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Role of Empathy and Learned Optimism in Distress Tolerance among Female Medical Professionals: A Cross-Cultural Perspective

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Abstract

Purpose of Study: *The major objectives of the present study were to investigate the role of empathy and learned optimism in distress tolerance among female medical professionals. It was also intended to determine the comparative differences between Pakistani and American female medical professionals in relation to the major constructs of the study.*

Method: *Convenient and Purposive sample of Pakistani (n = 230) and American (n = 198) medical professionals was acquired from hospitals of Pakistan and America. Age range of Pakistani 26-55 (M= 32.85) and American 33-58 (M = 38.11) and nature of job individuals should be permanent working in public hospital with minimum job experience of 1 year in present hospital. Job designation of the respondents were doctors (n = 66), nurses (n = 112), paramedics (n = 52).*

Findings and Results: *Findings showed that Positive relationship existed among empathy, learned optimism and distress tolerance among both Pakistani and American medical professionals. American female medical professionals reflected higher empathy, learned optimism and distress tolerance than Pakistani corresponding sample. Doctors in Pakistani sample; while nurses in American sample showed elevated levels of empathy, learned optimism and distress tolerance as compared to their counterparts. Medical professionals working in emergency ward expressed higher empathy and learned optimism as compared to professionals working in other wards.*

Conclusion: *Results show differences in gender and significant differences in different demographics.*

Keyword: *Empathy, Learned Optimism, Distress Tolerance, Medical Practitioners*

Introduction

People being inclined to examine the world from others perspective are likely to develop a positive mental attitude and nurture an optimistic view of life which enables them to tolerate stress. Empathy enables people to connect with one another when they empathize or want sympathy and it also helps them to build trust and heal up from the adverse events of life. Learned optimism always leads people to think positively and be able to view others perspectives with an open mind in the light of empathy. By tolerating stress, it gives power to people to heal from their pain which move them toward positive feelings. We can improve the world, basically just by investing more energy contemplating what others think and feel.

Empathy

Empathy has been defined in two ways: (a) as the cognitive awareness of another person's internal states, which includes thoughts, feelings, perceptions and intentions; (b) empathy is vicarious affective responses to another person (Hoffman, 2001). De Waal (2008) considered empathy as a transformative system that motivates altruistic behavior and comparative prosoical conduct. There are two prominent lines of imagining that may clarify this affiliation. To begin with, empathy may motivate altruistic, others centered helping conduct that happens in spite of its expense to the self. Then again, prosocial or altruistic behavior may be motivated by a desire to reduce the negative excitement prompted by review another's trouble (De Waal, 2008).

Stocks et al, (2009) concentrated on recognized these substitute inspirations by evaluating people helping practices when they are placed as witnesses to a person in stress, where a simple getaway from the troubling circumstance is or is unrealistic. Empathy is also an ability to understand other's emotional state and is most effective when they show that they additionally comprehend why the individual is upset empathy statement do not agreeing with the client, or their abusive behavior. Empathy just conveys that they are interested and concerned, and that one's see nothing more and nothing less (Bacal, 2010).

Learned Optimism

Optimism makes external, variable and specific attribute for the failure- like events rather than internal, stable and global attribution of the pessimist (Synder & Lopez, 2007). Optimism attitude is something

that comes from person temperament, personality and situation but something that person can learn (Seligman, 2006).

Optimism is defined as a tendency to expect favorable outcomes. Optimism is the desire that generally great things will happen (Kalat & Shiota, 2007) and portrayed by accomplishment and low levels of sadness and nervousness are for the most part among the qualities of idealistic people. With these positive attributes, optimism has turned into a focal building square in positive and wellbeing mental exploration (Fotiadou et al., 2007). To improve comprehension of optimism it is critical to perceive the complete inverse feeling, which is pessimism. Pessimism is the general desire of a negative result, with qualities including beginning sentiments of tension and low saw control of circumstance (Valle & Mateos, 2008).Optimism is seeing upside in events by viewing setbacks as learning opportunities and not personal flaws (Goleman, 2002).

Distress Tolerance

Distress tolerance (DT) has been defined as the perceived and actual ability to tolerate aversive emotional and physical experiences (e.g., negative affective states, physical discomfort; (Brown et al. 2005; Leyro et al. 2010). In medicine, distress is an aversive state in which an animal is unable to adapt completely to stressors and their resulting stress and shows maladaptive behaviors. Emotional and Stress response occurs when a perceived need is not met (Weiss, 2013). The capacity to experience and tolerate distressing situations is defined as distress tolerance. Distress might be the outcome of physical processes or mental but exhibits in an emotional state often defined by action tendencies to relieve the emotional experience. It is thought to be a meta-emotion idea that one's assessments and hopes of undergoing undesirable emotional in reverence to (1) aversiveness plus permissibility (2) acceptability plus appraisal (3) propensity to engross disturb functioning and attention and lastly, directive of feelings, exactly, the resulting as set of action tendencies to either escape or instantly decrease the experience (Simons & Gaher, 2005).

Relationship between Empathy and Distress Tolerance

According to the literature, empathy is connected with people distress and empathic distress. The order in which these concepts are displayed is intended to propose a sequence, with every after component falling from the prior.

Personal distress originates from empathy (Eisenberg, 2000) however its introduction is prepared internal as opposed to outward. Batson (2006) depicts it as a self-centered aversive response to another's distress "… associated with helping fundamentally when aiding is the best way to diminish the helper's own particular vicariously instigated distress; such helping is egoistically rather than altruistically motivated" (Eisenberg & Fabes, 1990, p. 133). The individuals who experience intense individual pain might likewise stay away from clash and/or presentation to others negative feelings. Prosoical good activity, subsequently, is only every once in a long while an ancient rarity of individual misery. Empathic distress, a negative full of feeling reaction activated by others distress, is other-focused thus may motivate prosocial good activity since the individuals who experience it really need to relieve others suffering (Hoffman, 2000, p. 30).

Relationship between Empathy and Learned Optimism

Madahi, Javidi, and Samadzadeh (2013) studied the relationship between emotional intelligence (i.e., self- regard, empathy, social responsibility, impulse control, self-actualization, reality testing, optimism and happiness) and marital status of university students. The results showed that their is a significant different between single individuals and married individuals in emotional intelligence (i.e., self- regard, empathy, social responsibility, impulse control, self-actualization, reality testing, optimism and happiness). In addition emotional intelligence married individuals score high on self-regard, empathy, social responsibility, impulse control, self-actualization and reality testing where as emotional intelligence single individuals score high on optimism and happiness.

Several researches have been conducted on relationship between emotional intelligence and learning styles. Some of them will be mentioned here: examination of the students learning styles based on Kolb theory (Azizi,2003); examination of the relationship between emotional intelligence and academic achievement of university students (Samare,2008); a comparison of gifted and normal students emotional intelligence and its relationship with academic achievement (KhalilyAzar,2008); the relationship between emotional intelligence with psychological well-being and academic performance of males and females students (Bakhshi,2009); Simmons researches, the relationship between gender and emotional intelligences, conducted by Loo (2002); differences between learning styles based on phenomena of interest (Sesar,2003); examination of the relationship between students learning styles, gender, race and achievement trends (Fang,2007); the influence of emotional intelligence on the learning styles of graduate managers in Saudi Arabia and Malaysia (Giadeaka,2008); the relationship between learning styles and emotional intelligence

(Suliman,2010);This study attempts to examine the relationship between students' emotional intelligence and learning styles and of course conceptualizing the relationship between these two variables.

Relationship between Learned Optimism and Distress Tolerance

Geirdal and Dahl (2008) explored associations between mental and cancer-specific distress (psychological distress) and personality traits in healthy women belonging to families with familial cancer and absence of demonstrated mutations. Significant associations between psychological distress and personality traits have been found in these women. The traits of Optimism and Harm avoidance showed the strongest association with mental and cancer-specific distress (psychological distress).

In meta-analysis of optimism and coping are crossed two distinctions (Nes & Segerstrom, 2006). Optimism is decidedly connected with wide measures engagement adapting, and to issue centered adapting. Optimism is likewise decidedly, and about identically, connected with the two subsets of engagement adapting reactions: those that are issue centered (e.g., intellectual rebuilding, acknowledgement). Besides, a hopeful person is receptive to what kind of stressor is being defied. Optimism anticipated more issue centered adapting to uncontrolled stressor (e.g., injury). Therefore, optimism anticipated active attempt to both change and suit to distressing circumstances, in ways that reflect adaptable engagement (Nes & Segerstrom, 2006).

Garrosa et al. (2010) examines the influence of role stress and personal resources (optimism, hardy personality and emotional competence) in nursing on burnout and engagement dimensions. Optimism as a personal resource, showed a moderator effect on exhaustion and the three dimensions of engagement. Study provides additional support about role stress as an important predictor of burnout and engagement in nursing, even after controlling for personal resources and socio-demographic variables.

Gender and Cultural Differences in Empathy, Learned Optimism and Distress Tolerance

(Rasoal, Jungert, Hau, & Andersson, 2011) investigated the association between basic empathy, as measured by the Interpersonal Reactivity Index (Davis, 1983) and ethnocultural empathy, as measured by the Scale of Ethnocultural Empathy (Wang et al., 2003). Results showed that the two forms of empathy were correlated, and that largely similar predictors were found for the two constructs.

Heinke and Louis (2009) studied cultural background and individualistic–collectivistic values in relation to similarity, perspective taking, and empathy. Asian and European Australian endorsed higher levels of collectivism than individualism; individualism scores were equal; and the two values were positively correlated. Moreover, neither cultural background nor values were consistently linked to similarity. Implications are discussed for research on cultural background, values, and social interactions.

(Butrus & Witenberg, 2012) investigate that some personality predictors of tolerance to human diversity the roles of openness, agreeableness, and empathy. Findings show that openness and agreeableness were predictors of tolerance in the belief dimension, whereas the most salient predictor of tolerance in the speech and act dimensions was empathic concern, which also mediated the relationships between agreeableness and tolerance for these dimensions. These findings are not unexpected because holding intolerant beliefs is inconsistent with having an open mind, and intolerant speech and actions are inconsistent with pro-social behaviour, of which tolerance is arguably one form.

Loewenthal, MacLeod, Lee, Cook, and Goldblatt (2002) examined tolerance for depression among UK Jewish and Protestant men and women. It was found that tolerance for depression was greater amongst Jews than Protestants, and this is consistent with the elevated levels of depression amongst Jewish men as compared to Protestant men. However, findings relating to gender were mixed and were not always consistent with our expectations. The findings suggest that there may be some cultural variations in willingness to admit to seek help for depression, and this may be worth examining in other cultural-religious groups. Individual variations in tolerance for depression may be clinically significant.

Loewenthal, MacLeod, Lee, Cook, and Goldblatt (2002) noted that females hold more positive attitudes towards mental illness than males, including showing more kindness, whereas males have more stereotyping, restrictive, pessimistic and stigmatising attitudes. Loewenthal et al. (2002) recognised that sociocultural factors are important in shaping help-seeking behaviour. Of particular interest is the finding that Jews have shown higher levels of help-seeking behavior than non-Jews for psychological problems.

This has been noted both in America (Yeung & Greenwald, 1992) and the UK (Bowling & Farquhar, 1993) and has been used to account for the increased incidence of observed depression within this cultural-religious group (Kohn et al., 1999 It is also noteworthy that Jews are more likely to express n. egative affect than Catholics (Glicksman, 1991)

Eisenberg and Fabes (1998) in their meta-analysis of studies with children and youths, discovered a significant impact showing more elevated amounts of prosocial practices in girls versus boys. Similar to the findings regarding gender differences in empathy, effect sizes favoring girls is generally larger when the prosocial behaviors were measured via self or other reports than with observational measures. Additionally, gender differences in prosocial behaviors favoring females is also stronger with increasing age, and when indices or indices reflecting behaviors such as aggregated and kindness and consideration were taken into account, in contrast to indices reflecting instrumental help, comforting, or sharing Eisenberg and Fabes (1998). In addition, it is observed that gender and age differences consistent with findings in the literature. Women reported higher scores in empathic concern and fantasy than men. Older adults reported less personal distress and less fantasy (Mella et al., 2013).

Baum and Nehami, 2012 studied that at least some of professional's distress derives from a self-perceived lapse of empathy. It contends that professionals living and working in a disaster-stricken community are caught in a trap of conflicting inner needs stemming from the defenses they mobilize to cope with the heightened mortality salience aroused by communal disasters. Furthermore, it proposes an etiology of their distress.

Ratzan and Richard M (2014) studied that not only stress and sleeplessness but the sense of the patient as the cause of one's distress contributes to the doctor's detachment. Such detachment can blinker our eyes from seeing why patients come to the emergency room and prevent our ears from hearing.

Metaphors for mental distress as an aid to empathy: looking through The Bell Jar (Smith & Martin, 2012) this study concludes by emphasizing the multi-faceted presentations of self by both caring professional and service user and the importance of recognizing the subtleties of these in the context of the would-be therapeutic relationship.

Rationale of the Present Study

Empathy is a capacity, which allows an appreciation of separateness of human beings, and at the same time allows them to connect by attending to and feeling the emotional experience of others. On a large scale, even society recognizes the importance of empathy, for without it, we would have no sense of mercy or clemency when dispensing justice. Our society seems to be proceeding in a direction which ignored all empathetic concerns for others, and where people are busy in pursuing their self-oriented goals. But empathy is one step beyond this insensitivity and egocentricity. It seems that the roots of all social tensions and conflict resides in the lack of empathy, as it is important part which provides a bond among the spirits of one individual and those of alternatives.

Psychological problems also cause physical illness. Stress is one of the most common psychological conditions which is responsible of many physical illnesses. Tolerance of stress plays an important role in coping of stress. A person with distress tolerance will have fewer chances to badly influence by stress than a person with less distress tolerance.

Optimistic explanatory style will help them to positively explain their life events which will enrich their motivation regarding to professional life. Because when they use positive attribution style to explain any failure they face, next time they will try even harder instead of give up in the face of failure they face. It is important to study this construct in medical practitioners because it is important for them to view any setbacks positively that they face during their professional period this would helpful for them to succeed in life. Empathy, Learned optimism and Distress tolerance may help medical practitioners in facing day to day challenges.

The present study is conducted on Pakistani and American sample of medical practitioners. It has been observed that in hospitals medical practitioners (Doctors, Nurses and other Staff) are facing hectic routine and burden of work, which can lead to suppress their feelings of empathy, learned optimism and distress tolerance. Medical practitioners by the vary nature of their jobs, empathic ability, optimistic attribution style lead them to distress tolerance. Contextual factors of medical practitioners affect their empathetic behavior, learned optimism and distress tolerance. Due to job security, job designation and the type of organization also affect the behavior of medical practitioners. Although previous studies focused on the effect of a particular component of empathy, learned optimism and distress tolerance, this study focused on broader trends. The specific purpose of the study was first to determine the causes of empathy, learned optimism and distress tolerance and to discover how stressful these sources were in Pakistani and American context. Next, the connection between empathy, learned optimism and distress tolerance was assessed.

The major objectives of the present study were to investigate the relationship between empathy, learned optimism, and distress tolerance among Pakistani and American medical practitioners. It was also intended to determine the role of varying demographics (gender, nature of job, job designation and type of working area) in relation to empathy, learned optimism, and distress tolerance among medical practitioners.

Hypotheses

In accordance to the objectives, specifically following hypotheses were formulated.

H1: Empathy is positively related with learned optimism and distress tolerance.

H2: Learned optimism positively predict distress tolerance.

H3: American medical practitioners will exhibit more empathy, learned optimism and distress tolerance as compared to Pakistani medical practitioners.

H4: Medical professionals working in emergency wards will reflect higher empathy, learned optimism, and distress tolerance as compared to those working in non-emergency wards.

Method

Sample

Convenient and Purposive sample of Pakistani (n = 230) and American (n = 198) medical professionals was acquired from hospitals of Pakistan and America. Age range of Pakistani 26-55 (M= 32.85) and American 33-58 (M = 38.11) and nature of job individuals should be permanent working in public hospital with minimum job experience of 1 year in present hospital. Job designation of the respondents were Pakistani: Doctors (n = 66), nurses (n = 112), paramedics (n = 52). American: Doctors (n = 41), Nurses (n = 94), Paramedics (n = 63).

Measures

Following instruments were used.

Toronto Empathy Questionnaire. Toronto Empathy Questionnaire (Spreng, Mckinnon, Mar, & Levine, 2009) was used to assess empathy having 16 items ranging from never to always high score reflecting high empathy with the possible score range of 16-80. There were no reverse scoring in Toronto Empathy Questionnaire. Previously reported alpha coefficients (.84) had been found satisfactory (Spreng, Mckinnon, Mar, & Levine, 2009), while in the present sample α of .78 was achieved.

Life Orientation Scale. Life Orientation Scale (Carver et al., 2010) consisted of 10 items was used to assess the leaned optimism. Possible score range for 6 items (minus the 4 filler items); was 6 – 30, with high score mean that individual would be more optimistic towards life event. Respondents were

required to respond on a 5- point Likert scale ranging from 1 = agree a lot to 5 = disagree a Lot. Earlier studies reported adequate α coefficient (.72) (Tariq, 2014) in Pakistani researches whereas in the present study α of .74 was achieved.

Distress Tolerance Scale. Distress Tolerance Scale was developed by Simon and Gaher (2005). It consisted of 15 items based on four subscales, Absorption (no. of items = 3), Appreciation (no. of items = 6), Tolerance (no. of items = 3) and Regulation (no. of item = 3). Respondent were required to respond on each item on a 5- point Likert scale ranging from 1 = strongly disagree,2 = mildly disagree,3 = neutral,4 = Mildly agree and 5= strongly agree with the possible score range of 5-75. Interpretation of scores was linear with high score showed high distress tolerance and low score would indicate low distress tolerance. Previous researches reported alpha coefficients satisfactory such as .89 (Simon & Gaher, 2005) and .76 (Khan, 2013). alpha coefficient (.77) was acquired for the present study.

Procedure

Official permission was acquired from the administrative heads of hospitals of Pakistan and America. Participants were approached through by visiting relevant hospitals, taking assistance from staff of hospitals and through references applying snowball technique. Questionnaires were distributed among the participants at their workplaces. Participants were informed about the rationale of the study and their consent was acquired. They were also ensured of the confidentiality of their data and were told that the acquired information would only be used for the research purposes only. Participants signed the informed consent and questionnaires were administered on one to one basis and also told them that if they like to have the result of study they will get them through e-mail. They were thanked and appreciated for taking time out of hectic routine. They were happy to participate in the research.

Results

Correlation bivariate was used to assess the role of empathy and learned optimism in distress tolerance; t-test was used to determine group differences on gender and type of organization. Whereas, one-way ANOVA was conducted to explore the differences among groups on the basis of job designation and group differences.

Correlation of Empathy, Learned Optimism and Distress Tolerance

To study the relationship between empathy, learned optimism and distress tolerance Pearson Product Moment Correlation was computed. Results showed that empathy is positively associated with learned optimism (r = .23**, p < .01) and distress tolerance (r = .19*, p < .05). Moreover, learned optimism is also positively associated with distress tolerance (r = .24**, p < .01) in Pakistani culture.

Whereas, learned optimism is positively associated with empathy (r = .44**, p < .01) and distress tolerance (r = .38**, < .01). Moreover, distress tolerance is also positively associated with learned optimism (r = .56**, p < .01) in American culture.

Correlation Matrix of Empathy, Learned Optimism and Distress Tolerance (N=428)

Variables	Empathy	Learned optimism	Distress tolerance
Empathy	-	.23**	.19*
Learned optimism	.44**	-	.24**
Distress tolerance	.38**	.56**	-

*$p < .05$, **$p < .01$*

Values above diagonal Pakistani sample and Values below diagonal American sample Cross Cultural Comparison Differences among Pakistani and American Medical Professionals on Study Variables (N=428)

	Pakistani sample (n= 111)		American sample (n =139)				Cohen's d
Variables	*M*	*SD*	*M*	*SD*	*T*	*p*	
Empathy	34.08	9.11	39.67	8.54	4.79	.00	.51
Learned optimism	31.50	9.88	36.22	10.01	6.53	.00	.61
Distress tolerance	40.16	8.24	44.77	9.66	5.46	.00	.57

Table 1 Cross Culture Comparison Difference among Pakistani and American Medical Professionals on Study Variables (N = 428)

Table 1 demonstrate significant group differences in relation to empathy, learned optimism, and distress tolerance among Pakistani and American medical professionals. It has been found that

American medical professionals (doctors, nurses and paramedics) showed higher level of empathy, more learned optimism, and better distress tolerance as compared to their Pakistani counterparts.

Group Differences on Job Designations

Pakistani *(N = 230)*	Group 1 (*n* =66)		Group 2 (*n* = 112)		Group 3 (*n* =52)				Post Hoc Difference
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	
Empathy	38.44	5.13	32.75	6.29	30.18	6.33	4.55	.00	1>,2,3
Learned Opt	37.27	6.87	34.53	7.91	32.58	5.55	3.25	.01	1>,2,3;2>3
DT	48.57	5.33	46.15	6.61	40.65	7.02	4.28	.00	1>2,3;2>3
American *(N = 198)*	Group 1 (*n* =37)		Group 2 (*n* =58)		Group 3 (*n* =54)				
Empathy	34.25	7.09	37.11	9.20	33.76	8.14	6.47	.00	2>1,3
Learned Opt	33.54	6.29	31.26	5.44	31.50	8.16	1.17	.23	ns
DT	46.89	8.66	40.38	8.66	44.48	9.55	9.33	.00	2>1,3;1>3

Note. Opt. = Optimism, DT = Distress Tolerance, Group 1 = Doctors, Group 2 = Nurses, Group 3 = Paramedics

Table 2 One- Way ANOVA for Job Designation on Empathy, Learned Optimism and Distress Tolerance (N=428)

Table 2 illustrated group differences in terms of job designations along study variables. Results showed significant differences among Pakistani and American groups on all the variables. It was found that doctors working in Pakistani and American hospitals reflected higher empathy, elevated levels of learned optimism, and better distress tolerance as compared to nurses and paramedics. In addition, paramedics showed more learned optimism as compared to nurses; while, nurses showed better distress tolerance as compared to paramedics across both cultural groups.

Pakistani *(N = 230)*	Group 1 (*n* =55)		Group 2 (*n* =75)		Group 3 (*n* =61)		Group 4 (*n* = 39)				Post Hoc Difference
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	
Empathy	33.63	7.01	33.45	6.88	38.21	6.50	32.09	7.26	4.79	.00	3>1,2,4
LearnedOpt	34.85	5.88	35.29	6.35	39.77	6.94	34.53	6.47	3.91	.01	3>1,2,4
DT	40.51	8.11	42.59	9.04	44.33	9.29	49.82	8.75	5.01	.00	4>1,2,3;3>1,2; 1>2
American *(N = 198)*	Group 1 (*n* =37)		Group 2 (*n* =58)		Group 3 (*n* =54)		Group 4 (*n* = 49)				
Empathy	38.11	9.77	39.05	7.88	44.33	7.51	36.88	6.71	6.25	.00	3>1,2,4
LearnedOpt	42.06	8.25	42.90	8.13	46.75	9.23	40.47	8.42	10.22	.00	3>1,2,4
DT	45.62	9.49	44.83	10.11	48.67	9.30	42.45	11.55	8.54	.00	3>1,2,4;1>2; 4

Note. Opt. = Optimism, DT = Distress Tolerance, Group 1 = Psychiatric ward, Group 2 = Surgical ward, Group 3 = Emergency ward, Group 4 = others (OPD, Gyne ward, General ward, Medical ward, Neurological ward and Dentistry department).

Table 3 Group Differences on Work Area of Medical Professionals (N = 428)

Table 3 this table showed group differences on work area of Pakistani and American medical professionals. Results showed that Pakistani medical professionals working in emergency units displayed higher levels of empathy and learned optimism, while those rendering their services in general medical wards expressed better distress tolerance, followed by those working in emergency units and surgical units, however there were non-significant differences on empathy, learned optimism and distress tolerance across Pakistani medical professional working in psychiatric ward.

On the other hand American medical professionals working in emergency units displayed augmented levels of empathy and learned optimism as well as better distress tolerance. Conversely, medical professionals performing their duties in medical ward showed least amount of empathy and learned optimism along with Distress tolerance.

Discussion

The first hypothesis proposed that Empathy is positively related with learned optimism and distress tolerance. The positive relationship between constructs is in consistency with the findings of the previous studies. A strong positive relationship had been found between empathy and learned optimism in earlier literature (Sharifi, 2008). The findings of the research suggest that empathy has significant positive relationship with learned optimism. Our emotional state can possibly impact our reasoning. For instance, understudies learn and perform all the more effectively when they feel secure, glad, and excited about the subject matter (Boekaerts, Oatly & Nundy, as referred to in Hammond et al., 2006). Despite the fact that feelings can possibly empower understudies' reasoning, enthusiastic states additionally have the potential to interfere with learning. If students are excessively energized or excited, they may work indiscreetly or quickly rather than working systematically or deliberately. Moreover, feelings, for example, anger, nervousness, and trouble have the potential to distract students' learning efforts by interfering with their capacity to take care of the current workload.

Findings of the present study indicated that learned optimism positively predict distress tolerance. Optimism 'includes positive, generally stable, good desires and results for the future; it is associated with making positive psychological examinations of circumstances, then with making dynamic, engaged coping efforts to manage anxiety, making the best of whatever is experienced' (Collins in squeeze, 11). Pessimism, or negative influence, is connected with unfavorable desires, an excessive concentrate on distress and separated adapting (Chang 1998). Dekel et al. (2006) refer to studies that have affirmed significant relationships between optimism and subjective prosperity, great self-regard, low rate of despondency, low negative feelings and high life fulfillment. They note additionally that a couple of studies have analyzed the positive relationship between optimism, lower danger of pain and occupation wear out, while Chang (1998) has stressed varieties among societies. For instance, his examination has noticed that for Asian Americans, truth be told, negativity is connected with more critical thinking ways to deal with adapting, as opposed to the methodology of Caucasian Americans (Chang 1998).Acute psychosocial stress and emotion regulation skills modulate empathic reactions to pain in others (Buruck, Wendsche, Melzer, Strobel & Dörfel, 2014). Acute psychosocial stress might impair empathic processes to observed pain in another person and the ability to accept one’s emotion additionally predicts the empathic reaction. Furthermore, the ability to tolerate negative emotions modulated the relation between stress and pain judgments, and thus influenced core cognitive affective functions relevant for coping with environmental challenges. In conclusion, our study emphasizes the necessity of reducing negative emotions in terms of empathic distress when confronted with pain of

another person under psychosocial stress, in order to be able to retain pro-social behavior (Buruck, Wendsche, Melzer, Strobel & Dörfel, 2014).

Findings indicate that there is a significant difference between female and male practitioners who were observed on empathy, learned optimism and distress tolerance. The third hypothesis female practitioners will exhibit higher empathy, learned optimism and distress tolerance as compared to male practitioners was supported by the findings. These results are consistent with the previous studies (Eisenberg et al., 1996). These findings are quite in line with earlier literature, for instance significant gender differences were found in the present study. It has been observed that female practitioners reflected higher empathy, learned optimism, and distress tolerance in earlier study. Females scored high not only on the empathy but also tend to be more optimistic and having high ability to tolerate stress. Several studies have found significant differences between males and females in empathetic tendency, where females are more empathetic than males (Eysenek & Eysenek, 1978; Hoffman, 1977; Kalliopuska, 1983; Mehrabian & Epstein, 1972). The results findings support that females would score high on effective quality of relationship as compared to males. Hoffman differentiated between studies in which empathy was defined as an emotional response and studies in which researchers measured role taking. Eleven studies were included in his review including sixteen samples. Females scored higher in all studies and this finding was marginally significant.

In another study, Buri (1991) studied that males were significantly higher defense of rights, directiveness, and confidence. On the other hand, the female were highly reflecting expression of positive feelings, approval need, empathy, and somewhat surprisingly, on perceived social approval. Male usually express more self-confidence and dominance (i.e., directiveness). Female, on the other hand, are more nurturing and empathic. Thus the preceding review of research concerning gender differences in empathy support the prevailing gender-role stereotype that the females are more empathic than males.

Third hypothesis that Medical professionals working in emergency wards will reflect higher empathy, learned optimism, and distress tolerance as compared to those working in non-emergency wards. Prior studies in organization structures showed that job security played an important role in generating positive emotions and lesser job related stress (Swarnalatha & Sureshkrishna, 2013).In such a focused mechanical environment in automotive industry, human asset administration in an association assumes an imperative part in the middle of workers and the association by making the representatives fulfilled in their occupation and in a manner driving the association towards the way of accomplishment. The achievement of an association relies on upon worker's involvement in their work and the administrative

activities that give work fulfillment to the representatives. The advantages gave by the association to the representatives will make them work all the more excitedly and energetically towards the objectives of the association. Findings demonstrate that a significant relationship exists between administrative activities and representatives' employment fulfillment. This also suggests a positive association between employees' job satisfaction leads to increase in production as well as reduction in absenteeism and stress among the employees (Swarnalatha & Sureshkrishna, 2013). Table 4 indicates that there is significant differences were observed on empathy, learned optimism and distress tolerance. Health professionals appraised working emergency units as stressful and challenging and were experiencing psychological distress. Nurses appraised working emergency units significantly more threatening and experienced more anxiety as compared to doctors. Findings have important implications for provision of psychological interventions for the hospital staff that deals with emergency causalities (Kasuar, Rukhsana & Khan, Qurat-ul-Ain, 2012).

Conclusion

The purpose of the study was to explore the role of empathy and learned optimism in distress tolerance among medical practitioners. Findings indicate significant differences between empathy, learned optimism and distress tolerance. In addition to that it also found that gender plays an important role in empathy, learned optimism and distress tolerance among medical practitioners. Furthermore, the demographic variables greatly affect the perception of empathy, learned optimism and distress tolerance among medical practitioners. Results show differences in gender and significant differences in different demographics.

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