PREFACE

Cardiovascular disease (CVD), including coronary heart disease (CHD) and stroke, is the largest cause of mortality in the world, and the majority of deaths occur in low and middle-income countries such as India and China. These diseases are epidemic in urban locations of these countries and are rapidly increasing in rural areas as well. With demographic shifts, epidemiological transition and increasing urbanization associated with increase in CVD risk factors (smoking, sedentary lifestyle, obesity, hypertension and hypercholesterolemia), and a lack of policy directives aimed at chronic disease control, CVDs are poised to accelerate further. There are no detailed reports on CVD mortality by the Indian government. The World Health Organization (WHO) periodically reports on the proportion of deaths from CVD in India but trends are not reported due to lack of specific data. Prior to 1998, the Indian mortality data were obtained from predominantly rural populations where vital registration varied from 5% to 15%.
Accordingly, the Registrar General of India reported that from the 1990s the proportion of mortality attributed to CVD or circulatory system diseases remained almost static at 15%-17%. However, these rates were based on limited data, mainly rural, and the only significant information on CVD mortality in urban subjects was from Maharashtra. However, it was reported that there were significant regional variations, with high CVD mortality in Goa, Tamil Nadu, Andhra Pradesh and Punjab, and low mortality in the central Indian states of Uttar Pradesh, Madhya Pradesh and Rajasthan. Since 2001, the Registrar General of India and Million Death Study investigators have systematically collected mortality statistics from all Indian states using the country-wide Sample Registration System. In the first phase of this study from 2001-2003, causes of deaths in more than 113 000 subjects from 1.1 million homes were retrospectively analyzed using a validated verbal autopsy instrument. CVD was the largest cause of deaths in males (20.3%) as well as females (16.9%) and led to about 2 million deaths annually. Mortality data from CVD in India are also
reported by the WHO. The Global Status on Non-Communicable Diseases Report (2011) has reported that there were more than 2.5 million deaths from CVD in India in 2008, two-thirds due to CHD and one-third to stroke. These estimates are significantly greater than those reported by the Registrar General of India, and shows that CVD mortality is increasing rapidly in the country.

There are large regional differences in cardiovascular mortality in India among both men and women. The mortality is highest in south Indian states, eastern and northeastern states and Punjab in both men and women, while mortality is the lowest in the central Indian states of Rajasthan, Uttar Pradesh and Bihar. Sub-analysis of the mortality trends shows that CHD mortality is higher in the south Indian states while stroke mortality is higher in the eastern Indian states. There is no currently available information on trends in CVD mortality in India or different regions and states.

Most of the older literature on stress-related factors and coronary heart disease was dominated by studies of
men. Extensive research links chronic stress to coronary heart disease. Hostility, depression and cardiovascular reactivity to stress are heavily implicated in the development of coronary heart disease. Acute stress, negative emotions and sudden bursts of activity can precipitate sudden clinical events, such as heart attack, that leads to diagnosed disease activity to stress or coping with it via hostility may interact with other risk factors, such as elevated cholesterol level, in enhancing overall risk. The pioneering work of Rosenman and Friedman noted a specific pattern.

In particular, with reference to the ways in which people cope with stress, it was found convenient to postulate the existence of two separate personality types characterised by differing sets of behaviour patterns known as Type A or Type B behaviour (Friedman and Rosenman, 1959). Individuals belonging to the Type-A group are those more exposed to stress and present a higher chance of suffering from a physical or mental disorder on account of the pressure of stressful events.
For example, Type-A people are very vulnerable with respect to cardiovascular disease (heart attack, stroke, hypertension etc.). Those in the Type-B category on the other hand reveal a greater capacity to cope with potentially stressful situations, consequently reducing their risk of becoming ill. The difference between the two types does not depend on the fact they present two different and well-defined personality structures but rather on the way in which they organise their responses to stressful situations.

In the present study attempt has been made to find out the significance of differences between male and female cardiovascular patients on various dimensions of psychological stressors, personality type and coping strategies.

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