




## Article

# Differential Effects by Caring and Positive Empathy on Depression and Anxiety: Gender Differences in a Sample of Spanish University Students

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**Abstract:** (1) Background: The literature to date has shown some contradictory findings regarding the associations between empathy and mental health. Thus, the caring component of the Positive Youth Development model has been related to more mental health symptoms, while positive empathy seems to have a positive impact on psychological adjustment. The present study aimed to analyze the associations between caring and positive empathy with youth depression and anxiety, as well as examine gender differences. (2) Methods: A cross-sectional study was carried out by administering an online self-report to a sample composed of 370 university students (67.2% women), aged 18–29 ( $M = 21.29$ ,  $SD = 3.61$ ), enrolled across 10 universities in the Spanish region of Andalusia; (3) Results: Women reported higher levels of the caring dimension of PYD, more positive empathy, but more symptoms of depression and anxiety. Mediation analyses to explain the gender differences in mental health concluded that (a) women reported more depression and anxiety partly due to their higher scores in caring, and (b) despite women had more positive empathy than men, this mechanism was only protective against anxiety in the subsample of men; (4) Conclusions: The promotion of mental health in the university context should address gender differences and the role of caring and positive empathy.

**Keywords:** caring; empathy; positive youth development; depression; anxiety; gender; emerging adults; undergraduates; mediation analyses



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## 1. Introduction

The Positive Youth Development (PYD) model proposed a strength-based perspective of the transition to adulthood, in which positive outcomes appear when the youth's personal skills and contextual developmental assets are properly aligned [1,2]. The 5Cs model of PYD was presented by Lerner et al. [3], in which five thriving indicators are differentiated and expected to be related to better health and well-being in adolescent and youth samples [4–7]. These 5Cs are defined as follows: confidence (overall positive self-worth), competence (positive self-efficacy in life domains such as academic or social), connection (positive interpersonal relationships), character (adequate internalization of the social rules and values), and caring (feeling sympathy and empathy toward others). Evidence to date has determined that the 5Cs showed cross-lagged prospective associations with some positive outcomes across the youth period. Each C of PYD describes a developmental regulation, that is, an intersection between youth and their contexts. However,

some paradoxical results have been observed concerning the dimension of caring in PYD (as a thriving indicator) and some mental health results. In a longitudinal study with adolescents in the US, Geldhof et al. [8] pointed out a small positive correlation between caring and depressive symptomatology. Along this same line, Dvorsky et al. [9] reached the same conclusion with a sample of US undergraduates. They also observed positive associations between caring, depression, and emotional regulation difficulties. Following Geldhof et al. [8], “Caring indicates developmentally and contextually appropriate levels of concern for others, and connection requires that the individual be embedded in, and supported by, a reliable and diverse social network” (p. 3). These authors supported the notion that excessive caring may be maladaptive because it produces a martyring developmental regulation characterized by overconcern about others’ thoughts and feelings.

In line with these results in US samples, several studies have also confirmed these paradoxical findings in European samples. Thus, Holsen et al. [10] found, in Norwegian youth, that caring was positively related to both anxiety and depressive symptoms. In Croatia, Novak et al. [11] found a protective role of PYD against adolescent mental distress, except for caring, which was related to more depression, anxiety, and stress. In this same line, Marin-Gutierrez et al. [12] demonstrated that caring was positively correlated with perceived stress, while Confidence and Connection played a protective role in Chilean adolescents. In Slovenia, Pivec and Kozina [13] have reported that caring was positively associated with anxiety and COVID-19 anxiety in a sample of adolescents. Some cross-national studies have also addressed this gap in the literature. Kozina et al. [14] analyzed youth samples from Slovenia, Portugal, and Spain, and showed that Connection and Confidence were protective factors against anxiety, while caring presented a detrimental effect. In a study with samples from Spain and Croatia, Gomez-Baya et al. [15] explored the associations between the 5Cs of PYD and depression with data collected before the COVID-19 pandemic. These authors concluded that more Confidence and more Connection were associated with less depressive symptoms, but more caring was associated with more depressive symptoms. Finally, a study with undergraduates from Peru and Spain during the pandemic, conducted by Manrique-Millones et al. [16], showed negative effects by Competence, Confidence, Character, and Connection on depressive symptoms, while Caring had a positive one in both samples. Other studies have reported the association between dispositional compassion and suicidal ideation [17] and depressive symptoms in adolescent and youth samples [18].

Based on these findings about the maladaptive consequences of caring, some authors have tried to provide some possible explanations. Geldhof et al. [19] argued about the importance of the interactions among the 5Cs of PYD. More than two decades ago, Schieman and Turner [20] found that the association between empathy and distress was stronger among people who reported less education, lower self-esteem, and lower mastery. Thus, they posited that one component can sometimes be related to psychological maladjustment depending on the quality of the interactions between youth and their contexts. Those youths who spend elevated and exhausting attention to others’ thoughts and feelings may have increased difficulties developing positive psychological adjustment. This kind of over-investment in others’ lives may lead to empathic stress when the boundaries between other people and themselves get blurred, and they cannot cope with that situation. Thus, high scores in the caring component of PYD may produce some exaggerated emotional hypersensitivity, instead of a way to provide useful prosocial and altruistic behavior. Adaptive help to others has been associated with positive mental health consequences [21].

Furthermore, some authors have pointed out the differential impact on mental health by empathy for positive or negative emotions. The concept of empathy has been used to refer to different phenomena associated with emotion sharing, including car-

ing for others, understanding others, and validating others' emotions, as underlined by Wondra and Ellsworth [22]. These authors concluded that the main issue in the study of emotions for others is what makes something that is happening to another person good or bad to the empathic observer. Thus, empathetic response is subject to other stimuli, and a range of different emotions may evoke empathy, distinguishing between negative empathy (i.e., empathy for others' pain or sadness) and positive empathy (i.e., empathy for others' happiness) [23]. Andreychik and Migliaccio [24] concluded that empathizing with the positive or negative emotions of others implied different patterns of social behavior and social emotion. In another study, Andreychik and Lewis [25] distinguished between positive and negative empathy, examining the motivation to help others. They found that negative empathy is related to a motivation to help others avoid negative emotions, contrary to positive empathy, which is associated with an other-oriented motivation to help others approach positive emotions. Furthermore, Morelli et al. [26] reviewed the emerging study of positive empathy. They concluded that positive empathy has been associated with more prosocial behavior (i.e., spending on others, emotional support, and tangible assistance), well-being (i.e., positive affect and life satisfaction), and more social connection (i.e., closeness, trust, and relationship satisfaction). Concerning the association with emotional problems, these authors argued that more evidence is still needed to more clearly understand how altered sensitivity to others' positive emotions may contribute to clinical problems. Morrison et al. [27] concluded that individuals with social anxiety, compared to healthy controls, were less able to vicariously share others' positive emotions. With regard to the link between positive empathy and prosocial behavior, Telle and Pfister [28] presented a model in which the perception of positive affect in others triggers vicarious positive emotion (positive empathy), which is associated with mood maintenance motive, which also triggers prosocial behavior, and in turn it, causes genuine positive emotion.

If the paradoxical effects of caring and empathy have generated some interest in the scientific community, the examination of gender differences seems to be a key aspect to guide the design of effective interventions to protect youth mental health. Some studies have found some gender differences in caring, with women showing higher mean scores than men [29,30]. Conway et al. [31] found, in Ireland, higher scores in caring among female adolescents, and Gomez-Baya et al. [32] found the same result in a sample of Spanish students from high school and university. Cross-cultural evidence has been documented concerning gender differences in caring morality, so women showed more interpersonal sensitivity in Korea, China, Thailand, and the USA [33]. Other studies have examined this tendency in gender differences along with its impact on related variables. In a 6-wave prospective study in the Netherlands, adolescent girls experienced an increase in prosocial behavior, which was predicted by higher scores in perspective-taking and empathic concern [34]. Moreover, in US undergraduates, women were found to report more empathy as well as more emotional reactivity than men [35]. Rochat [36] indicated that sex and gender differences in the development of empathy throughout the lifespan are due to the joint interaction of social and neurobiological factors, including early socialization, the brain's structural/functional variances, and genetics and hormonal factors. Furthermore, the literature to date has documented well the emergence of gender differences in emotional problems since adolescence [37]. Gomez-Baya et al. [38] have shown that gender differences in anxiety may be partly due to the lower scores in positive identity and higher scores in positive values in women. Some psychosocial mediators have been proposed to explain gender differences in depression and anxiety across the life span [39], such as mastery, behavioral inhibition, rumination, and perceived interpersonal problems. In this line, stressful life events and emotional reactivity to these life events may explain gender differences in adolescents' depression [40].

Given the mixed results regarding the caring dimension in PYD and the consistent gender differences observed, further research is needed to deepen our understanding of empathy's role in psychological well-being [19,41]. More research is needed to jointly examine caring (which includes empathy for others' suffering), and positive empathy (i.e., sharing others' positive emotions), and their differential effects by gender on different indicators of youth psychological adjustment (e.g., depressive and anxious symptoms). Moreover, because of the consistent gender differences in emotional problems reported by the literature, further study is needed to understand to what extent those gender differences in depression or anxiety may be partly due to gender differences in the responses to others' feelings. In addition to addressing a gap in the literature to understand the paradoxical effect of the caring dimension on youth psychological adjustment, this research may provide some insights for design intervention. Research evidence is needed to guide gender-based interventions to promote adaptive empathic skills in young people, aiming at enabling them to contribute to both their own and others' well-being. Thus, the present study aimed (a) to examine the gender differences in caring, positive empathy, depression, and anxiety in Spanish emerging adults; (b) to analyze the associations between caring and positive empathy with mental health outcomes; and (c) to explore the mediational role of caring and positive empathy in the gender differences in both depression and anxiety.

## 2. Materials and Methods

### 2.1. Participants and Data Collection Procedure

A cross-sectional study was carried out during Spring 2024 by administering an online self-report to a sample of undergraduates. The sample completed the questionnaire in around 30 min. Written consent was collected before participation, and no reward was given. The study was performed following the principles of the Declaration of Helsinki and previously received approval from the University of Huelva Ethic Board on 10 January 2019 (code UHU-1259711).

### 2.2. Instrument

Caring dimension of Positive Youth Development. The caring subscale included in the PYD short form created by Geldhof et al. [8] was administered. This overall questionnaire was adapted into Spanish by Gomez-Baya et al. [32] and demonstrated good factorial validity and excellent internal consistency. This subscale is composed of six items about sympathy and empathy for others, i.e., "When I see another person who is hurt or upset, I feel sorry for them" or "It bothers me when bad things happen to any person". These items have a 5-point Likert-type scale, which ranges from (1) "Not at all like me" to (5) "Very much like me".

Positive empathy. The Dispositional Positive Empathy Scale, created by Sallquist et al. [42] and adapted to Spanish by Hess and Mesurado [43], was used. This scale is composed of seven items, e.g., "I feel happy for others who receive good news" or "I am happy when I see others succeed". A 4-point Likert-type scale was presented, ranging from 1 = Never to 4 = Always.

Depression. The Patient Health Questionnaire 9 (PHQ-9) [44,45] was administered to assess depressive symptoms. This questionnaire was introduced with the question, "How often have you been bothered by the following over the past 2 weeks?" and presented nine items representing depressive symptoms (e.g., "Little interest or pleasure in doing things" and "Feeling down, depressed, or hopeless"). The response options followed a 4-point Likert-type scale ranging from 0 = not at all to 3 = nearly every day. This scale was also validated in the non-clinical Spanish youth sample [46], and a cutoff point  $\geq 10$  was established for clinical significance.

Anxiety. The Generalized Anxiety Disorder 7 (GAD-7) [47,48] was administered to assess anxiety symptoms. This questionnaire begins with the question, “How often have you been bothered by the following over the past 2 weeks?” and describes seven items, representing anxiety symptoms (e.g., “Feeling nervous, anxious or on edge” and “Not being able to stop or control worrying”). The response options followed a 4-point Likert-type scale ranging from 0 = Not at all, to 3 = Nearly every day. The validation of this scale in the non-clinical youth Spanish sample was performed by Casares et al. [46], and a cutoff point  $\geq 10$  was established for clinical significance.

### 2.3. Data Analysis Design

First, descriptive statistics were presented for caring, positive empathy, depression, and anxiety in the overall sample and by gender. *T*-tests were performed to examine gender differences in the study variables, and Cohen’s *d* was calculated. Second, Pearson zero-order bivariate correlations were conducted to examine the associations between variables in the subsamples of men and women. Third, two hierarchical regression analyses were separately conducted to explain depression and anxiety based on gender, age, caring, and positive empathy. Standardized coefficients and R-squared were shown. These analyses were carried out with SPSS 21.0. Fourth, a multiple mediational model was tested to examine the mediation by caring and positive empathy in the effect of gender on both anxiety and depression. Indirect, direct, and total effects were calculated. Standardized coefficients and confidence intervals were described in all the paths included. This analysis was tested with JASP 0.18.3.0.

## 3. Results

### 3.1. Sample Characteristics

The participants were a sample of 370 university students (67.2% women, 31.4% men, and 1.4% non-binary), aged 18–29 ( $M = 21.29$ ,  $SD = 3.61$ ), and enrolled at 10 universities in the Spanish region of Andalusia: University of Almeria, University of Cadiz, University of Cordoba, University of Granada, University of Huelva, University of Jaen, University of Malaga, University of Seville, University Pablo de Olavide (Seville), and Loyola University (Seville and Cordoba). Concerning habitat, most participants reported living in urban areas, such as cities with over 300,000 inhabitants (38.4%) or in cities between 50,001 and 300,000 (31.1%). With regard to cohabitation, most of the students lived with their parents (49.5%), or flatmates (30.5%), and 54.5% indicated that they did not have a couple. Around two-thirds of the participants (65.6%) were not looking for a job now. Concerning the area of knowledge of the degree, 39.7% studied a degree in Law or Social Sciences, 29.6% studied Sciences/Engineering, 19.2% studied Arts and humanities, and 11.5% were enrolled in a degree in Health Sciences. Finally, regarding the academic year, half of the sample was enrolled in the first or second year, 42.6% in the third one, and the 7.4% in the 4th or higher academic year.

### 3.2. Gender Differences and Bivariate Correlations

Table 1 shows descriptive statistics in study variables in the overall sample and by gender. High scores were observed in both caring ( $M = 4.17$ ,  $SD = 0.59$ ) and positive empathy ( $M = 3.44$ ,  $SD = 0.50$ ). Very high mean scores were also found in both depressive ( $M = 9.24$ ,  $SD = 5.41$ ) and anxiety symptoms ( $M = 8.48$ ,  $SD = 5.53$ ), indicating mild depression and anxiety clinical levels based on the cut-off points of the respective instruments. Furthermore, significant gender differences in all the study variables were found, with higher mean scores in women. The greatest gender difference was observed in positive empathy ( $d = 0.697$ ), while the lowest one was found in depression ( $d = 0.280$ ). Concerning

correlations, caring showed positive associations with depression ( $r = 0.16, p = 0.014$ ) and anxiety ( $r = 0.19, p = 0.002$ ) in women, and positive empathy had a negative association with anxiety in men ( $r = -0.25, p = 0.007$ ). Positive correlations were observed between caring and positive empathy ( $r = 0.44, p < 0.001$ ), and between depression and anxiety ( $r = 0.72, p < 0.001$ ), in both women and men. Concerning the internal consistency of the instruments, notable reliability was observed in caring ( $\alpha = 0.79$ ), positive empathy ( $\alpha = 0.84$ ), depression ( $\alpha = 0.84$ ), and anxiety ( $\alpha = 0.91$ ).

**Table 1.** Descriptive statistics, gender differences, and bivariate correlations.

	Overall M(SD)	Women M(SD)	Men M(SD)	<i>t</i> -Test	Cohen's <i>d</i>	1	2	3	4
1. Positive Empathy	3.44(0.50)	3.54(0.47)	3.25(0.50)	5.38 ***	0.697	(0.84)	0.35 ***	-0.09	-0.25 **
2. Caring	4.17(0.59)	4.28(0.53)	3.94(0.65)	5.29 ***	0.596	<i>0.43 ***</i>	(0.79)	-0.01	-0.01
3. Depression	9.24(5.41)	9.69(5.56)	8.19(4.88)	2.48 *	0.280	-0.02	<i>0.16 *</i>	(0.84)	0.73 ***
4. Anxiety	8.48(5.53)	9.34(5.65)	6.57(4.84)	4.54 ***	0.512	<i>0.01</i>	<i>0.19 **</i>	<i>0.71 ***</i>	(0.91)

Note. \*\*\*  $p < 0.001$ , \*\*  $p < 0.01$ , \*  $p < 0.05$ . In the correlations section, women's results are presented below the diagonal in italics, and men's results are presented over the diagonal. Cronbach  $\alpha$  scores in the overall sample are presented in brackets. M: mean; SD: standard deviation.

### 3.3. Regression and Mediation Analyses

Table 2 presents the results of two hierarchical regression analyses to explain symptoms of anxiety and depression based on demographics, positive empathy, and caring. The results indicate significant gender effects for both anxiety ( $\beta = -0.21$ ) and depression ( $\beta = -0.11$ ). Caring had a positive effect on both mental health outcomes (on anxiety:  $\beta = 0.17$ ; on depression:  $\beta = 0.14$ ), while positive empathy had a negative effect only on anxiety ( $\beta = -0.12$ ). A higher explained variance was found concerning anxiety ( $R^2 = 0.080$ ).

**Table 2.** Hierarchical regression analyses.

	Anxiety Symptoms <sup>1</sup>			Depressive Symptoms <sup>2</sup>		
	F/R <sup>2</sup>	$\beta$	<i>t</i>	F/R <sup>2</sup>	$\beta$	<i>t</i>
	7.66 ***/0.080			3.28 */0.036		
Gender		-0.21 ***	-3.92		-0.11 *	-1.96
Age		0.05	0.97		0.06	1.19
Caring		0.17 **	2.90		0.14 *	2.29
Positive empathy		-0.12 *	-2.02		-0.09	-1.54

Note. \*\*\*  $p < 0.001$ , \*\*  $p < 0.01$ , \*  $p < 0.05$ . <sup>1</sup> DW = 1.92; <sup>2</sup> DW = 2.00.

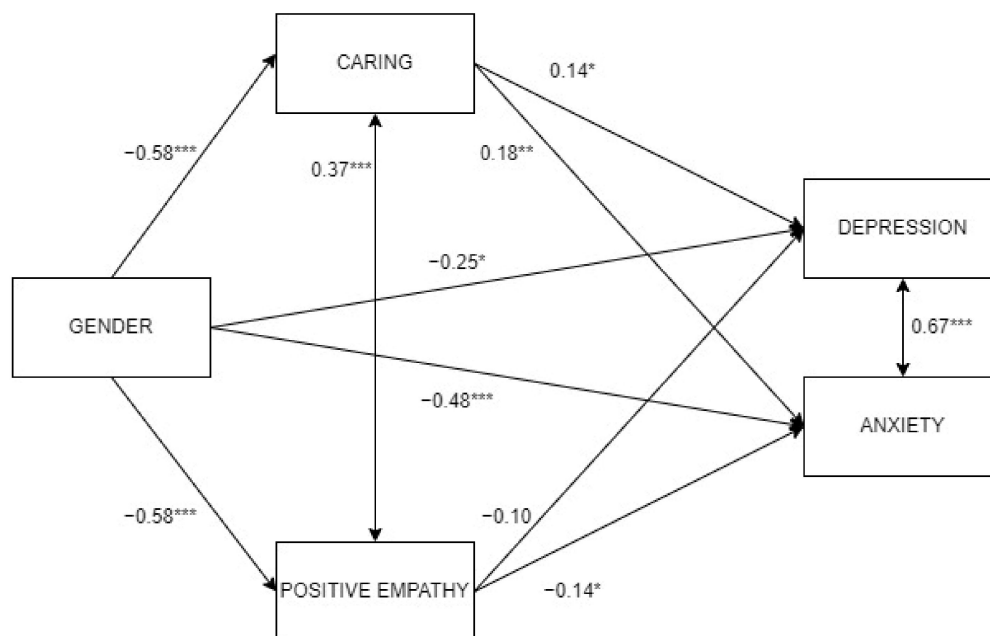
Table 3 describes the results of the multiple mediation analysis of caring and positive empathy in the gender effect on both depression and anxiety. Figure 1 shows the standardized coefficients in the paths included in this mediational model. The results showed significant direct effects by gender on depression ( $Z = -2.11$ ) and anxiety ( $Z = -4.18$ ) after including the mediators. Moreover, significant indirect effects by gender through the mediator of caring were observed on both depression ( $Z = -2.23$ ) and anxiety ( $Z = -2.72$ ). Thus, gender differences in both depression and anxiety were partly due to gender differences in caring. Higher scores in caring among women partly explained their higher scores in anxiety and depression. More caring was related to more symptoms of both depression and anxiety. Furthermore, positive empathy partially mediated the effect by gender on anxiety ( $Z = 2.22$ ), but not on depression. Higher scores in positive empathy were protective against anxiety in men. Finally, positive covariances were observed between the mediators (i.e., caring and positive empathy,  $Z = 7.03$ ) and between the outcomes (i.e., anxiety and

depression,  $Z = 11.04$ ). More explained variance was observed in anxiety ( $R^2 = 0.084$ ), compared to depression ( $R^2 = 0.034$ ).

**Table 3.** Multiple mediation model.

	Est	SE	Z	p	LLCI	ULCI
Direct effects						
G->Dep	-0.25	0.12	-2.11	0.035	-0.48	-0.02
G->Anx	-0.48	0.11	-4.18	<0.001	-0.70	-0.25
Indirect effects						
G-> Ca->Dep	-0.08	0.04	-2.23	0.026	-0.16	-0.01
G->Em->Dep	0.06	0.04	1.61	0.109	-0.01	0.13
G->Ca->Anx	-0.10	0.04	-2.72	0.006	-0.18	-0.03
G-> Em->Anx	0.08	0.04	2.22	0.026	0.01	0.15
Total effects						
G->Dep	-0.27	0.11	-2.44	0.015	-0.49	-0.05
G->Anx	-0.50	0.11	-4.55	<0.001	-0.71	-0.28
Residual covariances						
Ca<->Em	0.37	0.05	7.03	<0.001	0.27	0.47
Dep<->Anx	0.67	0.06	11.04	<0.001	0.55	0.79
Path coefficients						
Ca->Dep	0.14	0.06	2.45	0.014	0.03	0.26
Em->Dep	-0.10	0.06	-1.68	0.093	-0.21	0.02
G->Dep	-0.25	0.12	-2.11	0.035	-0.48	-0.02
Ca->Anx	0.18	0.06	3.17	0.002	0.07	0.29
Em->Anx	-0.14	0.06	-2.44	0.015	-0.25	-0.03
G->Anx	-0.48	0.11	-4.18	<0.001	-0.70	-0.25
G-> Ca	-0.58	0.11	-5.32	<0.001	-0.79	-0.36
G->Em	-0.58	0.11	-5.36	<0.001	-0.79	-0.37

Note. Dep = depression, Anx = anxiety, Ca = caring, Em = positive empathy.  $R^2$  Dep = 0.034,  $R^2$  Anx = 0.084,  $R^2$  Ca = 0.072,  $R^2$  Em = 0.074.



**Figure 1.** Multiple mediation model with standardized coefficients. Note. \*\*\*  $p < 0.001$ , \*\*  $p < 0.01$ , \*  $p < 0.05$ .

#### 4. Discussion

The present study had three aims. The first aim was to analyze the gender differences in caring, positive empathy, depression, and anxiety in Spanish emerging adults. The

results indicated that women presented more positive empathy, more caring, and more depressive and anxiety symptoms. These results are consistent with previous literature on gender differences in caring [31], empathy [36], and emotional distress [39]. The second aim was to calculate the associations between caring and positive empathy with depression and anxiety. The results indicated that more caring was related to more depression and anxiety in women, while more positive empathy was related to less anxiety in men. The relationship of caring with anxiety and depression in women is consistent with the works by Pivec and Kozina [13] and Manrique-Millones et al. [16], which highlighted the detrimental effects of the caring dimension of PYD on mental health. The protective role of positive empathy is in line with the conclusions by Andreychik and Lewis [25] and Morelli et al. [26], which showed the associations between positive empathy and better mental health and psychosocial adjustment.

Finally, the third aim was to explore the mediational role of caring and positive empathy in the gender differences in both depression and anxiety. The results pointed out that (a) caring mediated gender differences in both depression and anxiety, while positive empathy mediated the gender differences in anxiety; (b) higher caring was related to more depression and anxiety, while higher positive empathy was related to less anxiety. Women reported more depression and anxiety partly due to their higher scores in caring. Despite the fact that women had higher positive empathy than men, this mediator was only protective against anxiety in the men subsample. These results can be explained by the gendered socialization in which women are taught to be more expressive and sensitive, displaying more caring toward others [49], together with lower self-confidence, more ruminative responses to negative affect, and a lower perception of their emotional skills [38,50,51]. These gender differences in the strategies for managing negative emotions may explain why experiencing the suffering of others can increase symptoms, especially among women [52]. Empathy can be protective for mental health in youth, as Rieffe and De Rooji indicated [53], but may increase emotional vulnerability when youth do not possess adequate emotional regulation skills [54]. Increased emotional reactivity in stressful life events may lead women to suffer more emotional problems when they do not possess adaptive coping styles [40]. These possible emotional regulation mediators of the detrimental effects of caring should be addressed in future research. These gender differences in the responses to negative affect may be consistent with Response Styles Theory by Nolen-Hoeksema [55], which underlines a more frequent use of rumination in females, what exacerbates the experience of negative affect. In the case of empathy for others' positive emotions, positive empathy had been associated with positive upward spirals characterized by more prosocial behavior, well-being, and greater social connection. Thus, higher reactivity to others' negative emotions in women may reduce the positive consequences derived from their higher level of positive empathy [56]. Following the Broaden-and-Build theory by Fredrickson [57], positive emotions broaden an individual's momentary thought-action repertoire and build personal resources for coping, such as novel and creative actions, ideas, and social bonds. The higher protective role of positive empathy in men may be due to the use of more adaptive strategies to regulate positive emotions, which may increase the savoring of positive emotions and, in turn, foster life satisfaction and self-esteem [58], as well as decrease emotional symptoms [50].

Some limitations should be acknowledged in these results. First, the cross-sectional study design limits the analysis to associations between variables, preventing any inference of causation. A longitudinal design is necessary to investigate the directionality of the relationships between empathy and mental health outcomes. Second, the use of self-report instruments introduces subjectivity, which may be affected by social desirability bias, which may influence the results by a potential overestimation of dispositions and

an underestimation of emotional problems. Future research could provide evidence using objective measures and clinical diagnoses. Third, some variables should be controlled or included in the model to explain depression and anxiety. For example, emotion regulation strategies, neuroticism personality traits, resilience skills, or perceived social support may have an important role in the empathy effect on stress generation. Fourth, a more comprehensive examination of empathy is recommended, separating cognitive and affective components [59], and other elements, such as interpersonal reactivity, perspective-taking, or empathic concern [60]. Fifth, future works should assess a representative sample of Spanish youth to generalize the conclusions. The present work assessed a convenient sample from 10 universities in Southern Spain. Sixth, the lack of gender equity in sample composition is an important limitation in the present study. Future research about gender differences in mental health should examine a gender-balanced sample [61].

Some implications for practice may be derived from the results of the present study. Interventions to increase empathy in men in order to foster further contribution to others may also be necessary. PYD interventions should aim at promoting equal opportunities for males and females to develop in a healthy way [62]. The integration of PYD and empathy education programs may be recommended to jointly develop caring skills and well-being. Thus, empathy competency should be central in higher education curriculums [63], to train the social and emotional skills needed for healthy professional development with evidence-based interventions. With undergraduate samples, some empathy education interventions were found effective in increasing empathy competency among medical students [64] and nursing students [65,66]. With an adolescent sample, a school-based social and emotional learning (SEL) program was found to be effective in activating social empathy in Ireland [67]. The practice of social and emotional skills, such as identifying emotions, perspective-taking, problem-solving, teamwork, and goal setting, allows for building positive associations between empathy and PYD. From this SEL framework, Cullen et al. [68] argued the importance of faculty members' instruction in providing these skills to their students, especially during the transition from high school to university. Also, counseling/well-being offices at universities may implement group sessions or workshops to work with the students [69]. The results of the present study underline the need to improve empathy skills to protect psychological adjustment in male and female youth, by developing skills that enable them to care for others without experiencing symptoms and by developing skills to share and enjoy the positive emotions of others. The program Activate Empathy for Undergraduate College Students [70] was designed to teach empathy to students aged 18–25 with a 12 h module (including topics such as the definition of empathy, conflict resolution, the psychology of empathy, listening skills, and mindfulness exercises) using Kolb's model of experiential learning (i.e., including opportunities for abstract conceptualization, active experimentation, concrete experience, and reflective observation) [71]. This program underlined that the most effective components of this empathy education program were the ability to perceive typical emotions in a situation, the ability to respond appropriately to someone else's emotions, the ability to understand emotions in an interaction, and the ability to separate one's emotions from another's emotions. Thus, this intervention showed an integration between empathy and emotional regulation skills to prevent distress in caring situations.

## 5. Conclusions

The present manuscript has provided some interesting contributions to the literature about empathy, mental health, and the examination of gender differences. First, this work showed that women reported more caring dimensions of PYD, more positive empathy, but more symptoms of depression and anxiety. Second, the mediational analyses to explain the

gender differences in mental health concluded that (a) women reported more depression and anxiety partly due to their higher scores in caring, and (b) despite women having more positive empathy than men, this mechanism was only protective against anxiety in the subsample of men. These results underline the need to improve emotion regulation strategies to deal with stress while caring for others, and better social skills to build healthy social relationships. The promotion of mental health in the university context should integrate the development of empathic skills jointly with good opportunities to provide social contribution to the community.

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