

Research Paper

A Comparative Study of Emotional Competence among Chronic Disease Patients

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ABSTRACT

Keeping in the view the relevance of psychological factors the study was undertaken to examine relationship emotional competence among the patients suffering from different type of chronic disease. The study was also intended to see difference in emotional competence, among the patients suffering from different type of chronic disease. Three different groups of chronic disease patients would differ on the level of emotional competence. The study was conducted on two hundred six (206) chronic disease patients. The participants were taken from different public and private hospitals of Delhi NCR. Out of 206 participants, 109 were male chronic disease patients and remaining 97 were female chronic disease patients. The age of the participants range 25-60 years. All participants were selected for the study from the hospital's OPD department, various wards, or discharge rooms. The intensity of the challenges mentioned by the patients or their caretakers was used to divide them into three groups. The patients collected from the OPD were assigned to Group I since the majority of them were observed attending hospitals for routine check-ups just to consult with doctors for updates. Those who were contacted from discharge rooms were placed in group II; these patients reported frequent hospital admissions as a result of exacerbating their condition. Individuals in Group III had been hospitalised in the past few weeks. In group I (Diabetics/Hypertension) consisted eighty male and female both. The group II (Cardiovascular/Asthma) consists of sixty-five (65) male and female participants. and group III (Chronic kidney disease/Arthritis) was consist of sixty-one (61) male and female participates from private and public hospital among the groups. Emotional Competence Assessment Scale (ECAS) by Paiva and Kumar in the year 2009 was used to see level of emotional competence of chronic disease patients. The obtained data were analysed with the help of SPSS using various statistical technique like mean, standard deviation (SD), ANOVA, Post hoc analysis, correlation etc. The obtained results were interpreted and discussed in the light of hypotheses. The study was presuming difference in the level of emotional competence in the patients suffering from different types of chronic diseases. From the result it was obvious that patients belonging to three different groups were significantly differed with each other.

Keywords: *Emotional Competence, Diabetics, Hypertension, Cardiovascular, Asthma Chronic kidney disease, Arthritis & Chronic Diseases*

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A Comparative Study of Emotional Competence among Chronic Disease Patients

Patients with chronic diseases face future health and social adaptations that are unclear. Many persons with chronic conditions have faced the prospect of increased infirmity, loss of job, stigmatization of themselves and their families, and premature death. Many chronic disease patients, on the other hand, manage their disease well and live productive, meaningful lives. Unfortunately, many others struggle to cope with the stresses of their condition. As a result, neutralizing distress and managing to daily stresses are important for chronic illness patients because they can help with adherence to treatment, quality of life, and psychosocial adjustment. Several emotional, social, psychological, and spiritual variables impact one's capacity to effectively manage chronic diseases such as cancer, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, cerebrovascular disease, Hepatitis C, arthritis, asthma, HIV/AIDS, and so on.

Recognizing this vulnerability, there is increasing interest in different chronic disease management programmes with the potential to improve patients' quality of life (QOL) and encourage positive adaptation. This type of adaptation, which is fostered by reinforcing positive aspects rather than eliminating negative elements, has been shown to be useful for patients with chronic disease. Quality of life is now playing an important role in chronic disease management. There are multiple components including with physical functioning, psychological status, social functioning, and disease or treatment-related symptoms are all factors that are now being considered in chronic disease management (Kahn & Juster, 2002; Power, Bullinger, Harper & World Health Organization quality of Life Group, 1999).

The primary focus of this research is on the resilience of chronic illness patients. Resilience is a concept created from the perspective of increasing a patient's strengths; it refers to the capacity to overcome a shock or crisis and return to a pre-crisis condition (Rutter, Freedenthal & Osman, 2008; Wagnild & Young 1993). Furthermore, resilience, defined as the psychological ability to reduce negative emotions while increasing adaptation during a crisis (Yoo 2006), plays an important role in motivating patients to maintain mental health and engage in behavior that helps them cope with anxiety and depression caused by their life-threatening chronic disease, as well as improve their lives (Irwin, Sharience and Tim 2008). The investigators in this study used resilience as a trait to see it as a dynamic process (Margalit, 2004).

Individuals with resiliency are better able to cope with serious illness. Instead of obtaining a complete cure and developing reasonable, evidence-based interventions that can improve patient resilience and help patients independently reach positive adaptation, chronic disease treatment focuses on preventing complications and managing the disease while maintaining a superior quality of life.

The present study focused primarily on resilience in chronic disease patients, and it will aid in the development of a resilience-promoting programme for chronic disease patients. The study's researchers attempt to investigate different levels and some of the possible relationships that exist in the area, such as emotional competence among chronic disease patients.

Emotional Competence:

Emotional competence is defined as the ability to forecast overall performance as well as effectiveness in management solutions and leadership. According to Boyatzis et al. (1999), emotional competence is defined as "an individual explains the competencies that represent

A Comparative Study of Emotional Competence among Chronic Disease Patients

self-awareness, self-management, social awareness, as well as social skills at desirable times and ways with regard to sufficient frequency to be effective in the situation" (p.3).

According to developmental psychologists, the concept of "intelligence" focuses much more on an individual's "mental aptitude" as well as attributes than the concept of environmental circumstances. Recently, a new area of study has emerged that focuses on the understanding, recognition, and awareness of one's emotions, as well as their mastery and use in social interactions. Emotional intelligence (EI) is easily understood as a snapshot of emotional competence, and the concept of "emotional competence" is introduced in a more neutral manner. The term "competence" illustrates the generalisation of highly emotional situations. As a result, we completely agree with Ciarrochi and Scott (2006) that emotional competence involves the ability to identify emotions as well as individual variability in how well people deal with emotions and emotionally charged events (pp. 231-243). The concepts of EC and EI are sufficiently overlapped yet conceptually distinct. One of the two dominant viewpoints in developing EC is the attribute EI, which considers EI as a type of competence that generally indicates one's capacity to attain success in coping and addressing environment demands as well as challenges. EI and EC share similar concepts in that it conceptualises "intelligence" as "competences" and the traits of some persons that assist them to use the competence in real-life situations. The distinction between EC and EI is most probably the notion of researching emotions. Because of the emotion shown, the feature EI is substantially more an individual's attribute and personality. However, proponents of EC are susceptible to the notion of a developmental approach. Competence is obtained by the development of abilities learned through context and cultural encounters with others. In terms of social contact, young toddlers may absolutely learn some emotional behaviours from their environment. Emotional competence is seen as transactional inside oneself and between oneself and others, although it is less transactional since the model is oriented on the person.

Saarni (1999) proposed eight skill sets as obvious components of emotional competence to promote emotion-eliciting social transactions. These eight skills typically include (1) being aware of one's own emotions, (2) understanding others' emotions, (3) using the vocabulary of emotion and expressions, (4) having the potential for empathic involvement, (5) differentiating internal, subjective emotional experience from external, emotional expression, (6) coping adaptively with aversive emotions and distressing circumstances, (7) being aware of emotional communication within relationships, and (8) possessing the potential for emotional self efficacy.

According to Saarni (2011), in her most recent assessment, there are three significant conceptual distinctions between EI and EC. (1) EC is viewed as a set of developed skills; (2) emotionally competent people respond to emotion-eliciting environments with skill sets, whereas emotionally intelligent people respond with traits that reside within those individuals; and (3) the contribution of personal integrity to mature, emotionally competent functioning. Thus, we choose EC as the discussion topic because we feel that the major focus of growth should be on how much a person uses his potential and skills in everyday life circumstances, rather than stressing internal competence in coping with emotionally charged events. In classical Western psychology, the term competence may also refer to a person's mastery of certain abilities. (pp. 15–35)

A Comparative Study of Emotional Competence among Chronic Disease Patients

Dimensions of Emotional competence

Paiva and Kumar (2009) defined eight dimensions of emotional competence, which are as follows:

- **Happiness:** is an emotional state of well-being which can be described by positive emotions i.e. from ease to intense joy.
- **Love:** is a deep, affectionate, overwhelming feeling of liking and solicitude towards a person. It is a caring and an affectionate relationship between two people.
- **Interest:** Interest is a self-sustaining motive that leads an individual to engage with certain activities, objects and ideas for his own sake. It is known as the important emotion in aesthetic experience.
- **Sympathy:** It is a feeling of concern that may result in the awareness of sorrow or suffering from another person.
- **Fear:** Fear is a strong individual emotion. It is an unpleasant stage which comprises psychological and physiological responses to a real external threat or danger.
- **Anger:** Anger is a natural emotion. It is characterized by feelings of irritation, displeasure and antagonism.
- **Sadness** is said to be as one of the basic emotions and is commonly related to various circumstances of pain or loss or even a meaningful moment of connection or joy that makes us value our lives.
- **Jealousy:** is an undesirable emotion which typically appears when one perceives that some essential aspect of one's relationship with another, or the relationship itself, is being threatened by somebody else.

Rationale of the study

Since the world is becoming more and more competitive day by day, quality and performance is the prime requisite for growth and success in life. In this fast-moving world, people started ignoring their health and became trapped by various diseases. At present, chronic disease is not curable by medication nor do they just disappear. Therefore, lifelong treatment and self-care are crucial for managing chronic diseases that affect an individual's personality, resilience, cognition, emotions and bring change in an individual's life. It is very obvious that every individual has to face various situations where they have to present self. Interact with others, share ideas, views and also work with various settings. Since organ malfunctioning and deformity tend to hinder affect individuals self-esteem, self-confidence, social and emotional competence and make them psychologically vulnerable as a whole. In all such situations and day-to-day life affairs, such people need to develop psychological hardiness to face the challenges of life on one hand and fight with disease on the other hand. Various studies have been found that there is a positive relationship between emotional competence, spirituality, and resilience among chronic disease patients. But there is no adequate amount of research to demonstrate the relationship between metacognition with resilience. Therefore, researchers are curious to know if there is any relationship between emotional competence and spirituality among chronic disease patients.

Objective:

In view of the above, the study is planned with the following objectives:

- To examine difference in the level of emotional competence among patients suffering from three different categories of chronic disease.

Hypothesis:

On the basis of the above objectives, the following hypotheses are formulated:

A Comparative Study of Emotional Competence among Chronic Disease Patients

- Three different categories of chronic disease patients would differ on the level of emotional competence.

Sample:

In total 206 chronic disease patients were taken as participants for study. The participants were taken from different public and private hospitals of Delhi NCR and outside of Delhi NCR. Out of 206 participants, 109 were male chronic disease patients and remaining 97 were female chronic disease patients. The socio economic statuses of all categories were tried to keep constant. The age of the participants ranged from 25-60 years. All the nurses were selected on the basis of inclusion and exclusion criteria.

In the present study the technique that was used to obtain a sample of chronic disease patients (Arthritis, Asthma, Chronic kidney disease, COPD, Cardiovascular disease, Hypertension, Diabetic type II) was taken through purposive sampling. According to Trochim (2000), “Purposive sampling is a non-probability sampling strategy in which participants from a pre-specified group are purposively sought out and sampled”. Only those participants were included who met the inclusion criteria of the sample. Different chronic disease patients were selected from different public and private hospitals like Fortis escort hospital, Holy family hospital, Alshifa multispeciality hospital, Apollo hospital, Max hospital, All India institute of medical science, Safdarjung hospital, Moolchand hospital, etc. located in Delhi/NCR Region. All The participants were briefed on the study at the beginning. Informed, written consent was taken from them. Then the Metacognition 30 items questionnaire, Emotional competence scale, Spiritual Coping Scale and Resilience 14 items scale along with personal information sheets were administered in individual settings. For the comfort and convenience of the participant’s provision of break was also provided as per requirement.

Design:

Since the study three groups designs was used in the study with the first group (Diabetics/Hypertension) consist of eighty (80) male and female patients were the second group (Cardiovascular/Asthma) consist of sixty five(65) male and female patients. Similarly, the third group (Chronic kidney disease/Arthritis) of consist of sixty one (61) male and female participates from private and public hospital among the groups. The three groups of participants were compared on the level of emotional competence, spirituality.

Measures:

Emotion competence scale was used in this research measuring emotion competence, spirituality of the people suffering from different chronic disease. The following tool is administered on the participants.

Socio-demographic Data Sheet

A self made semi structured socio-demographic sheet especially designed for the study to collect information regarding patient’s age, gender, marital status, religious affiliation, education, occupation, family type and monthly family income, also clinical details would be collected as diagnosis, duration of illness and type of treatment.

Emotional Competence Assessment Scale (ECAS) (Paiva and Kumar,2009)

The scale has been developed by Paiva and Kumar in the year 2009, with total 40 items with dimensions each dimension consisting of 5 items. The authors received opinion from as many as eight experts in the field of education. Based on the opinion given by the experts

A Comparative Study of Emotional Competence among Chronic Disease Patients

the authors modified the items in the emotional competence assessment scale. The author was remove 5 items form original scale consists of 40 items. In this study total 35 items scale was used with eight dimensions. The eight dimensions of the scale are; Happiness, Love, Interest, Sympathy, Fear, Anger, Sadness and Jealousy. It is a four point scale where subject has to choose the statement on a four point scale such as “Always”, “Sometimes”, “Rarely” and “Never”. The points on the scale are assigned arbitrary weights. The final form of the scale consists of 35 items. The maximum score for this scale is 105 and minimum is 0. The average time for completing the scale is around 30 minutes. Reliability refers to the consistency with which a test measures, whatever it measures. Reliability of the scale are correlation between forms.0712, and Guttman Split-half 0.719. The emotional competence assessment scale was given to the experts in order to find out its content validity. The experts agreed that the items in the scale provided adequate coverage of the concept.

Data Collection:

The interview and survey method were used in this study was questionnaires to collect data. The researcher established first contact with the possible respondents in order to familiarise them with the study's broad concept. It was made clear during the contact time that this study has nothing to do with management and was initiated alone by the researcher. It had become necessary to ensure this because during personal interaction with some of the office-bearers of the hospital HR department, the researcher felt that this feeling might exist in the minds of certain respondents. Later, letters were sent to the respondents explaining the general purpose of the study and asking for their cooperation. Subsequently, respondents were contacted once again for administering the questionnaire. Once consent was obtained from them data were collected through face-to-face interview method. This was done because most of the participants were illiterate. Some Questionnaires were distributed offline because of they are educated on the convenience of the participant. Filled questionnaires were collected on the date suggested by the respondent.

RESULT AND DISCUSSION

Hypotheses I: Three different categories of chronic disease patients would differ on the level of emotional competence.

Table 1: Showing mean and standard deviation of the dimension wise emotional competence scores of the three groups of chronic disease patients.

	Group I (Diabetics+ Hypertension) (N=80)		Group II (Cardio + Asthma) (N=65)		Group III (Kidney + Arthritis) (N=61)	
	Mean	SD	Mean	SD	Mean	SD
Happiness	9.51	1.676	8.98	2.218	9.20	1.896
Love	9.73	2.387	9.72	2.132	10.15	1.806
Interest	8.35	2.556	9.63	2.126	8.46	2.760
Sympathy	10.24	1.982	10.48	1.786	10.57	1.774
Fear	8.05	3.031	8.65	2.683	7.64	3.241
Anger	9.36	3.594	11.09	2.951	10.44	3.222
Sad	9.81	2.943	9.68	2.664	9.72	2.484
Jealousy	10.21	3.645	10.25	3.067	9.62	3.040
Emotional competence	75.26	15.609	78.48	13.192	75.80	14.724

A Comparative Study of Emotional Competence among Chronic Disease Patients

Table 2: Showing ANOVA dimension wise emotional competence score of the three different groups of chronic disease patients

		Sum of Squares	Df	Mean Square	F	Sig
Happiness	Between Groups	10.262	2	5.131	1.384	.253
	Within Groups	752.611	203	3.707		
	Total	762.874	205			
Love	Between Groups	7.697	2	3.849	.834	.436
	Within Groups	936.638	203	4.614		
	Total	944.335	205			
Interest	Between Groups	68.116	2	34.058	5.476	.005
	Within Groups	1262.486	203	6.219		
	Total	1330.602	205			
Sympathy	Between Groups	4.306	2	2.153	.621	.538
	Within Groups	703.621	203	3.466		
	Total	707.927	205			
Fear	Between Groups	32.477	2	16.238	1.814	.166
	Within Groups	1816.727	203	8.949		
	Total	1849.204	205			
Anger	Between Groups	111.294	2	55.647	5.132	.007
	Within Groups	2200.983	203	10.842		
	Total	2312.277	205			
Sad	Between Groups	.699	2	.349	.047	.954
	Within Groups	1508.665	203	7.432		
	Total	1509.364	205			
Jealousy	Between Groups	15.738	2	7.869	.724	.486
	Within Groups	2205.777	203	10.866		
	Total	2221.515	205			
Emotional competence	Between Groups	405.337	2	202.669	.948	.389
	Within Groups	43393.34	203	213.760		
	Total	43798.68	205			

Table 3: Showing the difference between the possible pairs of groups.

	Diagnosis Group (I)	Diagnosis Group (J)	Mean Difference (I-J)	Std. Error	Sig
Emotional competence	Group I	Group II	3.214	2.441	.388
		Group III	.541	2.485	.974
	Group II	Group III	2.674	2.606	.561

There would be difference among three different categories of chronic disease patients with regard to their level of emotional competence. The hypothesis was tested by computing mean and SD of emotional competence scores for three categories of chronic disease patients separately. The obtained result showed that there was almost equal sense of emotional competence among three different categories of chronic disease patients. The difference between the two groups was not very large rather it was too small to be

A Comparative Study of Emotional Competence among Chronic Disease Patients

statistically significant. From the results given in the table 1 it was obvious that cardiovascular/asthma category was slighter higher on the sense of emotional competence than other two categories of chronic disease patients mean and the standard deviation for the first category of chronic disease patients were 75.26, and 15.609 respectively. For the second category of chronic disease patients mean and the standard deviation was 78.48 and 13.192 respectively. For the third category of chronic disease patients mean and the standard deviation was 75.80 and 14.724 respectively. Table 2 of ANOVA indicates that the main effect of the groups ($F=.948$, $p=.389>.005$) was not found statistically significant. The post hoc analysis 3 shows that people living with chronic diseases differed. Mean differences between group I and group II ($P=.388<.005$) was not found significant. Similarly, mean differences between group I and group III was not found significant ($p=.974>0.05$) and mean differences between-group II and group III ($p=.561>0.05$) was not found significant also. These findings suggest that people living with different chronic diseases in the different groups have not worked emotional competence differently.

Table 1, it was clearly showing dimension-wise analyses of the mean and the standard deviation of the emotional competence of the three different categories of chronic disease patients the difference among three categories of chronic disease were found statistically significant. As the interest dimension the mean and the standard deviation of the first category of chronic disease patients were 8.35, 2.556 respectively. For the second category of chronic disease patients mean and the standard deviation was 9.63 and 2.126 respectively. For the third category of chronic disease patients mean and the standard deviation was 8.46 and 2.760 respectively. Table 2 of ANOVA indicates that the main effect of the groups ($F=5.476$, $p=.005<.005$) was found statistically significant. Similarly, on the **anger** dimension, the mean and the standard deviation score of the three different categories differed. The mean and the standard deviation of the first category of chronic disease patients were 9.36, 3.594 respectively. For the second category of chronic disease patients mean and the standard deviation was 11.09 and 2.951 respectively. For the third category of chronic disease patients mean and the standard deviation was 10.44 and 3.222 respectively. Table 2 of ANOVA indicates that the main effect of the groups ($F=5.132$, $p=.007<.01$) was found statistically significant. Whereas, the difference of the mean and standard deviation score of remain dimension of emotional competence as happiness, love, sympathy, fear, sadness and jealousy were not found statistically significant at any level.

The differences in emotional regulation, psychological well-being and coping strategies in two diseases with great differences in their characteristics: cardiovascular/Asthma category patients Lifestyle modification is essential for the treatment. Therefore, this pathology requires a high capacity for adaptation and the modification of habits. Cardiovascular disease, in addition to the changes in lifestyle that the diagnosis requires, face social stigma, myths and negative beliefs associated with this disease. All this, and the complications that the disease can induce, have an impact on the lives of cardiovascular patients. Therefore, they participate in health care activity, maintain proper healthy diets, involve in spiritual practice for greater well-being and better quality of life

For patients and their families, hope is an integral part of coping. Maintaining hope is key for long-term survivors of cardiovascular disease. They maintain healthy coping, positive thinking.” It implies the capacity to tolerate and express concerns and emotions not just the ability to put anxieties aside. Being able to discuss the anxieties, uncertainties and fears, losses and sadness that usually accompany severe illness is generally helpful, despite the

A Comparative Study of Emotional Competence among Chronic Disease Patients

pressure commonly exerted by family and friends for the patient to always “keep a positive outlook.”

“Positive thinking” may represent an attempt to avoid confronting the distress of chronic illness. A study of women with breast cancer found that those who sought alternative treatments had higher levels of psychological morbidity the pursuit of such treatments might thus indicate the patient’s distress rather than their well-being.

According to Kauhanen, Kaplan, Cohen, Julkunen, & Salonen, (1996), has shown that deficits in emotion identification and expression, two components of EC, have been linked to an increased risk of all-cause mortality (Kauhanen, Kaplan, Cohen, Julkunen, & Salonen, 1996). According to Carpeggiani et al., (2005), conducted a studies that only considered emotional processes and Heart rate variability (HRV) together to predict prognostic in CHD patients has shown that low emotional sensitivity and low HRV were predictive of cardiac death in a eightyyear follow-up, although emotional sensitivity and HRV were not associated. According to Ciarrochi, Deane, & Anderson, (2002) higher emotional competence has been found to amplify the effects of chronic stressors on depression, hopelessness, and suicidal ideation.

CONCLUSION

Present study attempted to examine the metacognition, emotional competence, spirituality and resilience of three different groups of chronic disease patients. In this study emotional competence slightly different among three groups and was not found significant.

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A Comparative Study of Emotional Competence among Chronic Disease Patients

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Conflict of Interest

The author(s) declared no conflict of interest.

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