At The Cross Roads...
Awareness About Disease
Heart is a vital organ and denotes life itself. A healthy heart is an assurance for a healthy life. Heart disease and its chronic nature affect the individual at various levels, especially altering some of his day-to-day activities. A serious disruption of cardiovascular functions poses a significant threat to the well-being of an individual.

The advent of heart disease places an individual in a new social setting and presents a host of challenges. The experience of illness connects the “social and the cultural context and the biography of the person and remains unique in each particular case” (Kleinman and Seeman, 2000).

The process of reconstruction of new meanings, modifying existing ones results in making adjustments and adaptations at various levels. All this depends on the awareness and attitude of the individual towards illness and disease in particular and towards life in general.

Awareness and knowledge about the disease is central to the understanding of the individuals’ response and acceptance of the disease. Awareness or lack of it affects the process of recovery, recuperation and rehabilitation towards a good quality of life. Lack of awareness among individuals often results in self-enforced lack of activity or physical exertion, and involves abandoning previously enjoyed activities that may lead to tiredness and boredom. Individuals suffering from heart ailments often manifest high levels of anxiety and a phobic avoidance of activity or effort, along with a hopeless and a dependant attitude.

An individuals’ understanding of the disease often depends on factual information, as well as on his own subjective beliefs and personal interpretations. Incomplete information about cardiac disorder has been associated with a marked increase in emotional distress during early and late convalescence.
Added to this is the attitude and awareness level of the family of the respondent. Respondents and their families often interpret the onset of the disease as lack of physical well-being. This leads to increased anxiety and an increase in resting time, leading to steadily increasing disability (Lewin, 1995).

While increased awareness may not lead to favourable behavioural changes, it can decrease anxiety and give a person greater sense of control over his own progress. Education; counseling and behavioural interventions can increase an individual’s awareness and enhance their psychosocial functioning. However, increased understanding may not necessarily lead to improved health behaviour.

Inadequate understanding of the disease may cause unwarranted emotional distress, inappropriate coping behaviour, non-compliance with medication and unnecessary invalidism. Thus awareness and knowledge about the disease has been taken as an important variable to ascertain the responses of the respondents and their families.

In the present study, respondents’ awareness and knowledge about functioning of the heart and the occurrence of AMI and Angina was measured by way of Cardiac Knowledge Scale developed by Maeland and Havik (1987). This scale measures the overall awareness and knowledge of the respondents. This scale had a total of 55 items. The scale was further divided into three subscales comprising of Basic Cardiac Knowledge Scale [30 items], Cardiac Misconceptions Scale [10 items], and Cardiac Lifestyle Knowledge Scale [15 items].

The data was collected at T1 (N=100), T2 (N=98) and T3 (N=97). Two of the respondents passed away after T1 and one respondent passed away after T2, thus the difference in the number of respondents at T2 and T3. The results and the percentages calculated thereof are based upon the number of respondents who were alive at the given time.
Cardiac Awareness

The data related to cardiac awareness (Figure 6.1), which is a sum total of basic cardiac knowledge scale, cardiac misconceptions scale and cardiac lifestyle knowledge scale, infers that at T1, three fourth (75 percent) of the respondents had poor knowledge while only 1 respondent had good knowledge about the disease at all three times.

Cardiac Awareness
Figure 6.1

At T2, two third (65.3 percent) and at T3 a little over half (58.8 percent) of the respondents had poor knowledge. The number of respondents who had moderate knowledge about heart disease rose slightly from one fourth (24 percent) at T1, to be one third (33.7 percent) at T2 and (40.2 percent), at T3 respectively.

These following sub scales have been administered on the respondents to gather detailed information from them.
The scale on basic awareness (Figure 6.2) deals with awareness about specific issues related to AMI and angina, and the physiological functioning of the heart reveals that at T1, as high as 88 percent of the respondents were not at all aware of these and in turn had very poor knowledge. Only one respondent had somewhat good knowledge about the disease occurrence and functioning of the heart. Even at T2, still a three fourth (76.5 percent) of the respondents had poor knowledge about functioning of the heart. However, respondents who had good knowledge remained the same (1 percent). By T3, the number of respondents who were moderately aware rose by nearly three times to be nearly one third (32 percent) as compared to T1.
The misconceptions, which are associated with heart disease and its aftermath, are based on erroneous beliefs, which dominate the minds of people. One respondent belonging to a middle class background used to pester his wife to buy an air conditioner for him because he needed to have a more comfortable life after his AMI. He also wanted to buy a car since he felt that he should not be exerting too much while driving a scooter. His perception was that due to heart disease he should exert less physically. His wife told me that she understood that heart disease in her husband's case is not limiting in any manner. She also knew that her husband had begun to pick up fights with her merely because he was being irrational and making the episode of heart disease a crutch to get sympathy as well as to get his way.

The data shows (Figure 6.3) that at T1, two third of the respondents (62 percent) had one or the other false impression about the aftermath of heart disease, the level of which remained the same at T2 as well as at T3.
Lifestyle

This scale deals with false impressions and notions individuals have about their way of life after an AMI. Information regarding the respondent's awareness regarding the kind of life they could lead post AMI revealed that there were a number of misgivings on this account as well. One respondent did not want to stop smoking despite being asked to do so said, "mar hee to jaunga aur kya hoga — cigarette nahin chor sakta – dekha jayega" (at the most I'll die, what else – can't leave smoking – shall see later).

Lifestyle Awareness

Figure 6.4

The data on lifestyle knowledge scale (Figure 6.4) reveals that a little above three fourth of the respondents (78 percent) were moderately aware about the way of life and 10 percent of the respondents had few if any, mistaken beliefs. By T2, only 9.2 percent respondents were less aware. Those who had less erroneous beliefs rose slightly up to 14.3 percent. This figure rose further up to 20.6 percent by T3.
Attitude towards AMI

The way people are brought up, through the situations they encounter and the views that they are exposed to are key factors in the development of people’s attitudes and beliefs. This is why cultural differences exist in the perceived risk and recovery associated with health problems. A life-threatening disease like AMI produces emotional reactions such as anger, sadness, anxiety, depression, frustration, and fear. These are normal reactions experienced by almost all individuals. But for some, such reactions may add to the distress and suffering, and may also make the physical symptoms worse. The combination of weakness, loss of independence, perhaps inability to communicate fully, can lead to individuals’ experiencing depression and having a very negative view of their disease. Though there are many ways in which some individuals adapt and use their individual internal powers of healing to reduce the damaging effects of disease or severe physical limitations and accompanying depression, rage, and fear, there are others who are simply not able to cope with it at all. It is in such situations, that mental attitude of individuals has been found to be a very important part of recovery from a disease.

The mental attitudes of individuals have a lot to do with the course of their disease. It is common knowledge that mind influences body and vice-versa. A positive attitude improves the immune system while a negative attitude depresses it. Individuals often get trapped in the cycle of fear, depression, and panic that frequently accompanies a supposedly incurable disease (Cousins, 1981). People with chronic diseases may start to view life through a “telephoto lens” instead of a “wide-angle lens”. They stop planning ahead or making life changes. Fear is often enhanced when people know little about a disease; so combating it often begins with educating about the disease.

A sudden onset of a life threatening disease – a major crisis of life which is equally distressing emotionally, makes a person feel helpless and
depressed, thus adding distress and suffering and also at times making the physical symptoms worse. In the case of a chronic disease, seeing the positive presents a continuous struggle for individuals. AMI is one such major life-threatening disease. In recent years, there has been a quantum jump in researches examining the way people deal with this life stressor. Individuals have been found to differ widely in their reactions to the sudden onset of AMI. Some individuals show an intense sense of helplessness and anxiety, whereas others take much less time in recovering and returning to normal life routine (Ruberman, Weinblat, Goldberg and Chaudhary 1984). A positive outlook towards treatment and recovery helps immensely in dealing with the feeling of helplessness. Understanding and accepting the condition are the first steps towards a good mental outlook as the mental strength and attitude of an individual play a significant role in the curative process.

Attitude towards AMI

Figure 6.5

In the present study, the attitude of respondents regarding consequences of AMI was measured at all three times (T1, T2 and T3). A few respondents stopped going for parties and weddings because they said, "party aur shaadi par jaane ka kya maza – kuch kha pi to sakte nahin" (whats the fun of going to parties and weddings – we cant eat or drink anything). This
kind of mind-set about the disease resulted in frustration in most of the patients. At T1 half (Figure 6.5) of the respondents (50 percent) had a negative attitude and were not optimistic about their way of life. This trend worsened as almost two thirds of the respondents (60.2 percent) by T2 and (61.9 percent) T3 had developed more pessimistic and gloomy attitude towards life.

**Health Locus of Control**

Beliefs and attributions may influence a person’s health or recovery from a disease. Inherent with in the notion of reciprocal determinism is the concept that people have the ability to influence their destiny, while at the same time recognizing that people are not free agents of their own will. Humans are neither driven by inner forces nor automatically shaped and controlled by the environment. Thus, humans function as contributors to their own motivation, behaviour, and development within a network of reciprocally interacting influences.

People who are healthy believe that they are able to exert considerable personal control over most aspects of their life that are important to their happiness and sense of well-being. Psychologists refer to this as having an “internal” as opposed to “external” locus of control (Hanson, from the internet).

Locus of control is also defined as an individual’s belief or “inner power” over the outcome of internal and external events. Someone with an internal locus of control believes that he or she has the power to change things by the decisions he or she makes and the actions he or she engages in. Someone with an external locus of control believes that luck; fate or others are responsible for the outcome of events (Lathrop, 1998).

Internal locus of control refers to the perception of control in one’s life. It is the perception of positive or negative events as being a consequence of one’s own actions and thereby under one’s own personal control. It refers to
the belief that one’s outcome is directly the result of one’s behaviour. A person with an internal locus of control will feel that he or she can make a difference in a situation where help is needed, therefore implying responsibility. Such people have a sense of responsibility for their own health (Lathrop 1998; Wallston and Wallston, 1982). They appear more likely to engage in positive health behaviors like healthy nutrition, exercise, adherence to medical regimen etc. Internal locus of control has also been seen as a mediating factor of actions taken to prevent health problems.

In contrast, external locus of control refers to the perception of positive or negative events as being unrelated to one’s own behaviour in certain situations and thereby beyond personal control. It is the expectation that, events that happen are outside of one’s control – dependent on the control of others or on chance, fate or luck. People with external health locus of control believe that chance; God, destiny or the medical people etc. control their health and therefore consider it to be beyond their own control. They tend to focus on outcomes over which they have no control, and to blame others for their problems. Religious beliefs affect the amount of control people feel that they have over their lives and how things would affect them in the future.

People’s belief that their health can or cannot be determined by their own behaviour is assessed by health locus of control. Health locus of control scale has been derived from the Social Learning Theory developed by Rotter in 1966. The Social Learning Theory states that, an individual learns on the basis of his or her history of reinforcement. The individual develops general and specific expectancies. Through a learning process, individuals develop the belief that certain outcomes are a result of their own action (internals) or a result of other forces independent of themselves (externals) (Brown, 1999). Its theoretical basis relies on individual differences between how people perceive events: as a result of “their own behaviour or enduring characteristics” (internal), or as being controlled by “some other variable like chance, God or an authority” (external).
In the present study, a significant number (89 percent) of the respondents believed external factors to be responsible for their illness and thus had an external locus of control at T1 (Figure 6.6). Though more than half the respondents (51 percent) were smokers, they did not attribute their present condition to their unhealthy habits. One respondent who was a smoker, went on to blame his wife for his present situation saying that his heart attack occurred because “meri biwi ne raat ko mere saath sex karne se mana kar diya tha. Mujhe is baat ka dhakka laga. Isi liye mujhe heart attack ho gaya” (my wife had refused to have sex with me the previous night. I felt hurt about it. That is why I got a heart attack. Another respondent attributed his AMI to the “aspirin tablets”, “kuch saal pehle main gir gaya tha. Chot aane par doctor ne mujhe aspirin ki ek goli roz khane ko kaha tha. Bas usi aspirin ki wajeh se mujhe heart attack ho gayaa. (I had a fall a couple of years ago. I had got hurt and for that the doctor had asked me to take one aspirin tablet daily. I got this heart attack because of that aspirin tablet only).

Health Locus of Control

Figure 6.6
At T1, a majority (89 percent) of the respondents had external locus of control, whereas only 11 percent of the respondents had internal locus of control. Findings at T2 and T3 revealed facts that are worthy of note. More number of respondents started blaming “others” for their heart attack thereby meaning to be having an external locus of control. At T2, there were a significant majority (93.9 percent) of the respondents who had external locus of control. This number rose to 95.9 percent by T3 (Figure 6.6).

**Denial**

The emotional trauma an individual suffers after a chronic physical ailment is caused by loss of a valued level of functioning, such as the ability to drive or dance, for example. The chronically ill person thus, suffers the loss of immediate competency threatening a person’s sense of well-being, competence, and feelings of productivity.

To adapt psychologically to the drastically changed life conditions and the induced existential anxiety, individuals use different psychological defense mechanisms. Denial is the psychological process by which human beings protect themselves from the harmful effects of a disease, which threaten them, by blocking knowledge of those harmful effects from their awareness. It is a defense, which distorts reality; it keeps us from feeling the pain and away from uncomfortable truth about situations we do not want to face. In common parlance, denial is defined as a refusal to admit the truth of a statement.

Denial comes in many forms. As an individual, one has denial about something – his relationships, behaviour, health, family etc. Defenses are the specific ways we ward off attacks on our denial. Some defenses are conscious and we are aware of them. Others are subconscious. We use both to keep our denial intact.

How people react to chronic disease depends upon the severity of the disease and also on the available social support. (Le Maistre, 1999). Though
symptoms of a chronic disease differ, people suffering with it are united by the
denial, anger, fear, hope and acceptance, and other feelings the chronic
disease brings along with.

Accepting the realities of a disease is an important first step — and
often a very difficult one both for the person who has the disease and for the
spouse. It is not easy to admit to yourself that you are suffering from a
chronic disease, but it is an important condition in adapting to new
circumstances. It is also perfectly normal that one should sometimes find it
difficult to admit/accept that he has a chronic disease. Denial provides a
respite when, for a short time one has no worries about the future.

Denial is possibly one of the most controversial parts of the process of
psychosocial adaptation to chronic disease and or resultant disability. Denial
unconsciously prevents self from acknowledging the reality of the situation.
Initial diagnosis is not accepted or the consequences of the disease are not
acknowledged. Although denial is a distortion, it is a defense mechanism that
serves the purpose of protecting the self from the shock of the loss. (Facklam,
from the internet).

Denial is not usually a matter of deliberate lying or willful deception.
The denial system distorts a patients’ perception and impairs their judgement
so they become self – deluded and incapable of accurate self – awareness.
Alternating progression, where symptoms come and go, may lead patients to
deny their illness, especially during mild phases. By denying the severity of
the disease or the existence of the illness, patients may deny themselves
appropriate consultation, treatment and follow – up care.

Denial is not a single easily understood phenomenon, but a complex
coping mechanism that enables some patients to adapt to anxiety – provoking
stimuli (Robinson 1993; Druss and Douglas 1988). It is an emotional state that
can provide a successful and positive response to threatening and
overwhelming anxiety. (Robinson, 1993). When individuals experience
intolerable fear and uncertainty, denial is a natural, appropriate, valuable, and universal strategy used to gain control. Denying anxiety—provoking stimuli allows individuals to maintain hope and resilience. Another benefit of denial is that it allows individuals to deal with reality in a small, manageable manner.

Denial can thus be defined as an ongoing defense against anxiety in which actual or potentially disabling conditions and their consequences are prevented from being perceived or brought into awareness. Denial use is determined by the personality structure and anxiety relating to the disabling condition. Denial can also be defined as the negation of an unpleasant external reality. (Shaw et al, 1985).

Denial usually has negative connotations. It is psychological defense mechanisms that can help individuals retain a sense of control when confronted with an uncontrollable situation, to shield themselves from devastating feelings and cope with a frightening future. Other times, individuals may deny their disease simply because they are not prepared to confront the reality of their diagnosis. In any event, it is important for people to understand that denial is not a conscious act.

Denial varies greatly among individuals in extent of involvement, causal factors, and consequences. It appears that denial can prevent emotions that worsen the medical situation; denial avoids state of panic, emotional flooding and depersonalization. As a healthy response, denial serves as a buffer to protect individuals from feelings of fear and anxiety. Denial allows people to manage unwelcome situations they cannot change. It helps them adjust to conflicting ideas that create dissonance or discomfort. And it also gives them time to become accustomed to a major loss before responding to the pain of the situation.

Denial is considered healthy when it motivates people to do everything possible to live fully and take control of their disease. It may be adaptive at first to help the individuals cope with the disease, but if it persists for too long,
it may interfere with adjustment to the disease and adherence to rehabilitation. Denial and other avoidant strategies can be effective in reducing stress if there is nothing one can do to control the situation. It can be in fact useful in certain individuals by decreasing anxiety and favouring adjustment.

It is important that individuals come to terms with their disease in their own way. Denial can provide a protective safeguard until individuals gain the strength to cope with ill health, but it can also be detrimental in pursuing timely treatment. (Stewart, Gomez and Tesol from the internet; Bove and Bier from the internet). If denial goes on for too long and interferes with getting the care one needs, it’s not just counterproductive; it’s dangerous. Denial becomes unhealthy when it leads to a worsening of one’s disease or detracts one from the ability to live well. Unhealthy denial is a reaction that acts as a barrier and prevents the person adjusting to a new situation.

It can block the process of coming to terms with and adapting to the disease. Denial may prevent seeking proper medical attention and adherence to medical interventions. The individuals may also fail to realize the long-term effects of the disability (disease).

Problems arise if denial in an individual persists after a chronic ailment because it can lead to non-adherence during rehabilitation. It can just as easily contribute to the most disastrous outcomes when it prevents an individual from taking appropriate adaptive action, such as delay in seeking medical care or treatment (Johnson and King, 1995; Gentry, 1978).
Denial of AMI

Figure 6.7

In the present study, immediate denial of AMI and its impact was measured at all three times (Figure 6.7). Immediately after the heart attack, almost half the respondents (45 percent) denied having a heart attack and tried to put a brave front. As time passed, acceptance slowly seeped in and there was a marked increase in the number of respondents who started accepting their disease. At T2 level of acceptance was three fourth (74.6 percent) and by T3, this acceptance level in respondents increased further and was slightly more than three fourth (77.3 percent), thereby indicating that by one year, only around one fourth (22.7 percent) of the respondents denied their illness.

These following sub scales have been administered to gather detailed information from the respondents.
At T1 (Figure 6.8), only around one fourth (27 percent), of the respondents tried to be very courageous and felt that an unwarranted fuss was being created about their disease. There was a gradual decrease in the percentage of respondents who were initially not convinced that they have had a heart attack. From 27 percent at T1, the percentage of respondents decreased to 15.3 percent at T2 and 10.3 percent at T3 respectively.

Denial of Impact
Figure 6.9
At T1, (Figure 6.9) nearly half (45 percent), of the respondents tried to be courageous and portrayed that they are strong enough to bear the impact of the heart attack. Three months later (T2), one third of respondents (32.7 percent) had accepted the fact that they need to be more careful about their health thus denying the impact of illness. By T3, the percent of respondents who were denying initially decreased further and came down to one fourth (25.8 percent).

**Suppression**

Figure 6.10

A little less than three fourth (69 percent) of respondents (Figure 6.10) tried to suppress their feelings of fear and associated anxiety by trying not to think about their heart attack and thus ward off negative thoughts. By T2 and T3, there was not much change as the figures show that at T2 there were still almost three fourth (64.3 percent) respondents who were still trying to suppress their feelings. At T3, there was a slight change as the number of respondents suppressing their feelings (58.8 percent).
Life Expectations Post AMI

The process of socialization coupled with an individuals’ own biographical experiences, his conscious or unconscious assimilation of the social reality contribute to the attitudes and beliefs he formulates over time. It is these attitudinal patterns that surface when a life threatening illness suddenly brings him at a crossroads in life.

The trajectory of AMI involves having to make multiple adjustments by individuals as well as their family members as they reconcile to the impact of the disease and adapt to the uncertainties associated with the acute phase of the disease. Experiencing an AMI is a source of stress both for the individual suffering from it and each one of his family members. It is considered to be a crisis that disrupts normal functioning of the family. The brunt of a chronic disease on an individual depends not only on the severity of the disease but also on his needs and expectations. As the individual begins to reconstruct his every day life post AMI, he requires to adapt, modify, and change numerous aspects of his every day life as well as his long term and short-term goals. A chronic disease can make an individual feel that he must surrender all goals and lead a meaningless life as emotional reactions to illness may culminate in the feeling that life is meaningless. It is under such circumstances, that an individual goes through the phases of fear, anger, depression, anxiety and denial. He may also develop a negative attitude towards life in general.

Enforced occupation of a coronary care unit may constitute for some people, a “psychological hazard” (Hackett, Cassem and Wishnie, 1968). The collective action of nearness of death, and a long recovery and rehabilitation period thereafter, acts to produce a range of affective and behavioural responses in individuals. These feelings can bear an immediate effect on progress during the stages of medical recovery and hence, influence the long-term outcome for any individual patient (Julien, 1995; Byrne, 1990).
Not being able to live up to one's usual standard or not being able to live up to his family's or friends' expectations can be very intimidating for an individual recuperating from a life threatening ailment. On the other hand, optimism may allow individuals to mobilize highly effective coping resources (psychological, social, and behavioral) when confronted with adversity.

Present study was conducted to evaluate the positive or negative viewpoints of the respondents in relation to their perception of reduced autonomy, reduced physical ability, reduced work capacity and reduced emotional control at all three times (T1, T2 and T3).

Less than half (45 percent) of the respondents at T1 (Figure 6.11) had an overall positive outlook towards life despite having had an AMI. This number reduced to be slightly more than one third (38.8 percent) at T2, but at T3 it again rose to the same level as that at initial hospitalization which was a little less than half of the respondents (44.3 percent). Those respondents who had negative expectations were a little over one fourth (27 percent) at T1, one fourth (24.5 percent) at T2 and (18.6 percent) at T3. The number of
respondents who had moderately positive expectations at T1, was a little over one fourth (28 percent), a little over one third at T2 (36.7 percent), and (37.1 percent) at T3 respectively.

These following sub scales have been administered on the respondents to gather detailed information regarding various spheres of expectations from them.

**Expectations of Reduced Autonomy**

Figure 6.12

Not being able to live up to one’s usual standards or not being able to live up to his family’s or friends’ expectations can be very demoralizing for an individual recuperating from a life threatening ailment. Such people take a much longer time to recover as more time and energy is spent on negative thoughts and feelings. In the present study (Figure 6.12), nearly half (49 percent) of the respondents had positive expectations about the future at the time of initial hospitalization (T1). The number of respondents with a positive outlook dropped marginally from T1, to 40.8 percent by T2 but rose again just a little to be 44.3 percent by one year (T3).
At T1 as many as 45 percent of respondents (Figure 6.13) thought that they will not be able to manage to get back to their previous level of physical activity without anyone else’s help while there were only 18 percent of the respondents who had a positive outlook. With passage of time, a little over one fourth of the respondents (28.6 percent) at T2 started believing positively in their physical ability. By T3, almost one fourth of the respondents (21.6 percent) still believed that they needed help to go about with their lives in terms of physical mobility.
An individual's viewpoint of his work capacity plays an important role in rehabilitating him completely after an AMI. It is an important milestone for the individual, because for him, it is a means of resuming his normal way of life. In the present study (Figure 6.14), almost half (49 percent) of the respondents were optimistic at T1 about being able to go back to and manage their work. Only 15 percent of the respondents did not believe in their work abilities. By T2, those respondents who felt positive had gone down to be more than one third (40.8 percent). By one year, only 13.4 percent of the respondents were still not too confident about being able to manage their work all by themselves. Half of the respondents (50.5 percent) were optimistic about being able to manage their work.
Expectations of Reduced Emotional Control

![Expectations Positive Expectations](image)

Depression and reduced emotional control may heighten the elements of fear and helplessness in an individual. As a person gradually comes out of depression, these negative tendencies give way to the individual’s inherent ability to confront the challenge and deal with it. In the present study (Figure 6.15), only 16 percent of the respondents had negative emotions at T1. There was not much change in the number of respondents who had negative feelings (18.4 percent at T2 and 17.5 percent at T3 respectively). More than half (51.5 percent) of the respondents felt more in control of their emotions at T3.

Motivation to adhere to advice and prescribed medication is strongly influenced by patients’ understanding of the disease. Patients’ attitude towards disease and illness, his perception about and the cause of illness, perception of his own health and presence of psychiatric symptoms are said to be important variables that affect optimum rehabilitation of the patient after an acute myocardial infarction. Self perception of health predicts long term mortality independently of physical health status. Also it influences post illness adjustment more strongly than does clinically measured health. Patient
education thus, becomes an important aspect of rehabilitating individuals after a debilitating illness.

The aforementioned details reveal that the respondents in the present study had considerably low level of awareness and knowledge of the disease. Added to this is their own sense of denial, locating locus of control to external factors and their reservations about a healthy life, making the road to rehabilitation an arduous task. The process of rehabilitation and its various dimensions have been discussed in the next chapter.