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Measuring the Impact of Ego Strength Among Type 2 Diabetes

Dr. Charanpreet Singh* (PSY.D.), Dr. Gurpreet Singh**
Department of Psychology*, University Institute of Computing**
Chandigarh University, Mohali, Punjab-India
E-mail – Charanpreet.e9033@cumail.in *, gurpreet@cumail.in **

ABSTRACT

Diabetes is becoming one of the most common medically, scientifically challenging and economically taxing significant diseases of the 21st century. It is estimated that the total number of people with diabetes in 2010 to be around 50.8 million in India, rising to 87.0 million by 2030.World Health Organization criteria. Globally developed and developing nations are becoming subject in its epidemic proportions. This ubiquitous condition will have an ever-increasing impact on all aspects of medicine and public health domain. Diabetes is the paradigm of a condition that necessitates a multidisciplinary and holistic approach in its care management and control of treatment. Primary care physicians, surgeons, nurses, dieticians, psychologists and ophthalmologists etc. are all drawn into this process. Keeping these paramount important points, the researcher conducted empirical research to explore the impact of ego strength among type 2 diabetes. For this 200 samples of Hazaribag District were selected. Incidental cum random purposive sampling technique was adopted. The subjects were distributed between diabetics and non-diabetics and then further divided gender wise. (No.50 female diabetics), (No.50 male diabetics) (No.50 male non diabetics), (No.50 female non diabetics). Two scales Personal Data Sheet and Ego Strength Scale by Qamar Hasan were administered on the subjects. Data was collected, tabulated and analysed with the help of Mean, SDs and t-ratio of acquired data. It was found that t was not significant. Key features responsible for building ego strength such as social interaction, healthy interpersonal relationship, happy married life and many more relevant factors in this context. Moreover, the subjects were age group of 50 and their ego strength was not shattered by any misfortune and in addition to that even fear of death anxiety does not hamper their social life and simultaneously the harmony in their interpersonal relationship. They are employed, well settled and do not have any economic crunch and thus diabetes doesn't weaken their ego strength.

Keywords: Impact, ego strength, diabetics and non-diabetics.

Ego strength

Different School of Thoughts

In Sigmund Freud's psychoanalytic theory of personality, ego strength is the ability of the ego to effectively deal with the demands of the id, the superego and reality. Those with little ego strength may feel torn between these competing demands, while those with too much ego strength can become too unyielding and rigid. Ego strength helps us maintain emotional stability and cope with internal and external stress. According to Sigmund Freud, personality is composed of three elements; the id, the ego and the super-ego. The id is composed of all the primal urges and desires and is the only part of personality present at birth. The super-ego is the part of personality that is composed of the internalized standards and rules that we acquire from our parents and from society. The ego is the part of personality that mediates between the demands of reality, the urges of the id and the idealistic standards of the super-ego. In situations involving psychological disorders, ego strength is often used to describe a patient's ability to maintain their identity and sense of self in the face of pain, distress and conflict.

Researchers have also suggested that acquiring new defences and coping mechanisms is an important component of ego strength. An individual with strong ego-strength approaches challenges with a sense that he or she can overcome the problem and even grow as a result. By having strong ego-strength, the individual feels that he or she can cope with the problem and find new ways of dealing with struggles. These people can handle whether life throws at them without losing their sense of self. On the other hand, those with weak ego-strength view challenges as something to avoid. In many cases, reality can seem too overwhelming to deal with.

These individuals struggle to cope in the face problems, and may try to avoid reality through wishful thinking, substance use and fantasies.

Ego strength refers to virtues through which "human beings steer themselves and others through life" (Erikson, 1964). In his psychological stage theory Erikson (1964) identified strength as outcomes of successful stage resolutions. Adolescence marks the critical passage from childhood to adulthood. During the teenage years, young people begin to separate from their families align themselves with peers, make decisions on their own, develop intimate relationship. William Damon (1995) suggested that too many children, the affluent and poor alike, are drifting through their children years without finding the skills, virtues, or sense of purpose that they will need to sustain a fruitful life. Regardless of risk factors in which many adolescents engage, all adolescents have basic human needs that are enduring and that are crucial to healthy growth into adulthood. Hamburg (1990) has suggested that these needs include "the need to be a valued member of a group that provides mutual support and caring relationships; the need to become a socially competent individual who has the skills to cope successfully with everyday life; and the need to believe in a promising future with real opportunities". According to Erikson, the Ego strength of hope emerges from the successful resolution of trust vs., mistrust in infancy, Ego strength seem to imply inherent and internal strength characteristic of healthy individuals. Even through Erikson implied that ego strengths are inherent and internal, he also implied that ego strength must be nurtured in order for an individual to develop these healthy characteristic. It seems that environmental factors including socioeconomic status (SES) would contribute to the development of ego strengths as competence, the fourth ego strength. Erikson (1964) has suggested that the ego strengths include the "rootedness" of dealing with difficult times, or when one is feeling uprooted, or living in a diverse society. He seemed to suggest that these ego strength of hope (manifest itself into religiosity), will, purpose, competence, and fidelity provide a sense of personal control and support in times of up- rootedness, including fear of academic failure. Erikson (1963) described ego capabilities as progressing through eight psychological stages. He believed that the one has to spend at each stage is fixed by a maturational "ground plan" for development. Within each stage a particular capability of the ego must develop if it is to meet the adjustment demands placed on it by society. Each stage is a critical one since development proceeds in spite of whether the capability is developed. If one does not develop adequately within the time limits imposed by the maturational ground plan, development will proceed but that part of the ego (that capability) will be diminished. Erik Erikson (1964) postulated that ego virtues or ego strengths are instinctual, inherent, and internal strengths gained by healthy individuals. He contended that all ego strength is present throughout every stage of life. The potential for each strength to become fully actualized heightens toward the end of the corresponding life stage and provides evidence of successful stage resolutions. Erikson (1964) asserted that there are eight distinct and essential ego strength throughout the life cycle and that each strength demonstrates an ascendance in association with positive resolution of its corresponding psychosocial crisis. The eight strength are Hope, Will, Purpose, Competence, Fidelity, Love, Care, and Wisdom.

While accepting Freud's basic views on the structure and topography of the mind, the Ego Psychologist came to believe that too much emphasis has been placed on the role of ID and the unconscious in understanding personality. Prominent amount these groups were Heinz Hartmann, Ernst Kris; and David Rapaport. The Ego analysts subscribe to the importance of energy in explanation of the personality "However, they proposed that the Ego has energy of its own and thus is not dependent on the ID. In a sense, they were liberating the Ego and providing it with conflict free sphere, which is responsible for such activities such as thinking, perception, and learning ……. much behaviour is to be understood in terms of Ego's adaptation to reality and the personality forces that might affect the Ego's functioning". Lindzey, Hall and Thompson 1978: Psychology Worth publications INC New York, USA/ Page 474.

Balance and equal proportionate of ego strength act as a safety valves such; as to preserve the healthier life of an individual. Simultaneously it also inculcates strong coping mechanism skills

which are strongly needed to fight with the stresses of day to day life in order to prevent psychopathological diseases such as diabetes, cardiovascular problems and many more personality disorders. ***(Dr. Charanpreet Singh Associate Professor (Author))***

Diabetes

Diabetes is possible to become one of the most widespread medically, scientifically challenging and economically taxing significant diseases of the 21st century. And globally the developed nations and many of the developing nations are becoming subject in its epidemic proportions.

This ubiquitous condition will have an ever-increasing impact on all aspects of medicine and public health Diabetes is the paradigm of a condition that necessitates a multidisciplinary and holistic approach to its care management and control of treatment. Primary care physicians, hospital physicians, surgeons, nurses, dieticians, psychologists and ophthalmologists etc. are all drawn into this process.

Diabetes mellitus is a chronic medical illness presenting a potential risk for multiple life-threatening medical complications, including blindness, kidney failure; wounds refusing to heal can cause amputation of body organs, heart diseases, stroke and many more serious health complicacies and. Empirical literature suggests that tight metabolic control achieved through the adequate execution of self-care behaviours on the part of diabetic patients can significantly reduce the risk of developing such complications. Consequently, gaining a greater understanding of factors that determine diabetes, self-care practices and application of healthy life style practises are of vital importance.

There are three etiologically distinctive types of diabetes, type 1 and type 2 and Gestational diabetes mellitus. Other specific types of diabetes also exist.

Warning signs of diabetes: Frequent urination, Excessive thirst, Increased hunger, Weight loss, Tiredness, Lack of interest and concentration, Vomiting and stomach pain (often mistaken as the flu), A tingling sensation or numbness in the hands or feet, blurred vision, Frequent infections, Slow-healing wounds

Risk factors: Obesity, Diet and physical inactivity, Increasing age, Insulin resistance, Family history of diabetes, Ethnicity

Management of diabetes: Today, there is no cure for diabetes, but effective treatment exists. Good diabetes control means keeping your blood sugar levels as close to normal as possible. This can be achieved by a combination of the following:

Physical Activity: a goal of at least 30 minutes of moderate physical activity per day (e.g. brisk walking, swimming, cycling, dancing) on most days of the week.

Body weight: weight loss improves insulin resistance, blood glucose and high lipid levels in the short term, and reduces blood pressure. It is important to reach and maintain a healthy weight.

Healthy Eating: avoiding foods high in sugars and saturated fats, and limiting alcohol consumption.

Avoid tobacco: tobacco use is associated with more complications in people with diabetes.

Monitoring for complications: monitoring and early detection of complications is an essential part of good diabetes care. This includes regular foot and eye checks, controlling blood pressure and blood glucose, and assessing risks for cardiovascular and kidney disease.

`India and global scenario of diabetes

The numbers of diabetic patients are speedily mounting all over the world, but the trends are different for both developed and developing countries. At some places growth rate is faster than the others. According to recent estimates, approximately 285 million people worldwide (6.6%) in the 20-79-year age group will have diabetics in 2010 and by 2030, 438 million people (7.8%) of the adult population, is expected to have diabetes. (1) The largest increases will take place in the regions dominated by developing economies. A survey conducted by World Health Organization shows that the largest number of diabetic patients in the world is in India; hence India has been accorded the status of "Diabetic Capital" of the world. In 1995 every 7th diabetic person in the world was

an Indian and by 2025 every 5th diabetic person will be an Indian. In 1995 the number of diabetic patients in India was 1.94 Crores and by 2025 this number will swell up to 5.70 Crores. The number of diabetic patients is rapidly increasing in India but what is more worrying is the factor that the younger age group is being more affected. At present 30%of the diabetic patients are in the age group of 20to 40 years.

Literature Review [

Measuring Ego Strengths.

A measurement of ego strengths offers an indicator of psychosocial health. An ego strength score reflects its degree of ascendance in an individual, as well as the degree to which other ego strengths are operative at that life stage (Markstrom et al., 1997). Ego strengths seem to imply inherent and internal strengths characteristic of healthy individuals.

Theoretical Framework (Different Schools of Thoughts)

Erikson's theory grew out of his psychoanalytic work with Sigmund Freud; a brief background on the relationship between Freud's and Erikson's views provides a better understanding of the context for this research study.

Freudian Perspective.

Freud (1933) proposed that several different mental structures comprise the human personality. One of these, the superego arises out of the resolution of the oedipal conflict. Another, termed the "id" contains the libido (a term Freud assigned to the available energy of the Eros which are basic instincts of sex, self-preservation, love, life forces, and striving toward unity). The id functions in accordance with the "pleasure principle." In addition to the superego and the id, Freud described the ego that deals with reality.

The ego structure of personality was, according to Freud, formed as a result of the pull between the id, with its physiological drives and passions, and a reality which fails to gratify it consistently. The ego was a rational force that keeps the id from seeking gratification indiscriminately. Individual identity was defined by the inner conflict between id, ego, and superego and the outward behaviours and expressions that emerge from this conflict. According to Freud, these internal factors influence both a sense of self (personal identity) and self in relation to others (social identity).

Erikson's Psychosocial Perspective.

Erikson (1959) developed an approach to human development based on psychoanalytic principles. He accepted many of Freud's ideas, such as the tripartite mind (id, ego, and superego) and psychosexual stages. While Freud (1933) focused on the contribution of the id to development, Erikson focused on the ego. Erikson recognized the need for psychological development within the social environment and thus his theory describes patterns of psychosocial development. This perspective led Erikson toward an emphasis on the role of society in determining what the ego must do to fulfil its function of adapting to the demands of reality, a reality which is shaped and textured by one's society.

Erikson's Views on Ego Development.

Erikson (1963) described ego capabilities as progressing through eight psychosocial stages. He believed that the time one has to spend at each stage is fixed by a maturational "ground plan" for development. Within each stage a particular capability of the ego must develop if it is to meet the adjustment demands placed on it by society. Each stage is a critical one since development proceeds in spite of whether the capability is developed. If one does not develop adequately within the time limits imposed by the maturational ground plan, development will proceed but that part of the ego (that capability) will be diminished.

Psychosocial Ego Strengths

Erikson first investigated the "virtues" while examining the developmental roots and later the evolutionary rationale of certain basic human qualities. He contended that the term "virtue" suggests strength, restraint, and courage. In defining virtue, Erikson (1964) asked: What 'virtue goes out' of human being when he loses the strength we have in mind, and 'by virtue of' what strength does man acquire that animated or spirited quality without which his moralities become mere moralist and his ethics feeble goodness?". (p. 113). Thus, virtue became defined as certain human qualities of strength, which are related to that process by which ego strengths may be developed from stage to stage

and imparted from generation to generation. Hope, Will, Purpose, and Competence are considered the rudiments of virtues developed in childhood. Fidelity is considered the adolescent virtue, and Love, Care, and Wisdom are the central virtues of adulthood. Erikson (1964) suggested that these qualities depend on each other, and each virtue in the schedule of all virtues is vitally interrelated to other aspects of human development, including the psychosocial crises and the steps of cognitive maturation. Yet, this component of Erikson's broader psychosocial theory has received minimal attention. The absence of scholarly discussion on this topic is significant because, theoretically, the ego strengths should provide evidence of psychosocial stage resolution (Markstrom, et al., 1997).

Erik Erikson (1964) postulated that ego virtues or ego strengths are instinctual, inherent, and internal strengths gained by healthy individuals. He contended that all ego strengths are present throughout every stage of life. The potential for each strength to become fully actualized heightens toward the end of the corresponding life stage and provides evidence of successful stage resolutions. Erikson (1964) asserted that there are eight distinct and essential

ego strengths throughout the life cycle and that each strength demonstrates an ascendance in association with positive resolution of its corresponding psychosocial crisis. The eight strengths are Hope, Will, Purpose, Competence, Fidelity, Love, Care, and Wisdom. Hope. Hope, the ego strength that emerges from trust, is fundamental to life and living, and provides the individual with an instinctive feeling of certainty in the social context (Erikson, 1968).

Ascendance of Ego Strengths

Ego strengths that develop in the early years continue to develop in connection with later ego strengths (Erikson, 1985) and contribute to successful accomplishment of later psychosocial crises. An ego strength's ascendance begins when an individual is physiologically, cognitively, and emotionally equipped. When the appropriate psychosocial crisis has been successfully resolved, there is greater potential that the corresponding ego strength will flourish. Ascendance of ego strengths occurs with internal preparedness and successful completion of associated psychosocial crises; it also requires a unique interdependence between the individual and the surrounding social environment

Ego strength and Diabetes:

Numerous writings in psychoanalytic literature describe and conceptualize the 'ego construct' which was introduced with Sigmund Freud's structural model of personality. The term 'ego', was described as first, the person of the self as separate from other individuals, and second, the part of the mind that contains specific processes and functions. Freud defined the ego by its functions as well as in relation to the id and superego constructs. One of Freud's most general statements about ego strength was that it is manifested in an individual's ability to work and love.

The principal functions of the ego instincts were discussed by Freud as a forerunner to the ego concept (1923). Instincts in the ego construct are differentiated in 'The Origins of Psychoanalysis' (Bonaparte, Freud, and Kris, 1954) where the concept of drive energy was described by instinctual mechanisms and their relationships to other structures in the personality. One such instinctual drive of self-preservation was deemed as the search for pleasure and the avoidance of pain. Instinctual drive was theorized as motivational forces for human behaviour and inherent to any organism for survival Freud viewed the ego as acting in concert with such instinctual drives and as an interpreter in the external environment in deciding when to satisfy drives and when to recall from anxiety provoking stimuli. The ego was also described as a constellation of functions that attempts to avoid over-stimulating situations and reconcile the conflicting demands from superego, id and external sources (Bonaparte, et al., 1954).

Towards an understanding of sexual and aggressive instinctual drives, Freud (1915) utilized his clinical work with hysterical and obsessional-neurotic patients to identify symptomatology in the ego (1923). Conflict in the personality became expressed in symptoms that reflected displaced restricted or defended instinctual energy that the ego unconsciously protected. Identification was proposed as an important mechanism in building ego strength but also as the source of conflict in later adulthood (Bellak, 1973). Freud (1915) saw the

ego construct as formed through the child's tendency to identify with caregivers and objects that are cathected with libido energy and to identify with lost objects through death or separation. In addition to libidinal instincts and drives are the aggressive ones in which children also identify with parents and objects that are aggressively perceived or cathected.

From an ego psychology framework, Heinz Hartman (1950) identified instinctual drive as both harmonious and conflictual mechanisms in the ego construct in that.

The ego has from its start the tendency to oppose the drives, but one of its main functions is to help them toward gratification; it is a place where insight is gained, but also rationalization… it promotes objective knowledge of reality, but at the same time and by way of identification and social adjustment takes over in the course of its development the conditional prejudices of its environmental; it pursues independent aims but it is also characteristic of it to consider the other demands of the other substructures of the personality.

Hartmann (1958) also conceptualized the ego as equilibrium between subjective and objective states in the personality structure and between the individual and its environment.

Hartmann postulated that while ego weakness is manifested in schizophrenics because of weaknesses in the ego differentiation and integration of objective states, treatment of these patients needed to specify which ego functions were impaired in the ego constellation (1958). Pathology in the ego construct was termed as an adaptation disturbance in that Hartmann stressed adaptation achievements in the development of the ego through interfaces with instinctual drives. In relating the issues tantamount to ego development, Hartmann (1952) said the following.

'The earliest stages of ego development can be described from several angles; as a process of differentiation that leads to a more complete demarcation of ego and id and self and outer reality; as a process that leads from pleasure to the reality ego; as the development of the reality principle; as the way leading from primary narcissism to object relations; from the point of view of the sequences of danger situations; as the development of secondary processes'.

Ego psychology's concentration on the mechanisms of the ego construct has many implications for the dynamic interrelationship of ego functions in pathological manifestations (Bellak, 1973). Hartmann (1958) concentrated his studies on those ego functions that related to reality testing which included the organization and control of motoric activity and perceptions in the self. Here, the ego is an adaptive boundary between internal and external stimuli, it tests reality and it is a catalyst for action and through processes. The synchrony between through and action was described as an internalization tendency that requires a delay of discharge (Hartmann, 1958). This concept of internalization in an organism describes the ego as manifesting anxiety and using it as an aid in anticipating pain or pleasure or pleasure from the environment. Hartmann, Kris and Lowenstein (1946) proposed that thinking, action and perception are the three main function of the ego and that these functions also serve the demands of the id or superego. These functions become maladaptive in pathological disturbances such as schizophrenia (Bellak, 1973).

Theorists and practitioners in therapy have often identified intrinsic difficulties in differentiating and isolating one ego function from its constellation of other function in the personality (Bellak, 1973; Spitz, 1959; Smith, 1983). Ego functions tend to operate in groups of complimentary activities; reality testing, judgment and sense of reality of the self and the world are one such constellation (Hartmann, 1958).

Towards a theory of ego functioning in the pathological states of patients. Bellak (1973) proposed that ego strength be appraised on a scale towards the goals of evaluation and assessment towards treatment. Psychoanalysts have often held that assessments and behavioural observations cannot generate comparable evaluation to what can be achievement in clinical psychoanalytic settings with long term treatment. In view of modern, truncated hospital stays and chronic populations, however, further examination of direct, observational procedures seems both necessary and warranted (Smith, 1983). Clinical practitioner's application of ego functioning towards the treatment of patients can quantify or qualify strength and deficits in the ego (Bellak,

1973; Hartmann, 1958, Smith, 1983; Wilson, 1985).

As before mentioned, Freud conceptualized the ego as development initially out of the id and its drive energy. During child development, the fundamental function of the ego is seen as being a mediator between the instinctual energies of the id and the influences in the external world (Freud, 1923). Ego development has been further described by subsequent theorists as an element of differentiation (Mahler, 1952), a catalyst for the evolution of secondary processes (Arieti, 1976), as a development of reality principles (Ferenczi, 1916) or as a pathway that leads away from primary narcissism towards objects relations (Kohut, 1966). In pursuing how ego functions are manifested in the schizophrenic syndrome, many clinicians have formulated theories in which schizophrenia is caused by multifaceted disorders of ego functions (Bellak, 1973; Hartmann, 1958; Spitz, 1959).

Research methodology:

Aims:

1. To study the impact of type 2 diabetes on death-anxiety.
2. To compare the impact of death anxiety between type 2 diabetes and non-diabetes

Hypothesis:

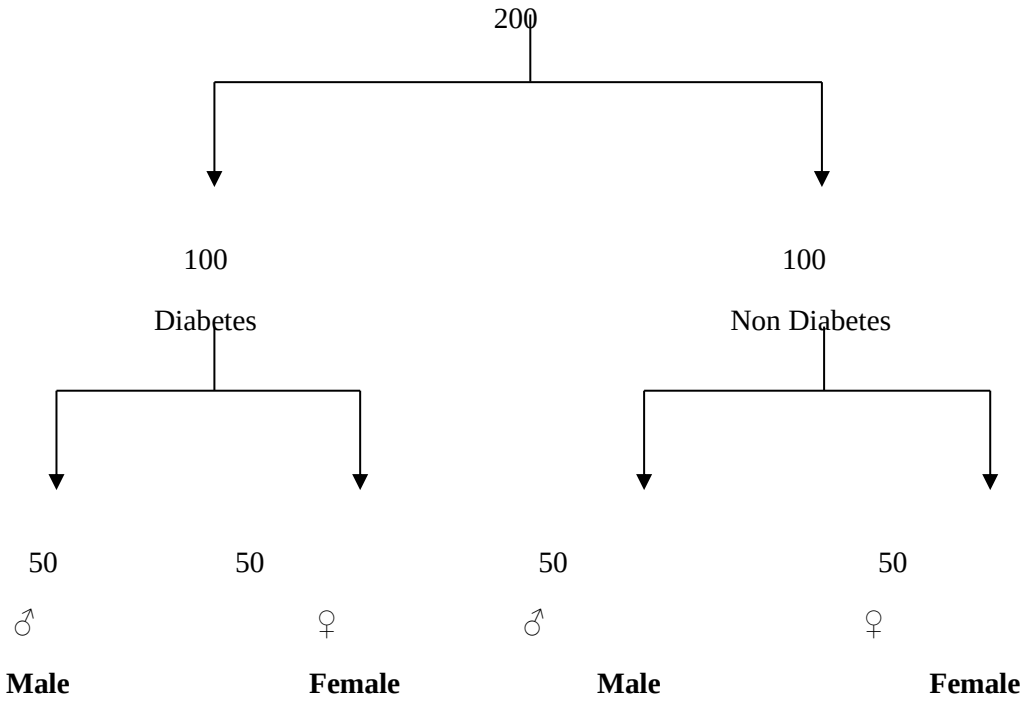
Keeping above mentions objectives in mind following hypothesis were formulated. Diabetic patients will have weak ego-strength than non-diabetic. (This hypothesis was made considering several factors in mind. Ego-strength depends upon several psycho social and psychological factors. Ego-strength is a person's capacity to maintain his/her own identity despite psychological pain, distress, turmoil and conflict between internal forces as well as the demand of reality. A diabetic patient always remains in fear of death-anxiety inconstant prier of death, organ failure, albeit, etc. Bearing in mind its disastrous effects on the health of diabetic patient's it was hypothesized that diabetic patients will have weak ego-strength than non-diabetic subjects.)

Sample: 200 Samples were selected

Sample area: The sample area was Hazaribag district of Jharkhand in India

Sample Selection: Incidental cum purposive sampling techniques was adopted because it was the most suitable method to the nature of research problem.

Sample distribution:

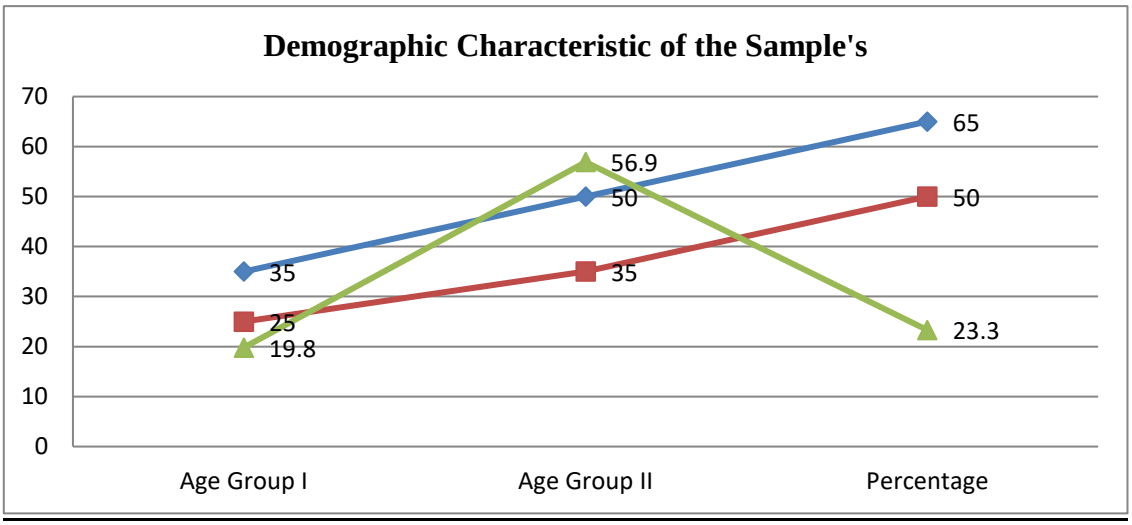


Demographic characteristic of the samples:

The sample was selected from various age groups. The age of the subjects has represented in table 1.1.

Table-1.1

S No.	Age group	Percentage
1	25-35	19.8
2	35-50	56.9
3	50-65	23.3



The above figure shows that more than half of the subjects were of middle age that is 35-50. Less number of employees was of old age (that is 19.8).

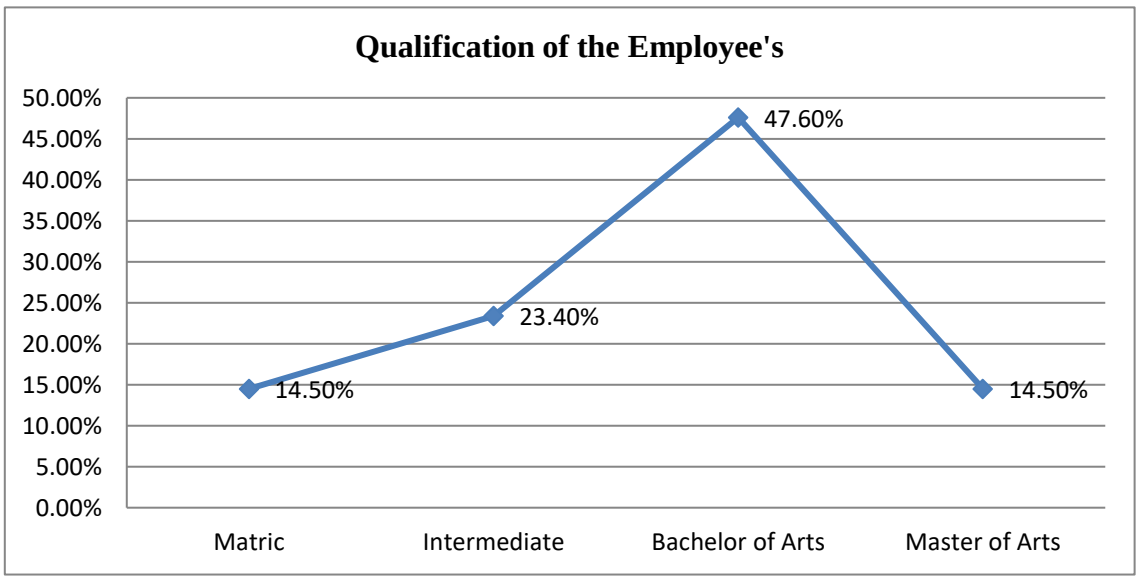
Qualification of the sample:

Subjects have different qualification. Some have Post Graduation degree; some were Graduated; some have Intermediate degree and some had Matriculation degree. This has represented in table 1.2.

Table-1.2

(Qualification of the employees)

Matric	Intermediate	Bachelor of Arts	Master of Arts
14.5%	23.4%	47.6%	14.5%



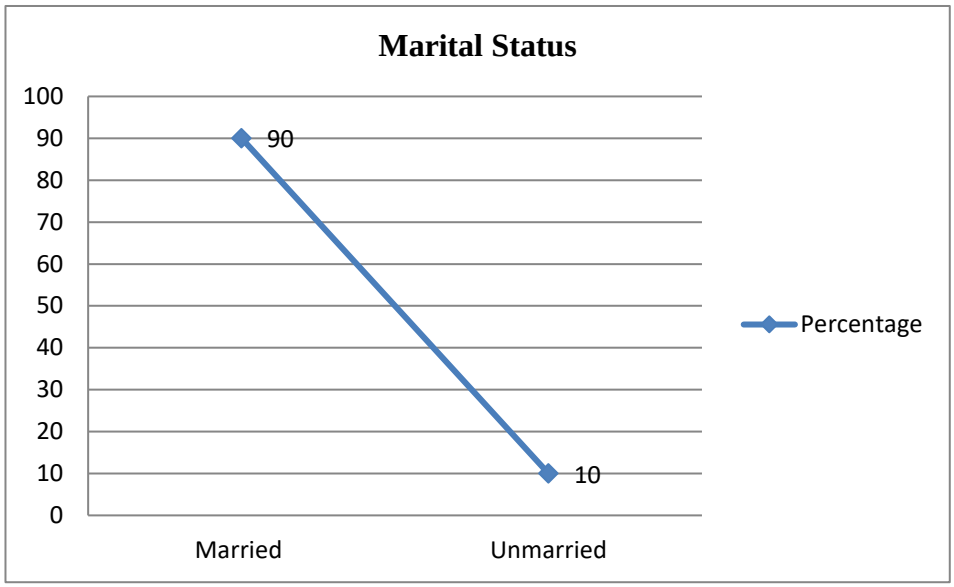
The above table shows that maximum numbers of employees were Graduate (that is 47.65)

Employment of the subjects:

Samples have different type of employment – Clerk, Supervisor, Engineer, Doctor, Bank Manager, etc.

Marital status of the sample:

Most of the subjects were married



The above figure indicates that 90% of the employees were married.

Tools used:

Pondering over above aims and objectives of the research two tools were used.

1. Personal Data Sheet (PDS):

The PDS was used to get some information about demographic variables like, name, sex, qualification, history of diabetes, name of medicine and the like. This scale was prepared by the researcher himself.

Ego-Strength Scale:

The Hassan's Ego-Strength Scale (1970); The Ego-Strength Scale has been developed by Prof. Q. Hassan of Aligarh Muslim University. The scale consists of 31 statements and all of them are negatively loaded. The subject is asked to put a cross under 'yes' and 'no' responses if he does not think applicable to him under 'yes' and 'no'. The entire cross marks under 'no' responses are given a score of 1. The total score obtained indicate the subject's ego-strength. Higher the score higher the ego-strength. The score range of the scale is o-31.

Data Collection:

After deciding sample its location and its method of selection the researcher visited at the DVC clinic of Dr. I.K. Sinha (Medical Officer) who is famous for treating diabetes. The researcher contacted diabetic patients and took their consent immediately under the guidance and supervision of Dr. I.K. Sinha. Some patients filled the questionnaire same day and some took them to their home promising to return in next visit. In this way all the scale was procured and scoring was done in accordance with the manual, then data was collected and interpreted in light of statistical techniques.

Findings and discussion

The hypothesis of this work was (diabetic patients will have low level of self-confidence than non-diabetic). To verify this hypothesis two tools were used. One was personal data sheet. Which was prepared by researcher himself and the second tool was inventory used to measure the self-confidence of the subjects. It has been developed by Rekha Agnihotry. These two scales were administered on 200 samples. This was divided into two groups diabetic and non-diabetic. These two groups two were divided. Again into two groups on the basis of gender male and female. This two scales were administered on these groups and data was collected and tabulated in table no.-1.3, and demonstrated in Bar Graph of 1.3, 1.4 & 1.5.

Pondering over this table 1.3, it is observed that it has three comparisons. The 1st comparison is between male diabetic and non-diabetic male. The 2nd comparison is between female diabetic and non-diabetic female. The 3rd comparison is between total diabetic and non-diabetic.

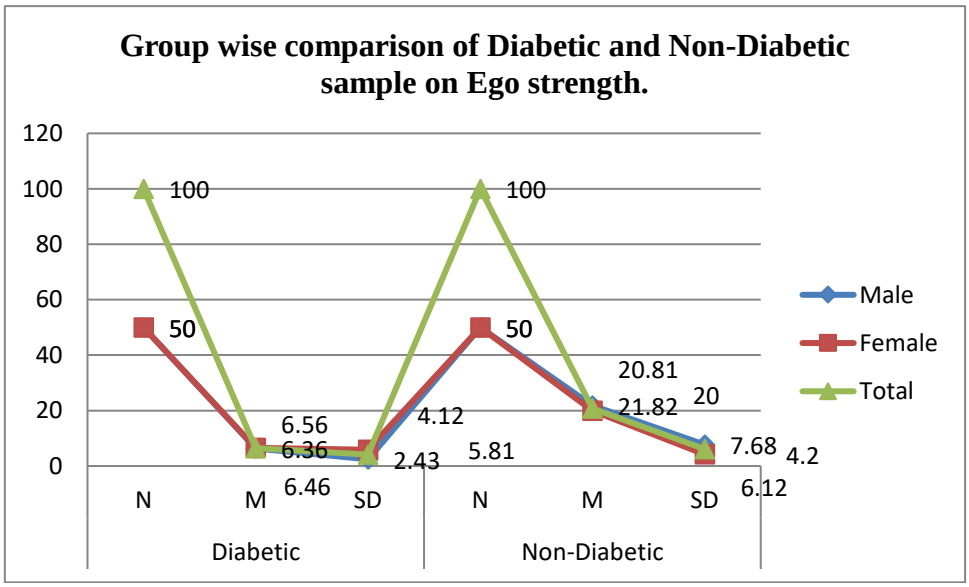
Table No-1.3

(N, M, SD and t – ratio of diabetic and non – diabetic samples on Ego Strength)

Group	Diabetic			Non-Diabetic			t	p
	N	M	SD	N	M	SD		
Male	50	6.36	2.43	50	21.82	7.68	1.42	NS*
Female	50	6.56	5.81	50	20	4.2	0.29	NS
Total	100	6.46	4.12	100	20.81	6.12	1.25	NS

*** NS = Not Significant**

Group wise comparison of Diabetic and Non-Diabetic sample on Ego strength.



The 1st comparison will have observed that ratio between male diabetic and non-diabetic male is 1.42. Which is not significant on any level it means this two groups are not significantly different on Ego Strength. So, it can be said that male diabetic and non-diabetic male are not different on Ego Strength.

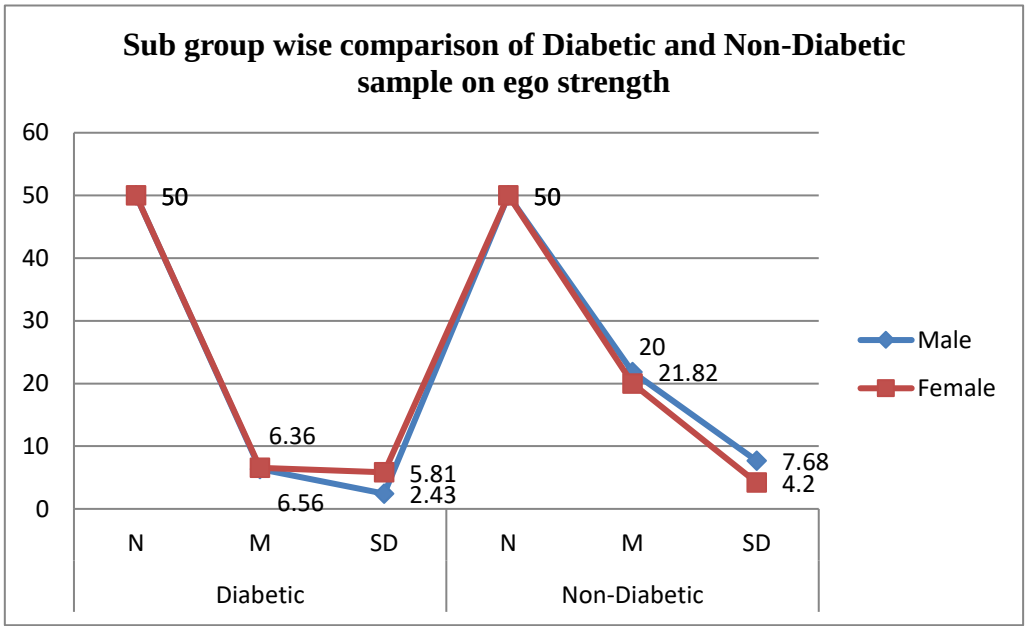
Table No- 1.4

(N, M, SD and t – ratio of diabetic and non – diabetic samples on Ego Strength)

Group	Diabetic			Non-Diabetic			t	p
	N	M	SD	N	M	SD		
Male	50	6.36	2.43	50	21.82	7.68	1.42	NS*
Female	50	6.56	5.81	50	20	4.2	0.29	NS

*** NS = Not Significant**

Sub group wise comparison of Diabetic and Non-Diabetic sample on ego strength.



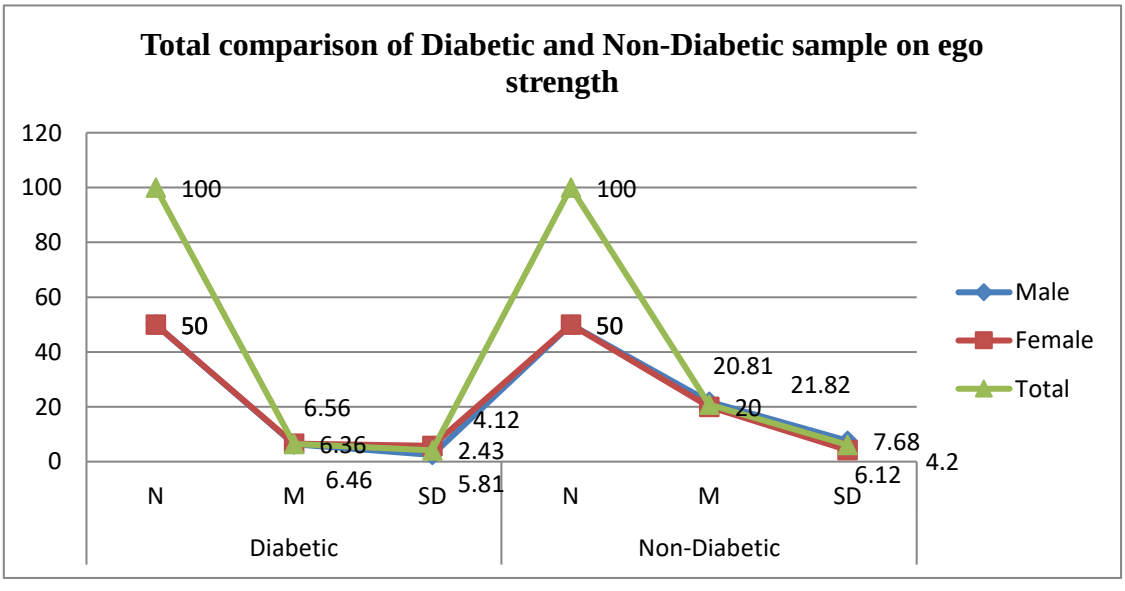
Considering 2nd comparison which is observed that ratio these two female diabetic and non-diabetic is 0.29. This is not significant on any level it means these two groups do not differ significantly on Ego Strength. In other word, this can be said that female diabetic and non-diabetic female are not different on Ego Strength.

Table No-1.5

(N, M, SD and t – ratio of diabetic and non – diabetic samples on Ego Strength)

Group	Diabetic			Non-Diabetic			t	p
	N	M	SD	N	M	SD		
Male	50	6.36	2.43	50	21.82	7.68	1.42	NS*
Female	50	6.56	5.81	50	20	4.2	0.29	NS
Total	100	6.46	4.12	100	20.81	6.12	1.25	NS

Total comparison of Diabetic and Non-Diabetic sample on ego strength.



Considering third comparison, it is observed that the t-ratio between these groups is 1.25 which is not different on ego-strength. In other words, it can be said that this two groups do not vary on ego strength.

Considering these three comparisons and t-ratios, it is observed that no t-ratio is significant on any level. So, it can be concluded that these sample neither are different on neither group wise nor sub-group wise. So, the hypothesis which says that diabetic patients will have weak ego strength than non-diabetic is rejected and null hypothesis which says that diabetic patients will have weak ego strength than non-diabetic is rejected and null hypothesis is accepted. Thus it can be concluded diabetic and non-diabetic are not different on ego-strength.

Statistical Analysis of Data:

Suitable statistical analyses were used depending upon the nature of data acquired. It involved mean, SD, t-ratio of acquired data. Graphical and chart representation were also done to represent the main findings.

Main finding and conclusion:

Diabetes did not affect ego strength. It means that both diabetic and non-diabetic people are not different on ego-strength.

Several factors were responsible behind this phenomenon. Most of the samples were more than 50 years old. They were almost free from their domestic responsibility, freedom from settlement. Almost all samples were selected are settled in Hazaribag district. They had their own house and there was no tension for livelihood. They had shed their own burden, which may produce anxiety. That is why the subjects did not vary on. Next measure cause behind this finding was settlement of their dependents and marriage of their children. The sample in this research has married their daughter, which is the main cause of anxiety of parents in India. The next important cause behind this finding is high level of religiosity of the sample. The samples were highly religious. Researches has proved that highly religious person have less death anxiety. Some sample was from Christian and Muslim communities, which has less death anxiety in comparison to other religious persons. That is why diabetic and non-diabetic persons did not differ on the hypothesized psycho –social aspects.

Results & discussion

It was assumption that diabetic patients will have weak ego-strength than non-diabetic sample. To test this hypothesis, two tools were used. The first tool was Personal Data sheet and second tool was Ego Strength Scale developed by Qamar Hassan. These scales were administered on 200 samples which were divided into two equal groups and then divided into two groups' male-female. Data were collected and scores were arranged in table.

Considering the tables, it is observed that it has three comparisons. One is between male diabetic and male non-diabetic on ego strength. The second comparison is female diabetic and female non-diabetic sample. The third comparison is between total diabetic and non-diabetic sample on ego strength.

Considering comparison first, it is observed that the t-ratio between male diabetic and male non-diabetic is 1.42 which is not significant on any level. It means both sub-groups are not different on ego-strength. In another words, it can be said that male diabetic and non-diabetic do not vary on ego-strength.

Considering second comparison, it is observed that the t-ratio between female diabetic and non-diabetic is 0.29 which is not significant on any level. Hence it can be said that female diabetic and non-diabetic are not different statistically.

Considering third comparison, it is observed that the t-ratio between these groups is 1.25 which is not different on ego-strength. In other words, it can be said that this two groups do not vary on ego strength.

Considering these three comparisons and t-ratios, it is observed that no t-ratio is significant on any level. So, it can conclude that these samples neither are different on neither group wise nor sub-group wise. So, the hypothesis which says that diabetic patients will have weak ego strength than non-diabetic is rejected and null hypothesis which says that diabetic patients will have weak ego strength than non-diabetic is rejected and null hypothesis is accepted. Thus it can be concluded diabetic and non-diabetic are not different on ego-strength.

Conclusion

Diabetes is becoming one of the most common medically, scientifically challenging and economically taxing significant diseases of the 21st century. It is estimated that the total number of people with diabetes in 2010 to be around 50.8 million in India, rising to 87.0 million by 2030.World Health Organization criteria. Globally developed and developing nations are becoming subject in its epidemic proportions. This ubiquitous condition will have an ever-increasing impact on all aspects of medicine and public health domain.

Diabetes is the paradigm of a condition that necessitates a multidisciplinary and holistic approach in its care management and control of treatment. Primary care physicians, surgeons, nurses, dieticians, psychologists and ophthalmologists etc. are all drawn into this process.

Balance and equal proportionate of ego strength plays as harmony between healthier life and it also develops strong coping mechanism skills which are needed to fight with the stress of day to day life in order to avoid psychopathological diseases such as diabetes, cardiovascular problems and other personality disorder.

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