The present study is concerned with the assessment of health-related quality of life and coping behaviour in cardiovascular disease patients. Cardiovascular diseases include myocardial infarction, angina pectoris and hypertension.

Diseases of the heart and blood vessels constitute a major health problem today. Cardiovascular diseases which include heart disease and stroke, are now the leading cause of death and disability in our country. Today, about 40 million Indians are suffering from coronary artery disease. In fact cardiovascular diseases are soon expected to be responsible for one out of four deaths in developing countries.

Sedentary lifestyle and psycho-physical-social stress associated with rapid urbanization, globalization and technological innovations have led to a high incidence of cardiovascular diseases. Smoking, high cholesterol, high blood pressure, diabetes, and lack of exercise are the main risk factors associated with coronary artery disease. These factors have a cumulative effect as the chances of developing the heart ailment multiplies with additional psychosocial factors such as Type A behaviour pattern anger, hostility, stress, depression, irrational thinking, and pessimism, and rapid
urbanization. Health has been deeply affected by these psychosocial factors or variables.

Hypertensive cardiovascular disease, involving high blood pressure, is also a major health hazard. High blood pressure is not the cause of cardiac diseases but their marker, who had for the first time identified the syndrome of right ventricular infarction. Salt intake, alcohol consumption, diabetes, obesity, lead, emotional and personal stress, and lack of exercise are the main risk factors for hypertension. High blood pressure is a major contributor to the India’s population’s morbidity mortality, and related cardiovascular diseases-stroke and renal insufficiency-. With the globalization and life-style changes that are now taking place in the region, around 10-15% of the adult population is already affected by hypertension in India.

In 1988, Kaplan has started work on the conceptualization and measurement of health-related quality of life. This soon led to a project (Orley J., 1994; WHOQOL Groups, 1995). On the assessment of quality of life in health care settings. “Quality of life was defined as individuals’ perceptions of their position in life in the context of the culture and value systems where that lived and in relation to their goals, expectations, standards, and concerns. It is, of course, coloured by physical health, psychological state, level of independence, social relationships, environmental factors and personal beliefs” (The WHOQOL Group, 1995).
This definition is not concerned with the objective measurement of people's condition of the cardiovascular diseases what they possess or suffer from.

A variety of methods has been proposed for the measurement of quality of life. However, the present investigator viewed that there is a need to develop an instrument for measuring health-related quality of life which should be based on a broad range of variables, not on a single issue such as disease. Health-related quality of life scale is developed to explore what impact cardiovascular diseases have on the patients' psychological, physiological, organizational, personal and social, and physical effects of life, rather by focussing exclusively on the disease itself.

The term “coping” is used to denote the way of dealing with stress, or the effort to master conditions of harm threat, or challenges when a routine or automatic response is not readily available. Psychologists have identified two different ways/strategies in which people cope with stress. They are: active/effective/functional, passive/ineffective/dysfunctional. These approaches are explained in greater detail in chapter one.

The present study has set the following objectives:

1. To examine the impact of awareness of coronary artery disease (Myocardial Infarction, angina pectoris) in patients on various health-related quality of life dimensions (Psychological, physiological, organizational, personal and social, physical).
2. To examine the impact of awareness of hypertension in patients on various health-related quality of life dimensions.

3. To explore various coping styles or strategies in patients who are suffering from myocardial infarction and angina pectoris.

4. To explore various coping styles or strategies in patients who are suffering from hypertension.

During the last decade of the century that has passed, numerous studies have been carried out on the topics of health-related quality of life and coping behaviour in cardiovascular disease patients, which are reported in chapter two under three major heads, i.e., quality of life, measurement of health-related quality of life, and coping with cardiovascular disease. A major breakthrough occurred in 1995 when The WHOQOL group defined the term quality of life. An effort is underway to give the precise definition of the term quality of life in order to determine the nature of the cardiovascular diseases and their impact on psychological, physiological, organizational, personal and social, and physical changes observed by the patients. Most attempts to evaluate quality of life in cardiovascular disease patients have focussed on psychological outcomes. Few studies have attempted to characterize the health status and impacts of cardiovascular disease on the health-related quality of life.

For the purpose of the present investigation, 105 myocardial infarction, 35 angina pectoris, and 60 hypertensive patients or subjects were
drawn from the OPD of the department of Cardiology and the department of Medicine, Institute of Medical Sciences, B.H.U. Varanasi.

Patients were contacted individually and were administered Health-Related Quality of Life (HRQOL) scale, Coping Behaviour Scale (CBS), and Personal Data Sheet (PDS) on one day. They were assured that their response would be kept strictly confidential and will be used for research only.

Simple percentages and rank-difference correlation coefficients were calculated. Rank-difference correlation coefficients revealed the following results:

- Rank difference correlation coefficients were found to be significant at 0.01 level in the ranking between myocardial infarction and angina pectoris, myocardial infarction and hypertensive, and angina pectoris and hypertensive patients on the psychological, physiological, organizational, and physical effects of HRQOL scale.

- On the 'personal and social effects' dimension of HRQOL scale rank-difference correlation coefficient was not found to be significant in the ranking between myocardial infarction and angina pectoris, myocardial infarction and hypertension and angina pectoris and hypertensive patients.

- Rank difference correlation coefficients were found to be significant at 0.01 level in the rankings between myocardial infarction and angina pectoris, myocardial infarction and hypertension, and angina pectoris and hypertensive patients on coping behaviour scale.
To sum up, the findings of the present investigation clearly indicate that the similarity exists in ranking among myocardial infarction, angina pectoris and hypertensive patients on psychological, physiological, organizational, and physical effects observed due to cardiovascular diseases. Results of this study also provide evidence that the patients are using multiple coping strategies to cope with illness. None of these strategies is inherently good or bad. How well the strategy work depends on the patient's condition or severity of illness, age, how frequently they are used, and the period to which they are used.