the capabilities and achievements of people with disabilities rather than focusing on their disability.

Suggestions: The researchers suggest conducting the following studies:

1. Emotional discrimination and its relationship to physical stigma among people with physical disabilities.
2. Psychological immunity and its relationship to thinking patterns among people with visual disabilities.
3. Physical stigma and its relationship to personality patterns among students with physical disabilities.

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