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Development of Clinical Psychology and Mental Health Resources in Vietnam

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Abstract

In this paper, we discuss development of the Vietnam National University graduate *Clinical Psychology Program*, which has the goal of training both Vietnamese researchers who will develop and evaluate culturally appropriate mental health treatments, as well as Vietnamese clinicians who will implement and help disseminate these evidence-based treatments. We first review the background situation in Vietnam regarding mental health, and its infrastructure and training needs, and discuss the process through which the decision was made to develop a graduate program in clinical psychology as the best approach to address these needs. We then review the development process for the program and its current status, and our focus on the schools as a site for service provision and mental health task shifting. Finally, we outline future goals and plans for

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the program, and discuss the various challenges that the program has faced and our attempts to resolve them.

Keywords

Mental health; Vietnam; Capacity development; Clinical psychology

Introduction

Developing countries face a wide range of significant challenges, including provision of mental health services for their people (Patel et al. 2008). In most cases, one of the key factors underlying this challenge is a lack of well-trained, competent mental health professionals, and the in-country infrastructure for training such professionals. For instance, in Cambodia prevalence estimates of the rate of diagnosable psychiatric illness among adults is approximately 35% (de Jong et al. 2001). Yet only 0.1% of the population accesses mental health services every year (Belford 2010); underlying this lack of access in Cambodia is a scarcity of mental health professionals (e.g., 40 psychiatrists to serve a country of 8 million people). Further, in addition to limited mental health service capacity in developing countries, there almost always is also a concomitant lack of mental health research infrastructure to develop and evaluate culturally-appropriate evidence-based treatments (Belfer 2008).

The present report focuses on development of mental health research and treatment services infrastructure in Vietnam. Similar to many developing countries, Vietnam has a relatively high mental health need (Hoang-Minh and Tu 2009) yet has limited treatment capacity in conjunction with limited research capacity to develop appropriate treatments (Dang and Weiss 2007). These development efforts have focused on children in particular, although not exclusively, as within this mental health gap, children represent a particularly underserved population (World Health Organization 2005).

Mental Health in Vietnam

Following the end of a long and destructive war in 1975, economic as well as social challenges in Vietnam were severe. To address economic inefficiencies associated with its centrally controlled economy, in 1986 Vietnam shifted to a more mixed, market-based economy. After two decades of this ‘Doi Moi’ reform, Vietnam achieved significant economic progress. GDP growth stabilized at around 8% per year (making it the second most rapidly developing economy in the world, although in the recent economic downturn growth has declined to 5.5% per year; World Bank 2010). However, although the policies of Doi Moi are generally recognized as quite successful economically, concerns have been raised that social policy, particularly with regard to health, has not developed comparably to economic policy. It has begun to be recognized that the rapid economic growth has come at some social costs, increasing stress for families and their children (e.g., Gabriele 2006).

These social costs include rapid, uncontrolled growth that has stressed and diminished families’ traditional ability to successfully protect and socialize their children into healthy, adaptively functioning adults (Korinek 2004). For example, in response to increased economic opportunity parents often work long hours with many young children left alone for long periods of time without adult supervision (Ruiz-Casares and Heymann 2009). This is particularly true for rural families who move away from their home village, where members have known each other for generations, to urban areas where they lack the generations-old social support and child rearing networks available in their rural homeland.

These changes place Vietnamese children at increased at risk for development of mental health problems (United Nations Vietnam Youth Theme Group 2010).

Vietnamese Children's Mental Health Functioning

Several studies have investigated Vietnamese children's mental health functioning. Overall, the studies suggest that many Vietnamese children have substantial rates of mental health problems. The Young Lives Project (Tran et al. 2003) was an epidemiological survey examining child developmental and health (including mental health) outcomes of children across Vietnam (as well as in several other countries). The project found that Vietnamese children face a wide range of stressors such as child labor and other poverty-related stressors, and 20% were above the cut-off of the mental health screening measure included in the assessment. In southern Vietnam, Anh et al. (2007) conducted an assessment of social and behavioral problems among high school students in Ho Chi Minh City. They found that 16% of students were experiencing significant affective problems, 19% had social relationship problems, and 24% were judged to have behavior problems. In a study of northern Vietnamese secondary school children in Hanoi, Hoang-Minh and Tu (2009) found that about 25% of children were above the clinical cutoff on one or more of the Child Behavior Checklist scales.

Mental Health Resources in Vietnam

As is true for most developing countries, in the early stages of modernization and development the Vietnamese government made an explicit decision to focus its limited financial resources on direct economic development, giving a low priority to social services, education and health, in particular mental health (Stern 1998). Consequently, resources for treatment of mental health problems have been limited (Gabriele 2006; Schirmer et al. 2004), especially among children (e.g., there currently are only about 20 child psychiatrists in Vietnam). According to a World Health Organization report on the mental health system in Vietnam (World Health Organization 2006), the total number of personnel working in the field of mental health in Vietnam is quite limited, with a total of 286 psychiatrists, the equivalent of each psychiatrist being responsible for approximately 300,000 people.

Most recently, there has been increasing recognition of the need for social policy change, and that attention and resources need to be shifted to social domains such as mental health (Schirmer et al. 2004; Gabriele 2006). However, not only are there few mental health service resources, there are few resources for training child mental health researchers or practitioners. In 2002, we (Dang and Weiss 2007) conducted a mental health needs assessment in six cities across Vietnam, meeting with 23 educational and mental health-related agencies; these meetings generally involved the director of the agency as well as other staff, and in meetings with universities we also met with students. Agencies included the *National Institute of Pediatrics*; the *National Psychiatric Hospital* (at Hanoi, and at Bien Hoa-HCMC); the *Department of Special Education, Vietnam National University; UNICEF*; the *National Institute of Mental Health*; the *National Institute for Educational Development*; the *Division of Psychology, Vietnam National University (HCMC)*; the *National Pedagogical and Psychological Association; Da Nang Psychiatric Hospital*; and the *Department of Psychiatry, Hue Medical College*.

Based on these meetings, we reached the following conclusions: **(a)** Vietnamese mental health and education professionals understood and appreciated a broad definition of children's mental health problems, one that included substance abuse, delinquency, depression, etc. People outside these fields (e.g., politicians, the general public), however, had a more traditional perspective (which limits "mental health" to schizophrenia, mental retardation, and seizure disorders), with little appreciation of how substance abuse,

depression, etc. were related to mental health or that they would be appropriate for mental health professionals to study or treat. **(b)** Professionals viewed children's mental health problems as a very serious issue facing the country. Across the 23 meetings, with one exception all groups were consistent in stressing that children's mental health was a serious national problem. **(c)** Non-professionals (again, e.g., politicians, the general public) also saw issues of drug abuse, suicide and depression, etc. as serious problems but did not connect these problems to mental health. Rather, they saw them as law enforcement issues, moral failings or weaknesses, etc. **(d)** Professionals were unanimous in regards to stating that there was an almost complete lack of research and clinical training in regards to children's mental health, and that training in children's mental health issues was deficient even relative to mental health training in general. Most post-graduate training in clinical psychology took place in France or Russia (or prior to the collapse of the USSR, in eastern Europe). **(e)** There was a very strong interest among professionals to obtain advanced training in regards to children's mental health issues. With one exception, agencies were very supportive of their staff obtaining additional training; the one exception was the director of a psychiatric hospital, who stated that he was so chronically short staffed that he could not afford to have staff involved in training outside of the city. **(f)** Theory and clinical research did not appear highly integrated, in the sense that much clinical research did not appear to have an explicit theoretical basis, or to have a focus on theory testing. However, research was well integrated into clinical practice. **(g)** Although there were some notable exceptions, the central importance of research as the fundamental basis for clinical practice and education was not yet fully appreciated by a substantial number of professionals in Vietnam (although in fairness, the same could be said about the U.S. and other western countries). **(h)** Despite the lack of training, people were eager to establish counseling clinics and had begun to do so. The people establishing the clinics were well intentioned, but often had little or no mental health training; consequently, these clinics were not providing empirically-validated treatments. Our Vietnamese colleagues were concerned that these clinics were potentially problematic, given the likelihood that the services would be lacking in effectiveness, which in the long-run would increase the general distrust of mental health treatments by the population. **(i)** Different regions of the country saw different child mental health problems as most problematic. For instance, in Hanoi drug abuse and delinquency were generally seen as the most serious mental health-related problem for adolescents, whereas in Hue school-related stress and suicide were seen as most problematic.

More recently, we (Weiss et al. 2010) began a national needs survey to assess the adequacy of mental health research, service, and training infrastructure in Vietnam. This survey was based in part on the World Psychiatric Association and World Health Organization Child and Adolescent Mental Health Resources survey (World Health Organization 2005). We used a key informant approach rather than a random sample, since we are not interested in the typical professional's perspective but rather on the most accurate appraisal of the situation. Informants judged as highly knowledgeable of the situation in Vietnam regarding research and the mental health system were selected to participate. Results from 12 informants confirm our original needs survey regarding the state of the field in Vietnam. Among various questions, the key professionals rated on a scale of 1–5: (a) *how serious of a problem are emotional and behavioral problems (*e.g., *anxiety; depression; substance abuse) in Vietnam*, mean response=4.0 ('very serious'); (b) *how adequate are current treatment services for these problems in Vietnam*, mean response=2.6 ('slightly' to 'somewhat adequate'); (c) *how adequate are current resources for clinical training in Vietnam*, mean response= 2.1 ('slightly adequate'); (d) *how important is conducting research on mental health in Vietnam*, mean response=4.3 ('very' to 'extremely important'), (e) *how adequate is current research capacity in Vietnam*, mean response=2.6 ('slightly' to 'somewhat adequate'), and (f) *how adequate is research training capacity in Vietnam*, mean response=2.1 ('slightly adequate'). For all areas of research, training and intervention

capacity, ratings were less than even ‘somewhat adequate’ (3), the half way point on the scale.

Developing Mental Health Resources in Vietnam

After our first needs survey (Dang and Weiss 2007) in 2002 identified the substantial mental health infrastructure needs, we conducted a review of the literature to identify potential ways in which these needs might be addressed. We identified three approaches that appeared initially feasible and potentially useful. These included: (a) short-term (1 to 2 week) focused in-country training seminar series, conducted by ‘foreign experts’; (b) overseas graduate or post-doctoral training for young Vietnamese professionals; and (c) mentored research and program implementation projects designed to enhance Vietnamese research and clinical skills.

To evaluate the utility of short term seminars, over a period of two years we conducted a series of mental health research and practice training seminars, led by ‘foreign experts’ from the U.S., Canada, and Australia, with Vietnamese participants from across Vietnam. Topics included research design and methodology, psychopathology research, statistical analysis, as well as clinical trainings focused on such topics as treatment of obsessive-compulsive disorder. After the conclusion of the seminars, we followed participants to assess the long term utility of such seminars. One conclusion readily apparent was that such seminars were of little or no value without extensive follow-up supervision or collaboration. That is, in these seminars participants could be given basic knowledge but when the participants attempted to apply this knowledge to the complex research and clinical problems they were trying to address, their knowledge and experience was too limited to address these complexities. Overall, we concluded that short-term in-country seminars could be useful—if extensive follow-up supervision was provided—for providing focused training for mid- to advanced-level professionals. But these seminars could not address the fundamental need for developing new professionals. This was because the seminars could not provide the extensive basic training needed to develop new professionals.

We also evaluated the utility of overseas graduate or post-doctoral training at foreign institutions of young professionals who were supported by the Vietnamese, U.S., and French governments. We found this to be very effective for the small number of individuals involved, but also so expensive as to not be sustainable as a means for directly increasing research or clinical capacity in mental health in Vietnam. Further, this approach carries the very real risk that the young professional studying abroad may find life in the U.S. or some other affluent Western country so attractive that he or she will elect not return to their home country. In addition, overseas training carries the risk that the individual will return home but rather than contributing to the development of the field through teaching or mentoring, will instead focus on developing their own career or making money.

The third method we considered involved mentored research projects, providing mid- to upper-level professionals with one-on-one mentoring. Our rationale was that often the best way to learn something is through direct experience guided by someone more senior than oneself (Allen and Eby 2007). We planned, conducted, and evaluated seven medium-term (approximately 1 year long) mentored research projects focusing on such topics as mental health epidemiological surveys in schools, assessments of the mental health functioning of street children, and individuals addicted to drugs, and development of a model for school-based mental health intervention. The results of these various projects are reported in Dang and Weiss (2007). Our conclusion was long distance mentoring was feasible and very useful for training of mid- to advanced-level professionals—more useful than short-term seminars. These projects also helped us identify factors that supported long-distance mentoring in Vietnam, including: (a) Vietnamese researchers’ commitment to increasing their abilities;

(b) an entrepreneurial spirit that allowed them to resolve implementation problems, and (c) a close-knit network of researchers. We also identified factors that impeded successful long-distance mentoring, including: (a) different supervision styles (e.g., our Vietnamese colleagues viewed it as impolite to remind a teacher/mentor to do something, whereas in the U.S. and other Western countries, trainees are not hesitant to remind teachers of the need to do something); and (b) a lack of research infrastructure, such as a basic pool of valid mental health assessment instruments. But as with the short-term seminars, we reached the conclusion that this mentoring still did not address the fundamental need that we were trying to address, which was development of new professionals.

Vietnam National University Graduate Program in Clinical Psychology

Thus, at the end of our evaluation of these three approaches to increasing mental health capacity, we concluded that none of them was sufficiently effective, efficient, and sustainable to address the mental health infrastructure needs. After more discussion, we decided that the most sustainable, albeit highly challenging approach, would be to support development of a child-focused, research-oriented Ph.D. clinical psychology program at the VNU School of Education. The research focus was essential because mental health programs developed and found to be effective in the West would need to be adapted for Vietnam, and could not be assumed to be effective in Vietnam.

Masters in Clinical Psychology at Vietnam National University—As the first step in the development of our graduate program in clinical psychology, in 2009 we began the Masters in Clinical Psychology program at VNU (Dang and Weiss 2011). This masters program serves two primary purposes. First, it serves as the initial step and precursor to our Ph.D. program. The courses and associated activities that comprise the masters program will be a major part of the training foundation for the Ph.D. program. Second, and equally if not even more important, the masters program will serve as a dissemination platform for the mental health interventions developed and evaluated by our faculty and other mental health researchers in Vietnam, and elsewhere. It is well recognized in interventions research that one of the greatest challenges that the field faces is the dissemination of efficacious treatments (Kerner et al. 2005). That is, efficacious treatments have been developed for a number of mental health disorders, but the biggest challenge has been the successful dissemination of the interventions into practice, to get ‘front-line’ clinicians to adopt these interventions (Southam-Gerow et al. 2008).

We anticipate that about 25% of the masters students will continue to pursue a Ph.D. in our clinical psychology program, and thus contribute to the sustainable development of mental health research infrastructure in Vietnam (and training as they become university faculty). However, the students who take a terminal master’s and become mental health clinicians also have an important role to play in the development of mental health in Vietnam. They will be trained in evidence-based treatments (EBT), and as new treatments are developed or as old treatments are modified based on research findings, new cohorts of students will be trained in these treatments. This dissemination will be relatively seamless because the researchers developing and evaluating the treatments will often be the same people (or colleagues of the people) training the master’s students.

Another key aspect of our masters students’ contributions to the development of the field is that although some of them may become primarily clinicians, they also will be trained in and supportive of research. So we envision that ultimately they will constitute a network of potential research clinicians who will allow for field testing of new interventions. Their close connections to our program and faculty will increase our ability to conduct

effectiveness and other research outside of the universities, institutes and other research settings.

Masters Program Structure—The program was developed with explicit emphasis that it: (a) be culturally appropriate; (b) sustainable in a low resource environment; and (c) follow a scientific, research basis. The program was developed based on a review of curricula of U.S, Canadian, and Australian clinical psychology programs, followed by discussion with Vietnamese education and mental health professionals. The program consists of (a) nine specialty clinical psychology courses, and (b) six non-specialty courses (e.g., research methods; foreign language requirement). Courses are jointly taught by a Western and Vietnamese instructor, with the same instructors teaching the same course across years; sustainability comes from the expectation that Vietnamese instructors will take responsibility for the course after a period of co-teaching. In the courses, there is an explicit focus on transfer of responsibility to the Vietnamese instructor, and establishing criteria for competency as an indicator of when final transfer can occur.

This master program began with an initial cohort of 16 Vietnamese graduate students in 2009, and in 2010 with a second cohort of 16 Vietnamese graduate students. The nine specialty courses include: (a) ***Psychopathology***, which focuses on (a1) description of mental health syndromes and disorders, (a2) prevalence and epidemiology, (a3) causal theories for the development of various forms of psychopathology, and (a4) psychopathology research evaluating these theories. (b) ***Theories of Psychotherapy***, which focuses upon review of the major families of psychotherapy (e.g., behavior therapy; mindfulness-based therapies) that have been scientifically evaluated and their perspective on (b1) the development of mental health problems, (b2) mechanisms of therapeutic change, and (b3) basic outcomes research regarding this model's efficacy. (c) ***Case Formulation***. The courses *Psychopathology* and *Theories of Psychotherapy* involve understanding mental health problems at the population and sub-group level, the problems' causes, and processes and mechanisms of change. The *Case Formulation* course involves training in taking this general knowledge and applying it to an individual client, to develop clinical hypotheses regarding the causes and functions and perpetuating factors regarding their mental health problems, finding evidence to evaluate these hypotheses, and then developing an empirically-based treatment plan for the individual (Eells 2007; Persons 2008). (d) ***Non-specific Factors in Psychotherapy*/*General Counseling Skills***, which focuses on (d1) discussion of the concept and research on the effects of 'non-specific factors' in therapy, and (d2) training in these factors (e.g. empathetic listening).

The last five specialty courses provide direct clinical training. These courses include: (e) ***EBT for Behavior Problems***, which focuses on empirically-based treatments for oppositional, aggressive, and anti-social behavior, and (f) ***EBT for Emotional Problems***, which focuses on EBTs for anxiety disorders such as OCD, phobias, and GAD, and for depression. (g) ***School-based Interventions and Mental Health Task-shifting*** focuses on EBTs in the school setting as well as more generally on issues related to conducting research and clinical interventions in school settings. In addition, the course focuses on mental health task shifting, which involves the training of paraprofessionals to deliver relatively narrowly focused mental health interventions (Patel 2009). In this course, we specifically focus on the training and supervision of teachers as task shifting para-professionals, but also more broadly on task shifting approaches to intervention. (h) ***Clinical Practicum #1***, in which students see clients through a mental health clinic connected to the VNU CRISP center, which coordinates the graduate clinical psychology program. The close connection to the graduate program for the first practicum allows for more close supervision and control over graduate students just beginning their formal clinical training; (i) ***Clinical Practicum #2***,

which focuses on a school-based practicum or a hospital-based practicum for students who are interested in adults.

Although the graduate program provides training in 'EBT' interventions, these are EBT as evaluated in the U.S. and other Western countries. No automatic assumption is made about their efficacy or even their appropriateness for the Vietnamese context. Development, adaptation, and evaluation of mental health interventions is the focus of VNU's clinical psychology research program. In the context of this training, during the courses students and faculty discuss how the various interventions might or might not apply in Vietnam, how they might need to be adapted, potential differences in how to engage clients, different possible models (focusing on school-level interventions; use of task shifting in primary care, etc.). These discussions are useful not only for training purposes but also to generate ideas for our program of research.

Challenges

A number of the challenges have been directly related to course instruction and implementation. In developed Western graduate programs, a substantial part of training and learning takes place outside the classroom, often through readings assigned and discussed in class. One challenge in the VNU masters program is that use of readings has been difficult, for two primary reasons. First, there are few high quality articles published in Vietnamese that we would want to use as exemplars of research. Translation of readings is possible, but time consuming. Second, as noted above the program has begun with a co-teaching model wherein courses are taught in intensive seven day blocks 8 AM to 5 PM, to accommodate the foreign teachers' schedules. Such a schedule makes it difficult for students to complete home-based assignments that would further their learning and allow for consolidation of knowledge. We anticipate that as the Vietnamese instructors take primary responsibility for teaching, the schedule will shift to a more traditional semester-based model to the greater benefit of the students.

Another initial challenge has been the master's students' general lack of prior research and statistical training, with students typically entering the program with limited prior coursework in research methods or statistics. Thus, their research training in the graduate program is relatively basic, which limits our goal of integrating research into each clinical course to develop students' understanding and appreciation of the role of research in mental health. One possible solution under consideration is to supplement the current research methods and statistics curriculum with targeted workshops or courses outside the formal curriculum.

Other challenges have been more political in nature. Although our program is the first successful graduate program in clinical psychology in Vietnam, there have been other attempts to establish graduate programs in clinical psychology or similar areas such as school psychology. Unfortunately, these programs have in general treated the VNU clinical psychology program as competition rather than as a source of potentially mutually beneficial collaboration. For instance, although it would be natural to do so, these programs have declined to provide their undergraduate students with information regarding the VNU graduate program, and voted against acceptance of the program at the university level (the one vote out of nine against the program).

This attitude and these behaviors probably reflect realities, or perceptions of realities, of operating in an environment where resources are scarce, and where cooperating or providing mutual support can be seen as potentially resulting in loss of these scarce resources or opportunities. For instance, it is likely that these programs decline to provide information to their college students regarding the VNU graduate clinical psychology program because

they are concerned that their students will attend the VNU graduate program rather than their own programs; i.e., even potential graduate students are seen as a scarce resource that must be protected. In addition, a more general factor underlying a lack of cooperation appears to be a belief that the success of another school's programs undermines the need for and prestige of one's own programs.

The clinical psychology program has responded in several ways. First, the program has offered to collaborate in areas of mutual benefit, such as statistics. Statistical analysis is a fundamental part of most areas within academic psychology (Sirkin 1999), yet training and expertise within statistics and quantitative analysis remain weak in Vietnam (Weiss et al. 2010). By working together in areas that are critical to development of the field but where there has been little development by any party, we hope that collaborative, trusting relationships can evolve. In addition, we have strived to develop positive, collaborative relationships with individual faculty in the departments, through collaborative projects and consultation. The hope is that these individual positive collaborative relationships will eventually supplant the more official competitive positions.

VNU Ph.D. Clinical Sciences Program—The ultimate goal of our program is to establish a Ph.D. clinical psychology program. Before this can happen, however, the masters program needs to be further refined, and the program's future faculty need to complete their training in the U.S. As is standard in Vietnam, the curriculum for the Ph.D. program will primarily involve mentored research experience as well as advanced seminars, culminating in the trainee's dissertation. We anticipate that our Ph.D. Clinical Sciences program will begin in 2014.

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