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"Attitudes and Beliefs toward Mental Illness in Central Assam"

Indranee Phookan Borooah[1], Snigdha Ghosh[2],
[1]*Ph.D, Professor, Department of Psychology, Gauhati University, Guwahati-781014, Assam, India*
[2]*Research Scholar, Department of Psychology, Gauhati University, Guwahati-781014, Assam, India*

Abstract: Stigma associated with mental illness is well recognized across the world. This study is carried out to assess the attitudes and beliefs toward mental illness in Central Assam. The sample was collected from two districts of Central Assam viz. Morigaon and Sonitpur districts. The size of the study sample was n = 480; equally distributed among males and females between the age groups 21 years to 40 years and 41 years to 60 years, according to rural and urban settings. A psychosis vignette was used for assessing attitudes and beliefs on three domains- acceptance, knowledge & exposure, and stigma & discrimination. The results show that there is a difference in attitudes and beliefs of public on acceptance based on their setting, gender and age; knowledge & exposure according to their age but there is no difference in terms of setting and gender; difference exists in stigma and discrimination by setting and age but no difference has been found in terms of gender. The study, thus, shows that there is difference in attitudes and beliefs toward mental illness by setting, gender and age.

Key words: *Acceptance, Attitudes, Beliefs, Discrimination, Exposure, Knowledge, Stigma.*

I. INTRODUCTION

Having of a good physical health does not mean one is healthy as health includes a healthy body with a healthy mind. To behave appropriately and think well the mind should be healthy. Mental Health refers to cognitive and emotional wellbeing - it is what and how a person thinks, perceives and acts. Mental health can also be defined as being free from mental illness. The World Health Organization (WHO) defines mental health as- "A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, is able to make a contribution to his or her community." Sound mental health is the key component of health. In fact mental health issues can create a great deal of stress in the overall upliftment of a community. Mental illness comprises a broad range of problems, with different symptoms. When one is not able to think rationally or behave properly in a socially appropriate manner, it does not mean that he is behaving in that manner knowingly, but that he may be afflicted with mental illness. Anyone can be afflicted with mental illness irrespective of intelligence, caste, culture, religion, gender, age or social status. It strikes in the prime stages of one's life, often during adolescence and late childhood. Without treatment it can lead to hazardous situations, viz. - chronic disability, unemployment, substance abuse, homelessness, wasted lives & suicide. Mental illness is generally characterized by a combination of abnormal thoughts, emotions, behaviors and interpersonal relationships. It also refers to the disturbances of an individual's behavior or cognitive functioning which are not expected culturally and which might lead to behavioral disability, psychological distress or impaired overall functioning. They can take the form of mania, phobia, depression, anxiety, schizophrenia, and so on.

Worldwide millions of people are affected with mental illness. In order to promote positive mental health, it is important to strengthen the mental health care services at all levels. However, tackling the mental health issue will be possible only when the public, or community, have positive attitudes toward mental illness and people suffering from mental illness.Stigma associated with mental illness acts as one of the biggest hurdles in providing treatment to people suffering from mental illness. Because of stigma people who are suffering from mental illness are perceived as "different" and are seen to have negative attributes and therefore are more likely to be rejected regardless of their behavior. The irony is that most persons – or someone they care for - are bound to be affected by these problems at one time or another. However, most of these can be successfully treated.Stigma is said to be a combination of three defined problems - a lack of knowledge, i.e. ignorance; negative attitudes, i.e. prejudice and exclusion; or avoidance behaviors i.e. discrimination. Scheff (1996) reported that people who are labeled as persons with mental illness are accompanied with society's negative conceptions of mental illness and that society's negative response contributes to the occurrence of mental disorder; the social rejection resulting from this may handicap mentally ill people even further.

A number of studies done on attitudes toward mental disorders and people suffering from mental illness have shown persistent negative attitudes. This negative attitude is often attributed to lack of knowledge regarding mental health and mental disorders. Studies done in different countries have found that many people

do not properly recognize mental disorders. Attitudes which hinder recognition and appropriate help-seeking have been commonly observed.

1.1. SIGNIFICANCE OF THE STUDY

There have been some recent studies that reveal considerable changes in public attitudes toward mental illness. This improvement in attitudes has been attributed to public education programs by mental health professionals and the mass media. Evaluation of attitudes and beliefs about mental illness will aid in the understanding, recognition, prevention and management of these illnesses. Also the common people and their attitudes toward persons with mental illness are important for the implementation of public sensitization programs concerning mental illness and community level interventions. Although there is a large number of related research work from around the world, very little is known about public attitudes and beliefs in Assam, a state in the north eastern part of India, as there is no research work to that effect as yet. An exploratory study would bring to light the existing attitudes and beliefs toward people with mental illness in Assam.

1.2. OBJECTIVE OF THE STUDY

To study the existing attitudes and beliefs toward people with mental illness.

1.3. HYPOTHESIS:

Ho1- There is no significant difference of attitudes and beliefs toward acceptance, knowledge & exposure and stigma & discrimination in regard to setting, gender and age of the respondent.

II. MATERIAL AND METHOD

1.4.1. Sample

Mixed sampling technique has been used. The data have been collected in three stages and as such it is a Multi- Stage sampling design.

The different towns and villages selected for the study were: Marigaon district: Towns - Jagiroad, Nakhola, Mayong, Villages- Karaiguri, Neli, Sapkati, Singimari, Matiparbat. Sonitpur district: Towns - Tezpur, Bishwanath Chariali, Gahpur, Villages- Alisinga, Balichapori, Na-pam, Dolabari.The distribution of the sample for the study is n = 240 for each district and (240 x 2) n = 480 for the whole sample area. The respondents includes both male (n=120) and female (n=120) between the age group of 21 years to 40 years (n=120) and 41years to 60 years (n=120). The distribution of the sample were according to Rural (n=120) and Urban (n=120). The total sample size of 120 x 2= 240 x 2=480 was equally distributed**.**

1.4.1. Short Description of the tools

1. Personal Identification sheet

The personal identification sheet is used to collect respondent's personal data like age, gender, locality, marital status, educational qualification, type of family, occupational status, exposure to mental disorders (illness).The sheet consists of the domains as cited above with multiple options.

2. A case vignette of schizophrenia developed in an Australian study by Jorm et al (2007) has been selected for use in this study, *"Influences on young people's stigmatizing attitudes towards peers with mental disorders: national survey of young Australians and their parents".* by Anthony F. Jorm, PhD, DSc and Anne Marie Wright, BA pp Sc (OT), M Med Sc (H.Prom) , ORYGEN Research Centre, University of Melbourne, Victoria, Australia."The vignette had been prepared to meet DSM-IV criteria and validated by mental health professionals. Permission / consent have been taken from the author to use the tool and modify to suit the respondents of Assam. The vignette refers to a 19 years old girl named Aroti –" Aroti Is A 19-Year-Old Who Lives At Home With Her Parents. She Has Been Attending School Irregularly Over The Past Year And Has Recently Stopped Attending Altogether. Over The Past 6months She Has Stopped Seeing Her Friends And Begun Locking Herself In Her Bedroom And Refusing To Eat With The Family Or To Have A Bath. Her Parents Also Hear Her Walking About In Her Bedroom At Night While They Are In Bed. Even Though They Know She Is Alone, They Have Heard Her Shouting And Arguing As If Someone Else Is There. When They Try To Encourage Her To Do More Things, She Whispers That She Won't Leave Home Because She Is Being Spied Upon By The Neighbor. They Realize She Is Not Taking Drugs Because She Never Sees Anyone Or Goes Anywhere." The Vignette Was Defined And Split In Sets Of Questions-

i) Attitudes and beliefs reflecting acceptance of persons with mental illness - the category consists of 5 items to be responded to on 4 point scale, which ranges from 'yes definitely', to definitely not'. Along each item options are given as yes definitely/ yes probably/ probably not/ definitely not together with their corresponding

points as 4, 3, 2, 1 respectively. The subject has to read each state statement carefully and tick the response which s/he thinks to be the most suited for him/ her. For example: yes definitely yes probably probably not definitely not

4 3 2 1

ii) Attitudes and beliefs reflecting knowledge and exposure to people with mental illness - the category consists of 4 items to be responded to on 2 point scale, as 'yes' or 'no'. Along each item options are given as yes and no with their corresponding points as 2 and 1 respectively. The subject has to read each state statement carefully and tick the response which s/he thinks to be the most suited for him/ her.

For example: yes no

2 1

iii) Attitudes and beliefs reflecting stigma, discrimination and beliefs toward people with mental illness - the category consists of 7 items to be responded to on 5 point scale, which ranges from 'strongly agree', to strongly disagree'. Along each item options are given as strongly agree/ agree/ neither agree nor disagree/ disagree/ strongly disagree together with their corresponding points as 5, 4, 3, 2, 1 respectively. The subject has to read each state statement carefully and tick the response which s/he thinks to be the most suited for him/ her.

For example: strongly agree agree neither agree nor disagree disagree strongly disagree

5 4 3 2 1

1.4.2. Procedure:

As the total sample is distributed in two districts of Central Assam, one by one the district was selected and the data was collected. At first the blue print of the sample collection process was made and data collection started with Morigaon District. Initially approach was made to the known persons residing in the respective districts and then the researcher visited and resided there for collecting responses. Researcher visited households for individual responses. Clubs, health camps, social institutions such as Naamghar etc. were visited and data were also collected in groups. The instructions and explanations given to the participants started with introduction of the researcher, objective of the research, and then they were provided the questionnaires and informed that the responses will be kept totally confidential. They were assured that their responses would be used only for research purpose, and that they are not compelled to respond. It was added that filling the questionnaire denotes their consent and willingness to participate in the study. Then they were asked to fill the questionnaire and if any of them did not understand any of the items they were explained. At first the Personal Identification Questionnaire was given and then the Vignette. As they completed, the questionnaires were collected and they were thanked for their participation, time and responses. The total time taken to complete the process of response for each individual was approximately 15 minutes, the time fluctuating by ± 10 minutes in different places.

1.5. Result and Discussion:

The Chi-square test was applied to see the significant differences by Setting, Gender and Age with regard to attitudes and beliefs on the three categories toward people with mental illness. To evaluate chi-square Table E was entered with the computed value of chi-square and appropriate numbers of degrees of freedom as shown in the following table.

Table 1: Chi Square Values for Various Categories of Attitudes and Values

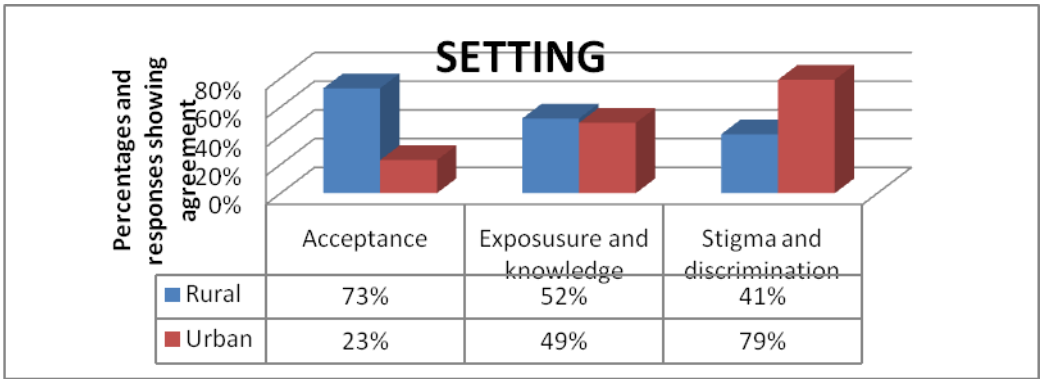
		Degrees of freedom	Setting			Gender			Age		
			X^2	0.05	0.01	X^2	0.05	0.01	X^2	0.05	0.01
Beliefs and	Acceptance	3	9.661	7.815	11.345	11.138	3.841	6.635	19.313	9.48	13.2
	Exposure and Knowledge	1	3.613			8.663			18.703		
	Stigma and Discrimination	4	24.127			9.325			19.752		

In the level of acceptance, with 3 degrees of freedom, it was found that

- The calculated chi-square value 9.661 for setting is higher than the tabulated value at 0.05 level of significance. With calculated value being more than the tabled value the chi-square value is found to be significant at 0.05 level. The calculated chi-square value 11.138 for gender is found to be higher than the tabulated value at 0.01level of significance and thus the chi-square value is found to be significant at 0.01 level of significance.The calculated chi-square value 19.313 for age is higher than the tabulated value at 0.01level of significance and thus the chi-square value is found to be significant at 0.01level of significance. In the level of exposure and knowledge, with 1 degree of freedom, it is seen thatThe calculated chi-square value 3.613 for setting is lower than the tabulated critical value at 0.05 level of significance and thus the chi-square value is found not to be significant at any of the levels of significance. The calculated chi-square value 8.663 for gender is higher than the tabulated critical value at 0.01 level of significance and thus the chi-square value is found to be significant at 0.01level of significance. The calculated chi-square value 18.703 for age is also found to be higher from the tabulated value at 0.01 level of significance and thus the chi-square value is found to be significant at 0.01level of significance.In stigma and discrimination, with 4 degrees of freedom, it is found thatThe calculated chi-square value 24.12 for setting is higher than the tabulated value at 0.01 level of significance and thus the chi-square value is found to be significant at 0.01level of significance. The calculated chi-square value 9.325 for gender is higher than the tabulated value at both the 0.05 and 0.01 levels of significance and thus the chi-square value is found to be significant at 0.01level of significance.The calculated chi-square value 19.752 for age is also found to be higher than the tabulated value at 0.01 level of significance and thus the chi-square value is found to be significant at 0.01level of significance.Thus, wherever the calculated chi-square value is found to be higher it can be said that there is a significant difference and hence the null hypothesis stands "not accepted".

1.5.1. SETTING

Figure 1: Differences in attitudes and beliefs according to setting

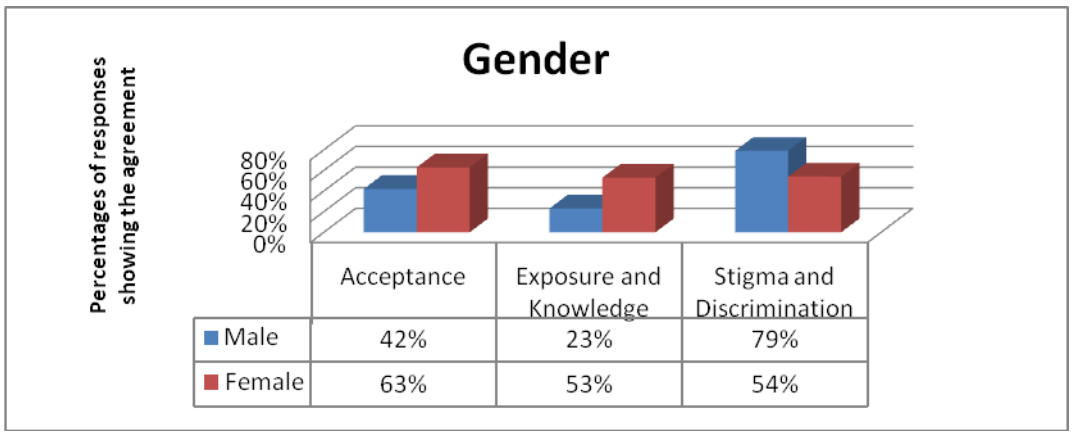


The percentages displayed in figure 1 shows that there is high difference in attitudes and beliefs reflecting acceptance as well as in stigma and discrimination between rural and urban; rural setting showing more acceptance and lower stigma and discrimination than urban. It is very clear from the above figure that there is negligible difference in attitudes and beliefs reflecting exposure and knowledge between people from rural and urban settings; it can be said that the exposure and knowledge on mental illness is same irrespective of rural and urban setting. It is clearly visible from the above figure no. 1 that people from rural setting have higher level of acceptance than people from urban setting. This finding is consistent with other research studies that have also supported the view that people from rural community have higher acceptance of mental illness than people from urban setting. Findings from the study by Poreddi (2013) suggested that people from the urban areas showed less percentage of acceptances of mental illness than the people from rural areas. Ineland et. al. (2008) also found that the caregivers of a person with mental illness very rarely takes their ward to a psychiatrist and accept the diagnosis. It has been observed too, during the collection of data for the research work, that people from the urban area are more conservative regarding their views on mental illness and very rarely talk about the matter or disclose its presence in their families, whereas people from rural area openly speak about the issue and shows their acceptance of people with mental illness.It was found that the calculated chi-square value for exposure and knowledge is non-significant at critical values and hence it may be inferred that there is no significant difference in the attitudes and beliefs reflecting exposure and knowledge toward people with mental illness by rural and urban setting. The above figure also shows that there is negligible difference in attitudes and beliefs reflecting exposure and knowledge between people from rural and urban settings and it may be said that the exposure and knowledge to mental illness is same irrespective of rural and urban setting. The present research findings are found to be consistent with some other research studies that have supported the view that

there is no difference in the exposure & knowledge based on the rural and urban setting. A study in North America by Scheff (2000) revealed that knowledge regarding the etiology and consequences of mental illness varies with practical exposure and not with placement or location of the person. The knowledge on mental illness is acquired through practical exposure to the illness.The calculated chi-square value for stigma and discrimination is found to be significant at the critical values and thus it may be concluded that there is a significant difference in the attitudes and beliefs reflecting stigma and discrimination by rural and urban setting. It was clear from the above figure that the percentage of urban is higher than rural setting, that is, the level of stigma & discrimination is greater in the urban setting. The findings are found to be consistent with studies that have supported the view that urban people are more stigmatized than the rural people regarding mental illness. It was revealed in studies by Jorm (2000) and Angermeyer (2005) that people living in urban areas show more stigma and they do not like to share the issues related to their illness with anyone. Another observation, which seems pertinent to the present finding, is that during the research work when different mental health institutions were visited it was found that people from rural areas were more comfortable in speaking about the illness as compared to the people from urban areas; and hospitalized patients too are more from rural areas.

1.5.2. GENDER

Figure 2: Differences in attitudes and beliefs according to gender



The percentages shown in figure 2 reflect that there are highly positive responses toward acceptance and exposure & knowledge by females whereas there seems to be higher stigma and discrimination among the males. It has been seen from the results that females are more accepting and seem to exhibit a lack of stigma and accept the issue of mental illness whereas the males showed more stigma. The calculated chi-square values also showed significant difference in all the assigned domains i.e. acceptance, exposure & knowledge and stigma & discrimination. Gender showed differences in all aspects of accepting mental illness with females taking up the issue of mental health and dealing with it more positively as compared to males. The findings of some other research are also similar and support the findings of the present research that females are more accepting, have higher knowledge & exposure and show less stigma than the males. Kumar and Singh (2011) also found that the level of stigma towards mental illness is less among females than males.It was found that the calculated chi-square value is higher and significant and hence it may be concluded that there is a significant difference in the attitudes and beliefs reflecting acceptance of people with mental illness as far as gender is concerned. Since the calculated chi-square value is found to be significant for exposure and knowledge it may also be inferred that there is a significant difference in the attitudes and beliefs reflecting exposure and knowledge toward people with mental illness with respect to gender. The calculated chi-square value is found to be significant for stigma and discrimination too and hence it may be stated that there is a significant difference in the attitudes and beliefs reflecting stigma and discrimination toward mental illness with respect to gender, indicating that both males and female have different attitudes and beliefs reflecting stigma and discrimination. And from the above figure no. 2 it is clear that males are showing more stigma and discrimination towards mental illness than the females.

It must be mentioned, that during the research work, there were many instances when the researcher approached people for their responses and found the males to be very co-operative but when it came to the topic of mental illness they were found to be more reluctant to respond to the queries in comparison to the females.

1.5.3. AGE

Figure 3: Differences in attitudes and beliefs according to Age:

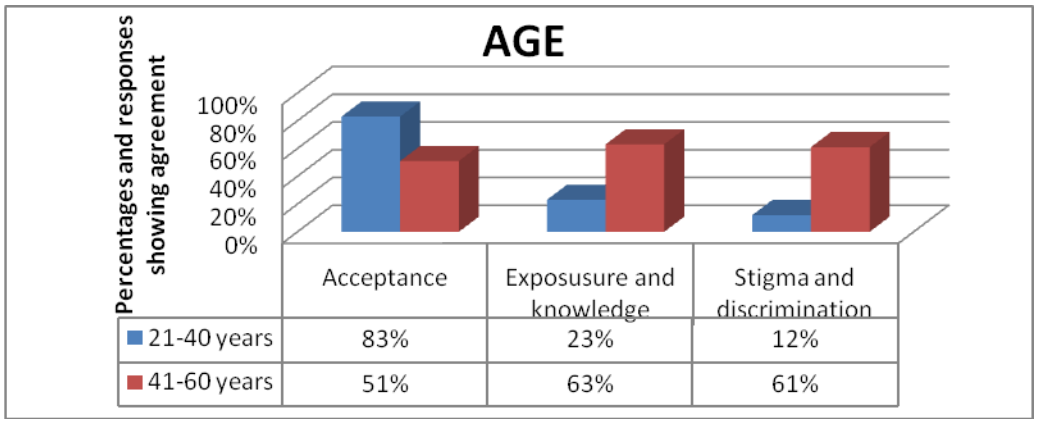


Figure 3 shows higher percentage among the 21-40 years age group (younger group) expressing acceptance of people with mental illness, whereas there is high responses for attitudes and beliefs reflecting exposure and knowledge among the 41-60 years age group (older group). It is also clearly visible from the given percentages that attitudes and beliefs on stigma and discrimination is higher in the older age group than the younger age group. Similar results were also found in a study by Jorm (2000) where the younger generation was more welcoming and outspoken of their psychological problems and the issue of mental illness. It is quite natural that the older group would have higher exposure and knowledge, given their longer years of living, but it appears that exposure and knowledge has not led to higher acceptance and lower stigma and discrimination among this group which is quite baffling and not in accordance with what is usually involved (exposure and knowledge) in processes of attitude change.These results have important implications for interventions in the field of mental illness as generation gap has always been a constraining factor in the process of modernization and in welcoming new approaches. Similarly, conflict among the younger and older generations is common in breaking down the old rituals and superstitions prevailing in any community. In the present research the results obtained seem to indicate generation gap and possibly a conflict working toward bringing about change in attitudes and beliefs toward mental illness in the future generations.Since it was found that the calculated chi-square value is significant it may be inferred that there is a significant difference in the attitudes and beliefs reflecting acceptance of the people with mental illness by age group. Ganesh K. (2011) has observed that, having higher levels of education, the upcoming generation has higher acceptance of mental illness.Based on the calculated chi-square values it may also be inferred that there is significant difference in the attitudes and beliefs reflecting exposure and knowledge towards people with mental illness with respect to age along with stigma and discrimination towards the people with mental illness. Stigma and discrimination attached to mental illness was identified as a strong factor in availing treatment in Goa, Goankar (2014).

III. CONCLUSION

The findings of the study highlight the existing attitudes on acceptance, exposure and knowledge, stigma and discrimination toward people with mental illness, among the people of two representative districts, that is Morigaon district and Sonitpur district, of Central Assam. The study reflects that there is a difference in attitudes and beliefs toward people with mental illness by the setting, gender, and age as well.

Summary of the findings:

1) Acceptance is higher in rural setting, younger age group and female.
2) Exposure and knowledge is higher in rural setting, older age group and female.
3) Stigma and discrimination is higher in urban setting, older age group and male.

Majority of the respondents from urban setting in this study seem to have lower level of knowledge and exposure to persons with mental illness. Likewise it was seen that stigma is higher in urban society than in rural society, although it has always been believed that people from rural area would be more stigmatized. Therefore, it can be said that more awareness programs are needed to be conducted and mass media need to take initiatives to make the people well aware about the root causes, possibilities, management and the consequences of mental illness in urban areas.

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