DOI:
10.1192/bjp.2021.221

Reconceptualising the treatment gap for common mental disorders: A fork in the road for global mental health?

Journal:	*BJPsych*
Manuscript ID	BJPsych-21-0087.R2
Manuscript Type:	Analysis
Date Submitted by the Author:	13-Dec-2021
Complete List of Authors:	Roberts, Tessa; King's College London, Health Service and Population Research Department; Institute of Psychiatry, Psychology and Neuroscience; King's College London, Centre for Society & Mental Health Miguel Esponda, Georgina; King's College London, Health Service and Population Research Department; Institute of Psychiatry, Psychology and Neuroscience; King's College London, Centre for Society & Mental Health Torre, Costanza; The London School of Economics and Political Science, Department of International Development Pillai, Pooja; Herbertpur Christian Hospital Herbertpur, Burans Cohen, Alex; London School of Hygiene and Tropical Medicine Faculty of Epidemiology and Population Health Burgess, Rochelle; University College London, Institute for Global Health; University of Johannesburg, Department of Social Work
Keywords:	Low and Middle Income Countries, Anxiety Disorders, Depressive Disorders, Psychosocial Interventions, Qualitative Research
Publishing Category:	Mental Health Services
Abstract:	In this analysis, we argue that the "treatment gap" for common mental disorders primarily reflects lack of demand, arising because services fail to address the needs of disadvantaged communities. We propose a route forward for global mental health, with explicit focus on action on the socio-economic determinants of psychological suffering.

Reconceptualising the treatment gap for common mental disorders: A fork in the road for global mental health?

Tessa Roberts, PhD[1]; Georgina Miguel Esponda, PhD[1]; Costanza Torre, MSc[2], Pooja Pillai, MSc[3], Alex Cohen, PhD[4], Rochelle A. Burgess, PhD[5,6].

[1] Centre for Society & Mental Health, King's College London
[2] Department of International Development, London School of Economics and Political Science
[3] Burans – Herbertpur Christian Hospital - Emmanuel Hospital Association
[4] Harvard-TH Chan School of Public Health
[5] Institute for Global Health, University College London
[6] Department of Social Work, University of Johannesburg, South Africa

Corresponding author:
Dr Tessa Roberts, tessa.roberts@kcl.ac.uk
David Goldberg Centre, De Crespigny Park, London, SE5 8AF, UK

Summary

In this analysis, we argue that the "treatment gap" for common mental disorders often reflects lack of demand, arising because services fail to address the needs of disadvantaged communities. We propose a route forward for global mental health, with explicit focus on action on the socio-economic determinants of psychological suffering.

The treatment gap for common mental disorders

The way we respond to a problem is shaped by how we frame and describe it. The treatment gap is defined as the proportion of people who meet diagnostic criteria for a given disorder whose condition is untreated (1). This concept, anchored to the twin claims that mental disorders are highly prevalent and that mental health services are scarce, has been a central tenet of the discipline of global mental health (GMH). Treatment gaps ranging from 82% to 98% have been reported for common mental disorders (2) (CMD), with these figures typically higher among communities that are marginalised or have fewer resources.

The 2007 and 2011 Lancet GMH series (3, 4) argued that the central mission of the field is to scale up evidence-based care in order to "close the treatment gap" for mental disorders, of which the most prevalent are CMD (defined as depression, anxiety and somatoform disorders). These arguments are mirrored in key WHO publications, which place "closing the treatment gap" front and centre of international mental health policy (5). Recent literature demonstrates how pervasive this concept continues to be in shaping the

narrative of the field, with many articles still framing findings in terms of the treatment gap for mental disorders (6).

However, there has been much critique of the evidence base for this gap, from arguments that the measures used ignore important local variation in conceptualisations of mental distress (7), to those that draw attention to the broader needs of people with mental illnesses (8). In response, the 2018 Lancet Commission (9), replaced "treatment gap" with the "care gap", referring to the unmet mental health, physical health, and social care needs of people with mental illness (8). However, we contend that maintaining the notion of a 'gap' misses a more fundamental point: Why do so few people access mental health treatment? And how does this influence how we conceptualise solutions to the lack of service uptake?

In this analysis, we consider a frequently-overlooked contributor to the treatment gap: low demand for services arising from non-medical interpretations of CMD-related experiences - and its implications for how we respond to the needs of people who are considered to suffer from CMD. Our arguments are written from the position of allyship or lived experiences of adversity; three of our authors are born in, or direct descendants from communities who face the structural determinants of poor mental health that are largely overlooked in this field. All authors have devoted their academic careers to advancing arguments that create meaningful space for the contexts of mental health to be taken more seriously. We argue that while providing appropriate services that consider the social and economic realities of people's lives is essential, global mental health must also advance a movement for improved public mental health measures targeting the structural and political determinants of mental health.

Our focus in the current piece is on CMD because this is frequently the target of GMH initiatives, and the majority of people in the "mental health treatment gap" are those considered to have CMD. Some of our argument will apply to other categories of mental disorder but exploring the extent to which it does is beyond the scope of this analysis.

Supply or demand?

The treatment gap is often taken to indicate a shortage of mental health services; in other words, a problem of supply, supported by evidence of resource deficits for mental health care. This is used to justify focusing on increasing access to mental health services, particularly in settings where resources are most scarce.

However, there is also evidence to suggest an alternative interpretation. The World Mental Health Surveys, conducted in 24 countries with 63,678 participants, found that *lack of perceived need for treatment* was by far the most frequently-reported reason given for not seeking treatment for mental health problems (10). This is consistent with the hypothesis that many people who fall in the "treatment gap" do not want treatment for their depression or anxiety symptoms. This alternative interpretation (the treatment gap as a demand rather than supply issue) was borne out in the PRIME programme – an eight-year initiative to increase the supply of mental health services in five low- and middle-income countries – which demonstrated that, in the absence of demand, increasing the supply of mental health services does not reduce the treatment gap for CMD (11). However, explaining the reasons behind the lack of demand for mental health services has received scant attention in the global mental health literature.

Why is demand for mental health care so low?

Low demand for mental health services is typically attributed to stigma, barriers to access such as travel costs, limited "mental health awareness", or limited service provision (9). While these may contribute to low service uptake, our research offers a simpler explanation that has received less attention. Our findings indicate that across multiple low-resource settings in both the global north and south, people fail to seek mental health services – and disengage from services – because people interpret their psychological and emotional states as reactions to social and economic problems, not as health conditions that can be addressed by medical services. Similar findings have been reported in both low- and middle-income countries and among marginalised groups in high-income settings.

Below we summarise findings from four qualitative studies (12-15).

Table 1. Summary of qualitative research from India, Mexico, Uganda and the UK exploring reasons for low engagement with mental health services for CMD.

Context	Services offered for CMD	Key themes	Illustrative quotes
Rural India, with high rates of poverty. Most participants did manual agricultural labour, often for very low daily wages in poor conditions, with little security. Many women complained of mistreatment and alcoholism by their husbands. Limited access to quality health care, and low life expectancy.	Mental health services based on mhGAP model provided in community health centres across the sub-district, including both pharmacological treatment and brief psychological interventions.	CMD conceptualised in terms of "tension" or stress arising from poverty and other stressors. Participants did not believe that health services could relieve these feelings because they cannot change their economic or social circumstances.	"What else can a poor man have except tension [stress]... Money is the issue. We have no money in our home. If I had money then all of my tension would be ended." "[The doctor] can't provide bread to your home. When your hunger is ended then your mind will become fine."
Rural villages in Mexico, located in a mountainous and remote area, with very limited access to internet and no mobile networks. Low availability to employment, health services, and other basic services (e.g. water, electricity). High rates of	Mental health services based on mhGAP model provided in primary care facilities and at the community, including both pharmacological treatment and brief	CMD symptoms attributed to adversities experienced. High rates of disengagement from services, explained in terms of services not being helpful since they address	"This is why I get ill. I worry about my son's drinking."

extreme poverty (i.e. family income insufficient to cover basic needs), alcohol misuse and family violence.	psychological interventions.	only symptoms, not causes.	
Refugee settlement in Northern Uganda, in which food and basic needs are frequently unmet. Self-reliance is encouraged, but land and other economic resources available to refugees are scarce. Most people live in chronic poverty, with little hope to sustain themselves and their family or to gain independence from the already inadequate humanitarian assistance.	Brief form of Cognitive-Behavioural Therapy (CBT-T); pharmacological treatment.	CMD explained as 'overthinking' due to lack of food, inability to afford medication when family members are sick, and other socio-economic hardships. Frustration with mental health services that ignore refugees' primary concerns. Futility of psychological intervention when basic needs unmet.	"The medicine cannot do anything to me to have less thoughts; I will only have less thoughts when I can support my children." "These people, they come here and they tell us not to think, to forget about the past. But how can you tell us to forget when you are not giving us anything to support ourselves? We have no work. The food is little. You are just fooling us."
Black African and Caribbean young people in central London, UK, who live in contexts of economic precarity, over- policing, and increased risks of exposure to traumatic life events. During the pandemic young people's exposure to precarity was heightened.	Increased access to online support groups. Increased resources for school-based mental health support provision.	CMD symptoms linked to social consequences of the pandemic. Frustration with a lack of understanding by government of the stresses young people face. Desire to lead their own responses; and to be trusted by authorities in doing so.	"It's a lot. It's like over a pound when I get on the bus... But it's just stress." "I'm fed up [with] thinking they're (the government) going to help - they're not going to help. They don't care, we are not a priority to them, they have their own people, and they don't care."

The research cited above adds to the evidence base that decontextualized approaches to mental health treatment make little sense to people whose psychological distress is linked with ongoing adversity. By ignoring the social determinants that frequently cause psychological distress, mental health services often fail to meet people's perceived needs, resulting in low uptake and high drop-out rates when these services are rolled out, despite

positive results in trials. Many people do not believe that psychological or pharmacological treatment will make them feel better if their basic needs remain unmet. Indeed, "feeling better" on its own is rarely people's primary goal, when understood solely as a psychological experience; to feel better, people need to see real change in their circumstances.

To be clear, we are not advocating the abandonment of mental health treatment. However, to ensure demand for services, community concerns and potential solutions must be central to the design and delivery of mental health programmes. This can be achieved through participatory action research or co-production with potential service users (16). However, this may require a fundamental re-think of interventions and their method of implementation: the resulting interventions may not look like mental health services as conceptualised by the health sector (see box 1).

Don't we just need more mental health awareness?

With low mental health literacy often blamed for low demand for mental health services, efforts to raise awareness have been increasingly mainstreamed in mental health programmes. Calls for awareness campaigns to change the community's current understanding of CMD may be misguided, however, not only because the principles of person-centred care recommend listening to patients and adapting services to their needs (rather than convincing patients that their needs should match the services offered), but also because a growing evidence base suggests that people facing ongoing adversity are indeed less likely to respond to treatment, in the absence of a change in their circumstances. Two recent systematic reviews provide preliminary evidence that both psychological and pharmacological treatments for depression are less effective for people living in greater deprivation (17, 18). Most of the evidence reviewed was from high-income countries, but in a CMD intervention trial in Goa, participants facing major current life problems were also far more likely to remain depressed despite treatment (19).

Given the extensive evidence on the social determinants of mental health, it should be unsurprising that trying to improve patients' mental health while the causes of the problem are ongoing frequently fails. Treating people and sending them back to the same conditions that made them sick is a Sisyphean task. This may go some way towards explaining the lack of association observed between mental health service coverage and prevalence of CMD (20).

A route forward for Global Mental Health

Arguments thus far illuminate why a treatment gap is a poor measure of unmet need, and GMH must move beyond "closing the treatment gap" – at least for CMD – as its primary goal. While there is a human rights case for improving access to and quality of mental health care for those who want to use formal services, scaling up these services without wider social and economic measures will not necessarily reduce the overall burden of mental ill health (20). We need upstream approaches, including social and economic interventions to reduce the causes of mental ill health, to make a meaningful impact on population mental health, especially for deprived or marginalised communities. In other words, in addition to a health sector response, we require a societal response to the causes of CMD that lie beyond the health sector.

We therefore propose an explicit distinction between two separate agendas in GMH, based on distinct rationales:

(1) Service improvement, based on human rights, co-production, and quality improvement principles.
(2) A prevention agenda to reduce the population burden of mental disorders through action on the social, structural, and political determinants of mental health (reflecting the explanatory models of people who attribute their CMD symptoms to their social and economic circumstances).

Importantly, these recommendations apply not only to low- and middle-income countries but also to high-income settings, particularly for marginalised groups who are most negatively affected by the structural determinants of mental health, and who are least likely to access formal mental health care.

(1) Reforming services

The development of effective and culturally appropriate interventions for CMD that can be implemented in low-resource settings, such as the Thinking Healthy intervention in Pakistan (21), or the Friendship Bench in Zimbabwe (22), has been an important step towards providing appropriate support to people experiencing CMD symptoms. However, the limits of what these interventions can achieve in the absence of social and economic change must be acknowledged, as well as the disparity between the service that is delivered in randomised controlled trials and that which is typically delivered in routine services to those who seek help for CMD.

While the GMH agenda has placed great emphasis on expanding services to reach all those who meet diagnostic criteria for CMD, many of whom do not consider themselves to need or want such treatment, the quality of care received by the minority of those who do seek treatment – typically those with more severe symptoms – is still frequently poor. We contend that rather than "closing the treatment gap" through identifying more non-treatment-seeking individuals with CMD, improving the quality of care for those who currently seek help should be a priority.

Poor quality healthcare and struggling health systems limit the extent to which it is possible to deliver effective interventions to those with CMD, particularly those living in vulnerable situations (23). Basic issues such as lack of health personnel, inadequate facilities and shortage of medications still affect a large proportion of the world's population and make it extremely difficult to offer person-centred care through health services. To fulfil the right to health for all, we need health systems that are adequately resourced and designed to address contextual challenges. Persuading more people to seek help for CMD when health services are unable to provide quality care may be counter-productive; our first priority should be to advocate for investment in systems strengthening so that those who do receive treatment receive high quality and dignified care.

Furthermore, our goal in terms of increasing access to services must be not only that the human right to care is met, but also that people have the ability to improve their lives in ways they consider meaningful. Achieving the above is only possible through actively involving communities and those who seek care in the design and evaluation of services and working collaboratively to build solutions with the families and communities that these

services serve (16). Such methods ensure greater attention to demand-side barriers – which are often strongly inter-linked with the social and economic contexts of people's lives – to create services that people want to engage with.

A case study from Burans of incorporating social and economic considerations into interventions for CMD.

Rajini is a woman in her thirties who lives in a slum near the bustling tourist town of Mussoorie in Northern India. As the daughter of a single mother, who is the sole breadwinner in the family, they are barely making ends meet. Rajini was diagnosed with CMD and has been confined to her house for most of her adult life due to these difficulties.

A Burans community worker worked with the pair for 4 months, not only looking at the biomedical aspect of recovery, but also working through the social aspects, including keeping busy and trusting her with responsibilities. Rajini was enrolled in a 3 month recovery-oriented care plan. Alongside counselling, the community worker contacted a chicken vendor, with the idea that caring for chickens would give Rajini purpose while easing the financial burden of the family.

This simple and sustainable program has shown surprising results. Rajini gets up early every day, freshens up, and takes care of the chicks. Her mother says; 'If each hen gives one egg every 3 days at 10-15 rupees per egg, then we will have a supplementary income. The best part of this has been seeing my daughter take up this responsibility. I never thought I would see this day.'

This story of change has helped the Burans team realise the importance of livelihoods interventions to support families, but also the impact of working on social determinants to improve mental health, apart from the biomedical services available.

(2) Upstream interventions to tackle social determinants of mental health

While good-quality treatment for the minority who want it is important, when it comes to the extensive "social suffering" (16) experienced by many people with CMD, individual-level treatment is not the answer to failed social systems. Improving population mental health will require improvements in the social conditions that give rise to social suffering. This is referred to as tackling the "prevention gap" (9), but has thus far received scant attention in the GMH literature. We contend that this stream of GMH requires far greater concerted efforts than it has received to date. It is through this stream, by contributing to collective efforts to advocate for structural changes, that substantive gains can be made in reducing the mental health burden of populations.

In this editorial we make clear the need to bring intervention efforts more in line with voiced concerns of people living through adversity globally. Elsewhere we have suggested models to bring us closer to a field where upstream and downstream approaches work in parallel to respond to social determinants of poor mental health (16, 24). We welcome recent modelling and quantitative evidence that confirms what has been said for decades

by the people who live through adversity and seek to maintain good mental health; that the socio-structural conditions of everyday life matter.

The evidence base for the mental health impact of policies and interventions to address social determinants originates disproportionately from high-income settings in Western Europe, North America and Australasia, and public mental health research is urgently needed that is relevant to other contexts. This will require a different set of research tools to those traditionally employed in GMH, since upstream interventions are not always amenable to randomised controlled trials.

Conclusion

In summary, we believe that “closing the treatment gap” for CMD should be revised as a goal of global mental health. We maintain that recent evidence suggests that the treatment gap for CMD also reflects lack of demand for mental health care because symptoms are explained in social or economic terms, mirroring known social determinants of mental health. A growing evidence base also suggests that people with CMD who face adversity are right to doubt the utility of treatment without a change in their social or economic circumstances. Providing interventions that address people’s mental health needs is central to global mental health, but "treatment" per se does not necessarily meet these needs. We must therefore expand the notion of what constitutes a mental health intervention. It is important to acknowledge two divergent agendas within global mental health – (a) public mental health, and (b) increasing access to and quality of healthcare – which require different skills, strategies, stakeholders and research agendas. We contend that greater transparency about these two parallel streams, and support for the often overlooked public mental health field, is necessary for the field to progress.

Declaration of interests

None.

Funding statement

This study received no specific grant from any funding agency, commercial or not-for-profit sectors. However, the lead author is supported by an ESRC post-doctoral fellowship (ES/T007125/1).

Data availability

This is an analysis rather than an original research article, so no new data are reported. The research referenced in Table 1 is reported elsewhere and the supporting data from these studies are available upon reasonable request from TR, GME, CT and RAB, respectively.

Author contributions

TR, GME and CT conceptualised the analysis and TR was responsible for drafting the manuscript. PP, AC and RAB subsequently provided critical feedback and suggested edits and additions to the text. TR, GME, CT, PP and RAB all provided illustrative examples of the phenomenon discussed from their own research.

References

1. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. Bulletin of the World health Organization. 2004;82(11):858-66.

2. Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. The Lancet. 2007;370(9590):841-50.

3. Chisholm D, Flisher A, Lund C, Patel V, Saxena S, Thornicroft G, et al. Scale up services for mental disorders: a call for action. The Lancet. 2007;370(9594):1241-52.

4. Patel V, Boyce N, Collins PY, Saxena S, Horton R. A renewed agenda for global mental health. Lancet (London, England). 2011;378(9801):1441.

5. WHO. mhGAP : Mental Health Gap Action Programme : scaling up care for mental, neurological and substance use disorders. World Health Organization; 2008.

6. Fuhr D, Acarturk C, McGrath M, Ilkkursun Z, Sondorp E, Sijbrandij M, et al. Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: a cross-sectional survey. Epidemiology and psychiatric sciences. 2020;29.

7. Ingleby D. How 'evidence-based' is the movement for global mental health? Disability Global South. 2014;1(2):203-26.

8. Pathare S, Brazinova A, Levav I. Care gap: a comprehensive measure to quantify unmet needs in mental health. Epidemiology and Psychiatric Sciences. 2018:1-5.

9. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. The Lancet. 2018;392(10157):1553-98.

10. Andrade LH, Alonso J, Mneimneh Z, Wells J, Al-Hamzawi A, Borges G, et al. Barriers to mental health treatment: results from the WHO World Mental Health surveys. Psychological medicine. 2014;44(06):1303-17.

11. Shidhaye R, Baron E, Murhar V, Rathod SD, Khan A, Singh A, et al. Impact evaluation of PRIME Mental Health Care Plan implemented in primary care in Sehore district, Madhya Pradesh, India. Unpublished. 2018.

12. Roberts T, Shrivastava R, Koschorke M, Patel V, Shidhaye R, Rathod SD. "Is there a medicine for these tensions?" Barriers to treatment-seeking for depressive symptoms in rural India: A qualitative study. Social Science & Medicine. 2019:112741.

13. Miguel Esponda G. What enables and hinders implementation? A mixed-methods case study of a mental health programme implemented in primary care clinics in rural Mexico: London School of Hygiene & Tropical Medicine; 2020.

14. Torre C. PhD research. (unpublished).

15. Burgess R, Kanu N, Matthews T, Mukotekwa O, Smith-Gul A, Yusuf I, et al. Exploring experiences and impact of the COVID-19 pandemic on young racially minoritised people in the United Kingdom: A Qualitative Study. SocArXiv Papers. 2021.

16. Campbell C, Burgess R. The role of communities in advancing the goals of the Movement for Global Mental Health. SAGE Publications Sage UK: London, England; 2012.

17. Finegan M, Firth N, Wojnarowski C, Delgadillo J. Associations between socioeconomic status and psychological therapy outcomes: A systematic review and meta-analysis. Depression and anxiety. 2018;35(6):560-73.

18. Elwadhi D, Cohen A. Social inequalities in antidepressant treatment outcomes: a systematic review. Social Psychiatry and Psychiatric Epidemiology. 2020:1-19.

19. Patel V, Weiss H, Mann A. Predictors of outcome in patients with common mental disorders receiving a brief psychological treatment: An exploratory analysis of a randomized controlled trial from Goa, India. African journal of psychiatry. 2010;13(4).

20. Jorm AF, Patten SB, Brugha TS, Mojtabai R. Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. World Psychiatry. 2017;16(1):90-9.

21. Rahman A. Challenges and opportunities in developing a psychological intervention for perinatal depression in rural Pakistan–a multi-method study. Archives of women's mental health. 2007;10(5):211-9.

22. Chibanda D, Weiss HA, Verhey R, Simms V, Munjoma R, Rusakaniko S, et al. Effect of a primary care–based psychological intervention on symptoms of common mental disorders in Zimbabwe: a randomized clinical trial. Jama. 2016;316(24):2618-26.

23. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health. 2018;6(11):e1196-e252.

24. Burgess RA, Jain S, Petersen I, Lund C. Social interventions: a new era for global mental health? The lancet Psychiatry. 2020;7(2):118.

Table 1. Summary of qualitative research from India, Mexico, Uganda and the UK exploring reasons for low engagement with mental health services for CMD.

Context	Services offered for CMD	Key themes	Illustrative quotes
Rural India, with high rates of poverty. Most participants did manual agricultural labour, often for very low daily wages in poor conditions, with little security. Many women complained of mistreatment and alcoholism by their husbands. Limited access to quality health care, and low life expectancy.	Mental health services based on mhGAP model provided in community health centres across the sub-district, including both pharmacological treatment and brief psychological interventions.	CMD conceptualised in terms of "tension" or stress arising from poverty and other stressors. Participants did not believe that health services could relieve these feelings because they cannot change their economic or social circumstances.	"What else can a poor man have except tension [stress]... Money is the issue. We have no money in our home. If I had money then all of my tension would be ended." "[The doctor] can't provide bread to your home. When your hunger is ended then your mind will become fine."
Rural villages in Mexico, located in a mountainous and remote area, with very limited access to internet and no mobile networks. Low availability to employment, health services, and other basic services (e.g. water, electricity). High rates of extreme poverty (i.e. family income insufficient to cover basic needs), alcohol misuse and family violence.	Mental health services based on mhGAP model provided in primary care facilities and at the community, including both pharmacological treatment and brief psychological interventions.	CMD symptoms attributed to adversities experienced. High rates of disengagement from services, explained in terms of services not being helpful since they address only symptoms, not causes.	"This is why I get ill. I worry about my son's drinking."
Refugee settlement in Northern Uganda, in which food and basic needs are frequently unmet. Self-reliance is encouraged, but land and other economic resources available to refugees are scarce. Most people live in	Brief form of Cognitive-Behavioural Therapy (CBT-T); pharmacological treatment.	CMD explained as 'overthinking' due to lack of food, inability to afford medication when family members are sick, and other socio-economic hardships.	"The medicine cannot do anything to me to have less thoughts; I will only have less thoughts when I can support my children." "These people, they come here and they tell us not to think, to forget about the past. But how can you tell