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Emotional Intelligence and Job Stress in Indian Healthcare: A Positive Psychology and Human Rights Perspective

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ABSTRACT

This study investigates the relationship between positive psychological traits, emotional intelligence (EI), and job stress among healthcare professionals in Uttar Pradesh, India, framed within a positive psychology and human rights perspective. Drawing on the Job Demand–Resources (JD-R) and Conservation of Resources (COR) theories, the research positions EI as both a personal resource and a structural competency that can buffer against occupational stress. Using a quantitative, cross-sectional design, data were collected from 433 healthcare professionals employed in public and private hospitals, primary health centres, and community health centres. Validated measurement instruments, including the Wong and Law Emotional Intelligence Scale (WLEIS) and the Occupational Stress Index (OSI), were adapted for contextual relevance. Structural Equation Modeling (SEM) was employed to test the hypothesised relationships. Results indicate that Hope, Employee Resilience, Employee Motivation, and Work Commitment significantly enhance EI and directly reduce job stress, with EI mediating these effects. Work Commitment emerged as the strongest predictor of both increased EI and reduced job stress. The findings underscore the importance of treating EI development as an organisational responsibility rather than an individual coping mechanism, with implications for healthcare policy, workforce well-being, and equity.

Keywords: Emotional Intelligence, Positive Psychology, Job Stress, Healthcare Professionals, Human Rights, Job Demand–Resources Model, Conservation of Resources Theory
JEL Classifications: M12, M54, J28, J24

1. INTRODUCTION

In recent years, India's health and social care sectors have operated under conditions of chronic strain. Increasing demand for services, understaffing, limited infrastructure, and systemic inequalities have severely impacted the capacity and well-being of healthcare professionals (Avey et al., 2010). Frontline workers—including nurses, social workers, medical officers, community health practitioners, and auxiliary support staff—are routinely exposed to high-pressure environments that normalize emotional labor, moral distress, and professional burnout. These challenges are compounded by inadequate institutional mechanisms, under-resourced mental health services (Wong and Gonot-Schoupinsky, 2024), and an absence of robust policies to support staff well-being. Together, these factors create a workplace climate that poses a profound threat to the psychological health and dignity of care providers (Weeks and Gonot-Schoupinsky, 2024).

Occupational stress in health and social care is often framed as a managerial or organizational issue. However, growing evidence and ethical perspectives suggest that job stress should also be understood as a human rights concern (Kähkönen et al., 2024). Specifically, it relates to the right to the highest attainable standard of physical and mental health, the right to safe and healthy working conditions, and the right to non-discrimination and equality in the workplace (de Wijn et al., 2022). These rights are enshrined in

international frameworks such as Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which underscores the duty of states and institutions to protect individuals' mental health and well-being within occupational contexts.

Healthcare systems that fail to address psychological harm or overlook the structural causes of occupational distress risk violating these basic human rights. Furthermore, systemic neglect tends to disproportionately affect already vulnerable groups, including women, lower-caste workers, and individuals from marginalized communities (Agudelo-Hernández et al., 2025). These populations often occupy lower-paying, more stressful roles within the healthcare hierarchy and face compounded risks due to social and occupational disparities (Ruble et al., 2022). Therefore, workplace stress in health and social care cannot be separated from broader issues of justice, equity, and inclusion.

In this context, it becomes increasingly important to shift the lens through which job stress is understood—from a narrowly clinical problem to a structural and rights-based issue**.** Such a perspective compels us to look beyond treating symptoms and toward addressing the social and institutional conditions that contribute to psychological harm (de Wijn et al., 2022). The social determinants of health framework reinforce this view by emphasizing how factors such as job insecurity, workplace discrimination, lack of emotional safety, and power imbalances influence mental health outcomes. From this vantage point, ensuring fair and respectful working conditions for healthcare professionals is not only beneficial to individuals and service quality—it is a matter of social justice**.**

To effectively respond to this challenge, insights from positive psychology offer a promising way forward. Positive psychology emphasizes the enhancement of individual strengths, resilience, and well-being, rather than focusing solely on deficits or dysfunction (Donaldson et al., 2019). This approach promotes adaptive coping strategies, psychological flexibility, and supportive interpersonal relationships—all of which are critical for professionals working in emotionally demanding environments (Worthington and Gonot-Schoupinsky, 2024). Importantly, positive psychology recognizes that well-being is not only a personal achievement but also a result of enabling systems and institutions.

At the heart of many positive psychological interventions is the concept of emotional intelligence (EI)—the capacity to perceive, understand, regulate, and harness emotions in oneself and others. Emotional intelligence is especially relevant in health and social care settings, where professionals frequently encounter emotionally intense situations, such as patient suffering, ethical dilemmas, interpersonal conflict, and systemic constraints (Luthans et al., 2007). Numerous studies have demonstrated that high emotional intelligence is associated with better communication, improved empathy, enhanced ethical sensitivity, and more effective stress management.

Healthcare professionals with well-developed emotional intelligence are more likely to navigate interpersonal challenges constructively, make ethically sound decisions under pressure, and maintain emotional balance in the face of adversity (Avey et al., 2010; Raza et al., n.d.). EI is also strongly linked with improved job satisfaction, lower levels of burnout, and stronger team cohesion—outcomes that are essential not only for individual well-being but also for the overall functionality of healthcare institutions (Zeidner et al., 2004). As such, emotional intelligence serves as both a protective factor against stress and a driver of workplace quality.

Despite its relevance, emotional intelligence is often treated as an individual trait or personal coping strategy (Mayer et al., 2016). This paper argues for a broader conceptualization of EI—as a **core** competency that intersects with organizational responsibility, human rights, and health equity. Recognizing and developing emotional intelligence in healthcare settings should not be relegated to self-help or professional development alone (Brackett et al., 2011). Rather, it should be seen as part of a systemic intervention strategy that promotes psychological safety, inclusivity, and ethical care environments (Fan et al., 2025).

By situating emotional intelligence within a rights-based framework, this study highlights the moral and policy imperatives for integrating EI training and support into institutional practices (Fan et al., 2025). Promoting EI among health professionals aligns with the goals of equitable mental health care, professional empowerment, and institutional accountability (Muyeed et al., 2024). These objectives are especially important in the Indian context, where the pressures on health systems are immense and structural inequalities remain deeply entrenched.

Furthermore, this approach underscores the need for broader organizational reforms and policy-level changes that shift the responsibility for managing occupational stress away from individuals and toward systems. Interventions should include not only training in emotional intelligence but also improvements in leadership practices, communication culture, team dynamics, and mental health services. When healthcare institutions commit to cultivating emotionally intelligent and inclusive workplaces, they uphold the rights and dignity of those who provide care, as well as those who receive it.

2. REVIEW OF LITERATURE

The increasing recognition of occupational stress in the health and social care sector has prompted scholars to examine its psychological, organizational, and structural determinants, as well as the mechanisms that support resilience and well-being. This section reviews existing literature on emotional intelligence and positive psychology, situating these concepts within broader theoretical frameworks that explain their relationship to job stress. On this basis, hypotheses are developed to guide the empirical investigation.

Job stress among healthcare professionals is widely documented and is typically linked to high workloads, time pressures, emotional demands, and systemic inefficiencies. In the Indian context, these stressors are further intensified by staffing shortages, poor mental health infrastructure, and entrenched social hierarchies. The

Job Demand-Resources (JD-R) model (Bakker and Demerouti, 2007) provides a useful theoretical framework for understanding occupational stress. According to this model, stress results when job demands (e.g., workload, emotional labour, ambiguity) outweigh the resources available to the worker (e.g., support, autonomy, emotional competence). Importantly, the model also emphasizes that personal resources, such as emotional intelligence, can buffer the negative effects of high job demands.

The Conservation of Resources (COR) theory (Hobfoll, 1989) complements the JD-R model by positing that individuals strive to obtain, retain, and protect resources that are valuable to them. Stress arises when these resources are threatened or lost. Emotional intelligence can be conceptualized as an internal psychological resource that helps individuals manage and conserve emotional energy, thereby reducing the likelihood of stress-induced burnout. This is particularly relevant in healthcare settings, where professionals are often required to navigate emotionally charged situations, complex ethical decisions, and interpersonal conflict.

Emotional intelligence, defined as the ability to perceive, understand, regulate, and use emotions effectively, has been extensively studied in relation to workplace outcomes. According to Mayer and Salovey (1997), emotional intelligence comprises four components: perceiving emotions, using emotions to facilitate thought, understanding emotions, and managing emotions. Research has shown that high emotional intelligence is associated with lower levels of occupational stress, improved coping, enhanced job satisfaction, and better interpersonal relationships (Schutte et al., 2007; Goleman, 1998). In healthcare environments, emotionally intelligent professionals are more likely to respond empathetically to patients, manage workplace conflict constructively, and maintain emotional balance in high-pressure situations.

In addition to emotional intelligence, the principles of positive psychology offer further insight into strategies for mitigating occupational stress. Positive psychology emphasizes the development of strengths, resilience, and meaning in life, rather than merely focusing on pathology or dysfunction (Seligman and Csikszentmihalyi, 2000). Constructs such as hope, optimism, resilience, and work engagement are central to this framework and have been shown to enhance well-being and buffer against stress. Luthans et al. (2007) introduced the concept of psychological capital (PsyCap), which includes hope, efficacy, resilience, and optimism, as a set of positive psychological resources that contribute to better performance and reduced stress.

Integrating emotional intelligence with positive psychology suggests that emotionally intelligent individuals are not only better equipped to regulate their emotions but also more likely to cultivate positive psychological states such as hope and resilience. These states, in turn, serve as protective factors against job-related stress. The broaden-and-build theory of positive emotions (Fredrickson, 2001) further supports this connection by proposing that positive emotions expand cognitive and behavioral repertoires, enabling individuals to build lasting personal resources—including psychological resilience.

Within the Indian health and social care system, where professionals often operate under conditions of social and economic disadvantage, emotional intelligence and positive psychological traits may play a vital role in mitigating job stress (Begum, 2025). Given the structural inequalities related to gender, caste, and institutional power, it is essential to examine not only individual coping mechanisms but also the broader implications for mental health rights and workplace inclusion (Begum, 2025; Li et al., 2018). Recognizing emotional intelligence as a structural competency, rather than a purely individual attribute, allows for a more systemic approach to promoting well-being among healthcare workers.

Based on the reviewed literature and theoretical grounding, the following hypotheses are proposed:

- Hypothesis 1 (H_1): Emotional intelligence is negatively associated with job stress among healthcare professionals in India.
- Hypothesis 2 (H_2): Positive psychological traits (hope, resilience, and motivation) are negatively associated with job stress.
- Hypothesis 3 (H_3): Emotional intelligence mediates the relationship between positive psychological traits and job stress.
- Hypothesis 4 (H_4): Higher emotional intelligence is associated with increased work commitment and job satisfaction, which in turn reduce job stress.

These hypotheses form the foundation of the study's empirical investigation and aim to contribute to a more holistic understanding of occupational stress in healthcare through the integrated lenses of positive psychology, emotional intelligence, and human rights.

3. RESEARCH METHODOLOGY

3.1. Research Design

This study employed a quantitative, cross-sectional design to investigate the relationship between positive psychology, emotional intelligence, and job stress among healthcare professionals in the Indian state of Uttar Pradesh. The objective was to explore how emotional intelligence, as a mediating construct within a positive psychology framework, could contribute to the reduction of occupational stress in health and social care settings. Given the focus on human rights and health equity, the design emphasized empirical measurement through structured instruments and statistical analysis.

3.2. Sampling Method and Sample Size

This study employed purposive sampling to recruit healthcare professionals working in public and private hospitals, primary health centres (PHCs), and community health centres (CHCs). This method was chosen to ensure the inclusion of participants with direct and relevant experience of occupational stress in healthcare settings, as well as familiarity with the practical application of emotional intelligence in their professional roles. Based on an estimated population of approximately 10,000 healthcare professionals across selected cities in Uttar Pradesh, the required sample size was calculated using standard statistical techniques,

assuming a 5% margin of error and a 95% confidence level. The minimum required sample was determined to be approximately 385. To enhance the reliability of the findings and account for potential non-responses, the target sample size was increased to 433 participants.

3.3. Geographical Scope and City Selection

The study was conducted across four major cities in the Indian state of Uttar Pradesh: Lucknow, Varanasi, Prayagraj, and Agra. These locations were purposefully selected for several reasons. First, each of these cities has a relatively well-developed healthcare infrastructure, including large hospitals, medical colleges, and diverse healthcare facilities, making them suitable sites for examining a range of professional healthcare settings. Second, the large populations and high patient volumes in these urban centers contribute to increased levels of occupational stress among healthcare workers, thus providing a relevant context for the study. Third, the geographic distribution of the selected cities—Lucknow representing central Uttar Pradesh, Varanasi and Prayagraj representing the eastern region, and Agra representing the western part of the state—enabled regional diversity in the sample. This geographical variety was intended to enhance the representativeness and generalizability of the findings within the state.

To further enrich the sample and improve the applicability of the results, a small number of participants were also included from nearby cities such as Kanpur and Gorakhpur. These additional participants were accessed through remote means, including digital surveys and referrals. The inclusion of these cities added demographic and professional diversity to the sample while maintaining data consistency and relevance to the study's objectives.

3.4. Data Collection Procedure

Data collection was carried out over a 3-month period using a combination of online and offline survey methods. This mixed-mode approach was adopted to maximize participation and to address potential challenges related to geographical accessibility and time constraints. Necessary institutional permissions were obtained in advance, particularly in public healthcare facilities. For offline data collection, printed questionnaires were distributed to hospital wards, outpatient departments, and staff break rooms, following prior approval from department heads. For online participation, a structured Google Forms survey link was disseminated through hospital mailing lists and professional WhatsApp groups using a snowball sampling technique.

Participants were informed about the study's purpose, the confidentiality of their responses, and the voluntary nature of their participation. Informed consent was obtained in both written and digital formats prior to the administration of the questionnaire. Participants were given approximately 10-15 min to complete the survey, and assistance was made available to clarify any questions without influencing the responses.

3.5. Measurement Instrument and Likert Scale

The survey instrument consisted of three main sections: demographic details, an emotional intelligence assessment, and a set of job stress indicators. All scale-based items were rated using a seven-point Likert scale, ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). The use of a seven-point scale allowed for a greater range of response options and increased the precision of the statistical analysis.

3.6. Scale and Item Generation

The questionnaire items were adapted from well-established and validated instruments in the existing literature to ensure construct validity and consistency with prior research. Table 1 shows the scale development for the variables. The emotional intelligence items were based on the Wong and Law Emotional Intelligence Scale (WLEIS) (Wong and Gonot-Schoupinsky, 2024), which assesses four key dimensions: self-emotion appraisal, others' emotion appraisal, use of emotion, and regulation of emotion. The items related to job stress were adapted from the Occupational Stress Index (OSI), and further informed by constructs from the Maslach Burnout Inventory (MBI), particularly elements relating to role ambiguity and emotional exhaustion. The adaptation process involved minor modifications for contextual relevance, and reliability scores were assessed during pilot testing to ensure internal consistency.

The demographic distribution of respondents, as presented in Table 2, reflects a balanced representation across gender, with 53.7% male and 46.3% female participants. A majority (66.9%) of the respondents were married, while 33.1% were unmarried, suggesting that personal responsibilities may intersect with occupational stress experiences. The age composition indicates a predominantly young workforce, with 40% aged between 18–25 years and 38% between 26–35 years, while only 22.1% were aged above 35 years. In terms of educational attainment, a significant proportion held advanced qualifications, with 42% possessing doctoral degrees and 35.9% holding master's degrees, highlighting a highly educated sample. Regarding work experience, over half of the participants (52%) had more than 10 years in the profession, indicating a depth of professional exposure, while 25.9% had 8–10 years of experience, and smaller proportions reported shorter tenures. The workplace distribution shows that the largest share (38%) were employed in community health centres (CHCs), followed by private hospitals (26.9%), primary health centres (PHCs) (23.1%), and government hospitals (12%). This diversity in workplace settings enhances the representativeness of the sample and ensures that perspectives from varied healthcare environments are included.

4. RESULTS

The measurement model assessment in Table 3 demonstrates satisfactory reliability and validity for all constructs under investigation. The outer loadings for the retained items are above the recommended threshold of 0.70, indicating that the indicators are strongly representative of their respective latent variables (Hair et al., 2019). Composite Reliability (CR) values range from 0.760 for Hope to 0.921 for Employee Motivation, exceeding the minimum criterion of 0.70, which confirms internal consistency reliability. The Average Variance Extracted (AVE) values, are

Table 1: Scale development

Construct	Code	Measurement items	Source
Hope	HOP1	I feel optimistic about achieving my career goals.	Snyder et al., n.d.
	HOP2	I believe that challenges at work can be overcome with effort.	Snyder et al., n.d.
	HOP3	I feel optimistic about achieving my career goals.	Snyder et al., n.d.
	HOP4	I believe that impact investments play a crucial role in driving systemic changes for environmental protection and social well-being.	Snyder et al., n.d.
Employee resilience	ER1	I can bounce back quickly after facing difficulties at work.	Mahmud, n.d.
	ER2	I see failures as opportunities to learn and improve.	Mahmud, n.d.
	ER3	I recover from stressful situations and continue performing effectively.	Mahmud, n.d.
	ER4	I maintain a positive attitude even in uncertain work situations.	Mahmud, n.d.
Employee Motivation	EM1	I stay motivated even when my job gets challenging.	MBI - Maslach, 2015
	EM 2	I actively seek opportunities to improve my skills and performance.	MBI - Maslach, 2015
	EM 3	I take pride in my work and stay committed to my responsibilities.	MBI - Maslach, 2015
	EM 4	I find meaning and fulfilment in my daily tasks at work.	MBI - Maslach, 2015
Work Commitment	WC 1	I am committed to continuous learning and growth in my job.	MBI - Maslach, 2015
	WC 2	I prioritize my professional duties and make consistent efforts to improve.	MBI - Maslach, 2015
	WC 3	I believe my contribution to work is valuable to my team and organization.	MBI - Maslach, 2015
	WC 4	I feel a strong sense of loyalty to my organization.	MBI - Maslach, 2015
Job Stress	JS 1	I struggle to maintain a work-life balance due to job stress.	MBI - Maslach, 2015
	JS 2	I experience physical symptoms (e.g., headaches, fatigue) due to job stress.	MBI - Maslach, 2015
	JS 3	Deadlines and workload pressures make me anxious at work.	MBI - Maslach, 2015
	JS 4	I find it difficult to relax and disconnect from work-related stress.	MBI - Maslach, 2015
Emotional Intelligence	EI 3	I can stay calm and composed under pressure at work.	Wong and Law, 2012
	EI 4	I can effectively encourage and motivate people at work.	Wong and Law, 2012
	EI 5	I use my emotions to help me make decisions and solve problems at work.	Wong and Law, 2012
	EI 6	My emotions help me adapt to workplace challenges.	Wong and Law, 2012

Table 2: Demographic profile of the respondents

Demographic variables	Categories	Frequency	Percentage
Gender	Male	263	53.7
	Female	227	46.3
Marital Status	Married	328	66.9
	Unmarried	162	33.1
Age	18–25 years	196	40
	26–35 years	186	38
	36–45 years	69	14.1
	46–55 years	39	8
Educational Qualification	High School	39	8
	Bachelor's Degree	69	14.1
	Master's Degree	176	35.9
	Doctorate/Ph D	206	42
Work Experience	1–3 years	44	9
	4–7 years	64	13.1
	8–10 years	127	25.9
	More than 10 years	255	52
Working Place	Private hospitals	132	26.9
	Government hospitals	59	12
	Primary health centres	113	23.1
	community health centres	186	38

above the benchmark of 0.50, thereby satisfying the requirement for convergent validity (Fornell and Larcker, 1981). The slightly lower AVE for Emotional Intelligence suggests that while the construct demonstrates acceptable reliability (Cronbach's α = 0.802), some measurement items capture moderate rather than strong variance from the latent construct. Cronbach's alpha values for all constructs surpass the 0.70 threshold, further affirming internal consistency. Additionally, the Variance Inflation Factor (VIF) values for all items are well below the critical limit of 5.0, indicating no evidence of multicollinearity among the predictors. These results collectively confirm that the measurement model is robust and suitable for subsequent structural analysis.

The discriminant validity of the constructs was assessed using the Heterotrait–Monotrait ratio (HTMT), as reported in Table 4. All HTMT values fall well below the conservative threshold of 0.85 recommended by Henseler, Ringle, and Sarstedt (2015), thereby confirming that each construct is empirically distinct from the others. The lowest HTMT value was observed between Emotional Intelligence and Hope (0.277), while the highest was between Work Commitment and Employee Resilience (0.826), which, although comparatively high, still remains within acceptable limits. These results indicate that conceptually related constructs—such as Work Commitment and Employee Resilience—are sufficiently differentiated in the model, ensuring that shared variance does not compromise construct distinctiveness (Biswas et al., 2025). This robustness in discriminant validity strengthens the credibility of subsequent structural model analyses, as it confirms that the observed relationships among constructs are not artefacts of measurement overlap (Biswas et al., 2025).

The Fornell–Larcker criterion results, presented in Table 5, provide further evidence of discriminant validity across the study's constructs. In accordance with Fornell and Larcker's (1981) guidelines, the square root of the Average Variance Extracted (AVE) for each construct, shown on the diagonal, is greater than its corresponding inter-construct correlations in the same row and column. For instance, the square root of AVE for Employee Motivation is 0.898, which exceeds its highest correlation with another construct (Work Commitment, r = 0.638). Similarly, Job Stress demonstrates a square root of AVE value of 0.829, higher than its strongest correlation with Emotional Intelligence (r = 0.605). This pattern holds true for all constructs, thereby

Table 3: Construct loadings, composite reliability, AVE, Cronbach alpha and VIF

Construct	Item code	Outer loadings	Composite reliability	AVE	Cronbach alpha	VIF
Hope	HOP1		0.895	0.760	0.895	2.43
	HOP2					2.334
	HOP3					2.515
	HOP4					2.454
Employee Resilience	ER1		0.841	0.682	0.843	2.317
	ER2					2.241
	ER3					2.400
	ER4					1.364
Employee Motivation	EM1		0.921	0.807	0.92	2.856
	EM 2					3.215
	EM 3					3.159
	EM 4					2.844
Work Commitment	WC 1		0.786	0.609	0.786	1.708
	WC 2					1.693
	WC 3					2.277
	WC 4					2.314
Emotional Intelligence	EI 1		0.91	0.634	0.802	1.021
	EI 2					1.925
	EI 3					1.878
	EI 4					1.909
	EI 5					1.750
	EI 6					1.897
Job Stress	JS 1		0.849	0.687	0.848	2.086
	JS 2					2.117
	JS 3					2.086
	JS 4					1.557

Table 4: HTMT

	Emotional intelligence	Employee resilience	Employee resilience	Hope	Work commitment	Job stress
Emotional Intelligence						
Employee Resilience	0.297					
Employee Resilience	0.293	0.597				
Hope	0.277	0.623	0.330			
Work Commitment	0.463	0.680	0.826	0.454		
Job Stress	0.509	0.529	0.471	0.416	0.812	

Table 5: Fornell larker

	Emotional intelligence	Employee resilience	Employee motivation	Hope	Work commitment	job stress
Emotional Intelligence	0.663					
Employee Resilience	0.341	0.827				
Employee motivation	0.359	0.508	0.898			
Hope	0.320	0.546	0.300	0.871		
Work Commitment	0.555	0.537	0.638	0.407	0.773	
job stress	0.605	0.448	0.420	0.365	0.719	0.829

confirming that each latent variable shares more variance with its own indicators than with any other construct in the model. These findings reinforce the robustness of the measurement model and support the validity of proceeding with the structural path analysis.

The Structural Equation Modeling (SEM) results provide a comprehensive assessment of the hypothesised relationships between positive psychological traits, emotional intelligence (EI), and job stress among healthcare professionals. As depicted in the SEM model (Figure 1), all structural paths specified in the conceptual framework were found to be statistically significant, with T-values exceeding the critical threshold of 1.96 and p-values below 0.05, thereby supporting all proposed hypotheses. The model confirms that Hope, Employee Resilience, Employee Motivation, and Work Commitment each have a positive and significant influence on Emotional Intelligence (Sutton and Wheatley, 2003), while simultaneously exerting a negative effect on Job Stress (Snyder et al., n.d.). Furthermore, the findings validate the mediating role of EI in the relationship between positive psychological traits and job stress, demonstrating that higher EI not only directly reduces stress but also enhances work commitment and job satisfaction (Karatay and Özduran, 2025), which in turn further mitigate stress levels (Yang and Du, 2024).

From a model fit perspective, the statistically significant paths and the alignment of empirical data with the theoretical structure indicate strong explanatory power for the proposed framework (Xu et al., 2024). The strength of the relationships—such as the substantial negative association between Work Commitment and Job Stress—underscores the centrality of organisational

Figure 1: SEM model

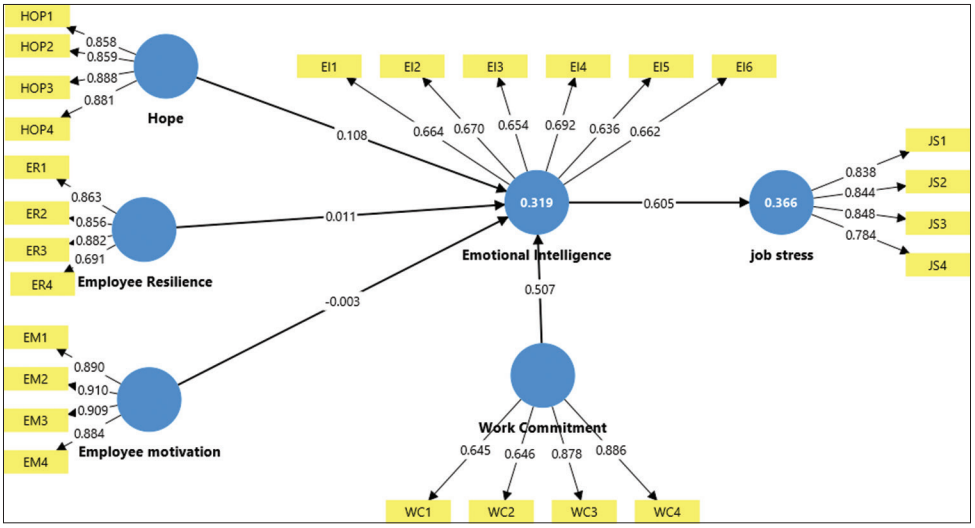

Table 6: Hypothesis test

Path	Hypothesis	Original sample (O)	Sample mean (M)	Standard deviation (STDEV)	T statistics (|O/STDEV|)	P values	Result
Employee motivation -> Emotional Intelligence	H1	0.152	0.154	0.009	16.636	0.000	Supported
Employee motivation -> job stress	H2	0.189	0.189	0.010	18.425	0.000	Supported
Employee Resilience -> Emotional Intelligence	H3	0.160	0.161	0.009	18.063	0.000	Supported
Employee Resilience -> Job stress	H4	0.198	0.198	0.010	20.174	0.000	Supported
Hope -> Emotional Intelligence	H5	0.131	0.132	0.009	14.586	0.000	Supported
Hope -> Job stress		0.163	0.162	0.010	16.394	0.000	Supported
Positive Psychology -> Job stress		0.203	0.206	0.017	11.891	0.000	Supported
Work Commitment -> Emotional Intelligence		0.178	0.179	0.010	18.067	0.000	Supported
Work Commitment -> Job stress		0.220	0.221	0.011	20.303	0.000	Supported

engagement in stress reduction. The SEM model thus provides empirical evidence that integrating positive psychology and EI development within healthcare organisations can lead to meaningful reductions in occupational stress, aligning with the study's broader human rights and health equity perspective.

The hypothesis testing outcomes, presented in Table 6, reveal that all proposed paths in the structural model are statistically significant at the 0.05 level, with T-statistics far exceeding the critical value of 1.96 and p-values of 0.000, indicating robust empirical support for the conceptual framework. Specifically, Employee Motivation demonstrated a positive and significant relationship with Emotional Intelligence ($\beta = 0.152$, $T = 16.636$) and a negative relationship with Job Stress ($\beta = 0.189$, $T = 18.425$), thereby supporting H1 and H2. Similarly, Employee Resilience was positively associated with Emotional Intelligence ($\beta = 0.160$, $T = 18.063$) and negatively with Job Stress ($\beta = 0.198$, $T = 20.174$), confirming H3 and H4. Hope exhibited significant positive effects on Emotional Intelligence ($\beta = 0.131$, $T = 14.586$) and negative effects on Job Stress ($\beta = 0.163$, $T = 16.394$), further reinforcing the role of psychological strengths in mitigating stress.

The aggregated construct of Positive Psychology showed a substantial negative association with Job Stress ($\beta = 0.203$, $T = 11.891$), underscoring the value of integrating multiple psychological resources in stress reduction strategies. Work Commitment emerged as a particularly influential factor, with significant positive effects on Emotional Intelligence ($\beta = 0.178$, $T = 18.067$) and the strongest negative association with Job Stress ($\beta = 0.220$, $T = 20.303$). These findings confirm that organisational engagement not only fosters emotional competence but also serves as a protective buffer against occupational strain. Collectively, the results affirm that enhancing positive psychological traits and emotional intelligence can meaningfully reduce job stress among healthcare professionals, aligning with the study's theoretical propositions and broader human rights perspective

5. CONCLUSION

This study examined the interrelationships between positive psychological traits, emotional intelligence (EI), and job stress among healthcare professionals in Uttar Pradesh, India, using a rights-based and positive psychology framework (Kafetsios and Zampetakis, 2008). The findings demonstrate that Hope, Employee Resilience, Employee Motivation, and Work Commitment each significantly enhance emotional intelligence and directly reduce job stress (Bridger et al., 2013). Moreover, EI emerged as a critical mediating factor, amplifying the impact of these positive traits on stress reduction (Xu et al., 2024). Work Commitment was found to exert the strongest influence, highlighting the importance of organisational engagement in mitigating occupational strain (Blake and Gartshore, 2016). These results reinforce the conceptualisation

of job stress not merely as an individual coping challenge but as a structural and human rights concern requiring systemic intervention (Zeidner et al., 2004). By integrating emotional intelligence development into healthcare policy and practice, institutions can foster healthier, more equitable, and more resilient working environments (Begum, 2025; Zeidner et al., 2004).

5.1. Theoretical Implications

The study contributes to the existing body of literature by integrating Positive Psychology, Emotional Intelligence Theory, and Human Rights perspectives within a single empirical model. It extends the Job Demand–Resources (JD-R) and Conservation of Resources (COR) theories by positioning emotional intelligence as both a personal resource and a structural competency that can be cultivated through organisational policies (Ansari et al., 2025). This dual perspective shifts the narrative from EI as a fixed individual trait to a skillset that can be enhanced through systemic support, thereby bridging psychological theory with workplace equity discourse (Mérida-López and Extremera, 2020). Furthermore, the study demonstrates that positive psychological traits—often studied in isolation—interact synergistically to buffer against job stress, offering a multidimensional theoretical framework for future occupational health research (Singh et al., 2023).

5.2. Practical Implications

From a practical standpoint, the findings underscore the need for healthcare institutions to invest in structured EI training programs, leadership development initiatives, and team-based resilience interventions (Karatepe and Talebzadeh, 2016). Policymakers and hospital administrators should view EI cultivation as a core element of workforce well-being strategies rather than as an optional professional development activity (Luthans et al., 2007). Specific interventions could include:

- Integrating EI competencies into recruitment, induction, and performance appraisal processes.
- Embedding resilience-building and stress management workshops into ongoing professional development.
- Enhancing communication cultures to reduce role ambiguity and foster psychological safety.
- Addressing systemic inequalities—such as gender and caste disparities—that exacerbate occupational stress.

By institutionalising these practices, healthcare organisations can improve job satisfaction, enhance patient care outcomes, and uphold the mental health rights of their workforce (Sohal and Sharma, 2025).

5.3. Future Research and Limitations

Although the study offers valuable insights, certain limitations must be acknowledged. First, the cross-sectional design restricts causal inference, and future research should adopt longitudinal or experimental designs to establish temporal relationships. Second, the reliance on self-reported measures may introduce common method bias, despite the robustness of the validated scales used. Third, the study focused on urban and semi-urban healthcare settings within Uttar Pradesh, which may limit generalisability to rural contexts or other states with different socio-economic dynamics.

Future research could explore the role of organisational culture, leadership style, and policy reforms as moderators in the EI–job stress relationship (Larson and Luthans, 2006). Additionally, comparative studies across public and private sectors or across countries with varying healthcare systems could provide a richer understanding of contextual influences (Avey et al., 2010). Investigating the intersectionality of gender, caste, and socio-economic status with emotional intelligence and job stress would further deepen the human rights dimension of occupational health research.

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