A Collaborative Needs Assessment and Work Plan in Behavioral Medicine Curriculum Development in Vietnam

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An important aspect of family medicine education in the United States and abroad is behavioral medicine. Interpersonal and communication skills, mental health assessment, and sensitivity to diverse patient populations are areas of curricular importance. This article describes the behavioral medicine portion of a family medicine consultation with Vietnam, in progress since 1999. The needs assessment for behavioral medicine reveals few monetary or personnel resources available for training family physicians or caring for patients with mental health problems. Challenges of conducting cross-cultural consultations are many and include confronting language barriers.

Since 1996, the Division of International Family Medicine (DIFME) at the Maine Medical Center and the Ministry of Health of the Socialist Republic of Vietnam have been collaborating on the Vietnam Family Medicine Development Project. A 5-year needs assessment/pilot project funded by the McKnight Foundation led to a 6-year development project funded by the China Medical Board of New York, Inc. The outcome of the initial needs assessment was a recommendation by the U.S. consultant team to develop the specialty of family medicine in Vietnam. In 2000, the specialty was established, along with the Ministry of Health's recommendation to develop training programs in three of the medical schools in Vietnam.

The Hanoi Medical University and DIFME have collaborated to develop and implement a training network in family medicine. As of spring 2004, the medical schools in Hanoi, Ho Chi Minh City, and Thai Nguyen have first-degree family medicine...
In 2001, the World Health Organization (Prentice & Beusenberg, 2001) published a report confirming the need to integrate the assessment and treatment of mental health disorders into primary care. According to the report, mental disorders are among the leading causes of ill health and disability worldwide. Nearly two thirds of persons with known mental health disorders do not seek help from a health professional. The top recommendations to all countries include providing treatment in primary care, giving care in the community, educating the public, and involving communities, families, and consumers (Prentice & Beusenberg, 2001).

CULTURAL IMPLICATIONS

Cross-cultural issues are paramount with relation to behavioral medicine curriculum development in another culture. What works in the United States does not necessarily apply in a country that has a very different history and culture.

The Vietnamese culture emphasizes interdependence, with family and community taking precedence over individual needs and self-fulfillment. The historical family hierarchy is paternal. Particularly in the rural, agricultural areas, people with health or mental health issues rely heavily on family members (children, teens, and adults) to provide support. There is an emphasis on filial piety, respect for others, modesty, and restraint of hostile and aggressive emotions (Lee, 1997).

Traditional medicine informs the health and mental health beliefs of many. This includes the concept of all living matter having four elements: cold, hot, wet, and dry. Treatment can involve achieving balance by treating cold with hot or wet with dry or by releasing air to balance the body. The other beliefs around the healing power of nature support traditional treatment with herbs and other natural substances to provide harmonious equilibrium. These be
liefs may affect the use of allopathic medicines if the side effects are seen as negatively influencing balance. Traditional medicine treatments, including herbs, cupping, coining, and acupuncture, are commonly used.

Differing cultural views on mental illnesses within the country depend on variables such as whether someone lives in a rural or urban community, level of education and training, or religious tradition. Buddhism, the dominant religious tradition in Vietnam (World Stats, 2004), interprets mental health issues as a sign of past life transgressions. In this tradition, mental health issues are perceived as resulting from family inheritance or past family behaviors, creating much shame and guilt. This leads to care of family members with mental health problems in the home; patients rarely receive help from health care professionals until their symptoms are severe (Ferron, Barron, & Chen, 2002; Naegle, Ng, Barron, & Lai, 2002). A Vietnamese person with depression may present with difficulties with sleep, headaches, a feeling of being out of balance, or multiple physical complaints rather than say that he or she is down and depressed and has difficulty functioning.

Consistent with the Buddhist culture, the strong emphasis on respect and interpersonal harmony affects communication between the physician and patient. This is often portrayed as pseudoacceptance of or agreement to a prescription or plan when the intention or ability to follow through may be otherwise, as we have observed in clinics and hospitals in Vietnam. The doctor must be willing to probe beyond this "yes" response.

Adding to the cultural differences between countries, the economy, health, and mental health care systems are different in Vietnam than in the United States. The gross domestic product of Vietnam is $2,300 per capita, compared with $36,300 in the United States (Central Intelligence Agency, 2003). The combined annual public and private health care spending in Vietnam is 4.8%, compared with 13% in the United States (WHO, 2001). According to this same WHO document, most countries spend less than 1% of their total health expenditures on mental health issues. As far as inpatient mental health treatment is concerned, the United States has over 10 times the number of inpatient psychiatry beds and 40 times the number of psychiatrists than Vietnam (see Tables 1 and 2).

**PERTINENT HISTORY OF VIETNAM AND DEMOGRAPHICS**

Throughout the history of Vietnam, its people have had occupations by and wars with other countries. In the 19th and 20th centuries, this has included occupation by the French, Japanese, Chinese, and Americans. Following the 1976 reunification of the northern and southern regions of the country, a slow opening to the West evolved. In 1986, the government initiated the concept of doi moi, creating economic reforms to encourage private enterprise and foreign investment. Since then, Vietnam has experienced a greater interchange of ideas and commerce with other countries. At that time, Vietnamese physicians were given permission to practice independently in a fee-for-service manner in addition to their government-funded positions.

The distribution of the total Vietnam population of 73 million people is as follows: people 0-14 years old, 31.6%; people

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Psychiatric Beds per 10,000 in Vietnam and the United States</th>
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</thead>
<tbody>
<tr>
<td>Psychiatric beds</td>
<td>Vietnam</td>
</tr>
<tr>
<td>Beds in mental health hospitals</td>
<td>0.59</td>
</tr>
<tr>
<td>Beds in general hospitals</td>
<td>0.04</td>
</tr>
<tr>
<td>Beds in other settings</td>
<td>0.00</td>
</tr>
<tr>
<td>Total psychiatric beds</td>
<td>0.63</td>
</tr>
</tbody>
</table>

*Note.* Data from World Health Organization (2001), www.cvdinfobase.ca/mh-atlasindex.htm.
Table 2

<table>
<thead>
<tr>
<th>Mental Health Professionals per 10,000 in Vietnam and the United States</th>
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<tbody>
<tr>
<td>Mental health professional</td>
</tr>
<tr>
<td>Psychiatrists</td>
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<tr>
<td>Psychiatric nurses</td>
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<td>Psychologists</td>
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<td>Social workers</td>
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15-64 years old, 62.9%; people 65 years and over, 5.5%. The population is relatively young because of the death of close to 2 million people during the American war (Mintz, 2003). Eighty percent of the population lives in rural areas. The recent transition of rural families to the more modernized, urban areas of Hanoi and Ho Chi Minh City creates movement away from extended family and community, accompanied by increased teen rebellion and experimentation with alcohol and other substances (Nguyen Thi Kim Chuc, personal communication, March 2004). A growing Western cultural influence is appearing, and it conflicts with traditional values and adds to generational conflicts.

NEEDS ASSESSMENT BACKGROUND

Very little has been written about needs assessments in the development of behavioral medicine, psychiatry, or family systems programs in foreign countries. A recent guidebook describes the content (including behavioral medicine), but not the process, of developing family medicine training programs (Boelen, Haq, Hunt, Rivo, & Shahady, 2002).

Our model for this cross-cultural curriculum consultation takes as its theoretical approach a collaborative, learner-centered model, similar to the patient-centered model of physician-patient communication or the learner-centered model of teaching. It is supported by organizational leadership literature and deals constructively with cultural differences (Linden, 2002). Pertinent steps include building rapport, opening a dialogue, establishing a focus, gathering information, understanding the context, reaching common ground, sharing information, and providing closure. The first three steps were established through consultations and E-mails immediately prior to the 2004 visit. Gathering information and learning about contextual issues of the culture and mental health system has been ongoing (Montegut & Dung, 2002; Schirmer & Le, 2002). It has included access to organizational publications, literature, and cultural informants; touring medical and mental health services in Vietnam; and conversing in person and via E-mail with Vietnamese faculty members. The agenda was established several months prior to the visit through E-mail conversations with the project and residency leadership at each site. The Results section of this article reviews the information gathered, the assessment, and plans and strategies for improvement.

The spring 2004 two-week consultation in Vietnam by the U.S. team included a needs assessment of behavioral medicine/psychiatry resources in the different training programs. The U.S. team conducted a 3-day national family medicine faculty development conference with a half-day workshop on behavioral medicine attended by 46 faculty and residents from all eight Vietnamese medical schools.

METHOD

A behavioralist (Julie M. Schirmer), two psychiatrists (George K. Dreher and Jeffrey Stovall), and an education specialist (Cynthia Cartwright) conducted individual and group interviews with 30 family medicine residents, 10 family medicine faculty, 5 psychiatrists, 2 psychologists, and 3 social medicine faculty from Hanoi, Ho Chi Minh City, Thai Nguyen, Can Tho, and Hue. The goal of the assessment was to explore teaching resources at each site and determine the need for other teaching re
sion of sources from outside of Vietnam. Questions included the following:

1. What mental health and substance abuse services exist in each community?
2. What are the roles of the mental health care providers, including psychiatrists, psychiatric nurses, psychologists, and the women’s association workers, and what are their relationships with the primary care physicians?
3. What resources are currently available to teach the behavioral medicine curriculum to primary care physicians? The behavioral medicine curriculum includes concepts of psychiatry, brief crisis work, behavioral change, physician-patient relationship, family systems, domestic violence, primary care counseling, differential diagnoses for mental health disease, cultural competency, and physician self-care.
4. Who has the interest, ability, and availability to teach the behavioral medicine curriculum, and what are the attitudes of proposed faculty to teaching this new curricular area?

The plan for the first portion of our spring 2004 visit was to have the U.S. faculty spend time in Ho Chi Minh City (Julie M. Schirmer and George K. Dreher) and Thai Nguyen (Jeffrey Stovall) interviewing faculty, residents, and mental health care providers to explore clinical and teaching resources for the behavioral medicine curriculum. Despite numerous E-mails back and forth prior to the visit to develop collaborative goals for the visit, when we arrived, we were scheduled to spend most of that time teaching residents and faculty about behavioral medicine concepts and interactive teaching models. Tours and more formal interviews were replaced by group and individual interviews interspersed during and between our half-day teaching sessions.

**ASSESSMENT RESULTS: THE MENTAL HEALTH SYSTEM**

Assessment results are derived from the 2004 consultation, three previous visits of the behavioral medicine faculty to Vietnam, personal exchanges between behavioral medicine faculty and Vietnamese visiting fellows to the United States, the literature, and cultural informants from Vietnam who currently live in the United States.

Similarities exist between the Vietnamese and U.S. mental health care systems, including a psychiatry presence at every medical school and a common nomenclature for mental health and substance abuse diagnoses that uses the International Classification of Disease codes. The Vietnamese mental health system places more emphasis on inpatient rather than outpatient treatment services, with patients receiving treatment on psychiatry units in general hospitals or specialized psychiatric hospitals, which tend to be in urban settings. Psychiatrists affiliated with the hospitals follow patients who live close to the hospital on an outpatient basis. The primary health care doctors in the rural health centers continue mental health treatment for those who live farther away. Little communication occurs between the rural doctors and the psychiatrists. There has been little continuing training in mental health diagnosis and treatment for the primary health physicians in Vietnam (WHO, 2001).

The percentage of persons identified with mental and behavioral disorders in Vietnam is 1.07% (Hoc & Hoach, 2000). This is extremely low compared with rates found in Asian Americans, even after several years in America. The few studies of mental health disorders in Asian Americans have found prevalence rates of depressive disorders to be 12%-40% (Chung et al., 2003; Takeuchi et al., 1998). Household surveys are currently being conducted in.
the district of Bavi, a town north of Hanoi, to
determine the prevalence of mental health
disorders, substance abuse disorders, and
domestic violence (Giang & Allebeck, 2003).

According to psychiatry faculty interviewed,
the most common diagnoses treated on an
outpatient basis are schizophrenia, epilepsy,
depression, substance abuse, and brain injuries.
These same faculty members estimated the prevalence of
alcohol abuse to be around 68%, with alcohol
dependence around 20%. The few psychiatrists
with private outpatient practices treat patients
with adjustment disorders and psychosomatic
disorders.

Thus far, the only visit by the consulting team
to a mental health treatment site was
a tour of Cho Quam Mental Hospital, a
140-bed acute treatment psychiatry hospital in
Ho Chi Minh City. Cho Quam Mental Hospital
serves a population of 6 million. The
predominant illnesses treated at the hospital are
schizophrenia, depression, and epilepsy. There is
one other mental health hospital outside of the
city designated for patients with chronic
conditions who are unable to be cared for in
their home. Of the 53 provinces in Vietnam, 19
have mental hospitals; in the other provinces, the
psychiatric units are located in general hospitals
(Candib & Stovall, 2002).

Substance abuse treatment centers are
available in the cities (Hanoi and Ho Chi Minh
City), with an average length of stay of 5 days.
Treatment for intravenous drug users is several
years in duration. One member of the consulting
team was able to visit a commune health center
in Thai Nguyen, where there was an
accompanying 10-bed substance abuse center. Volunteer health
workers, trained in the urban substance abuse
centers, provided support to patients at the
treatment center and to those in the community
who needed mental health support. According to
faculty and students from other areas, this type
of substance abuse center is unusual.

Mental Health Professionals' Training
and Roles
There is one psychiatrist for every 300,000
people in Vietnam. Four of the eight medical
schools have a first-degree specialty training
program in psychiatry, which is equivalent to
psychiatry residency programs in the United
States. Rehabilitation and mental health
counseling options are minimal. Therapy training
is not part of the psychiatry curriculum.
Psychiatrists who practice therapy have been
trained in other countries, such as France and
Sweden. Academic physicians, including psy-
chiatrists, who wish to open a private-pay
outpatient practice must get approval from their
department chief and government officials prior
to opening their practice.

The Department of Psychology at the
University of Hanoi graduates 200 psychologists
per year, each with the equivalency of a
bachelor's degree. The psychologists conduct
psychological tests and do some counseling,
primarily with schools and businesses. There are
no psychologists who work in the health or
mental health care system and few who are
employed in areas other than Hanoi. There are no
master's degree equivalent programs in
psychology, social work, or other counseling
fields.

Psychiatric nurses have 3 years of training
after high school and then begin employment in
psychiatric hospitals. Their role is that of a
"guardian," giving shots and intravenous therapy
treatments. The nurses have no formal counseling
training.

Women's associations are informal groups that
are very active in most communities. They are
funded solely from contributions from the women
in the community. Monies are donated to help
poor college students and families who might
need help secondary to alcohol abuse,
deteriorating physical health, or other
circumstances.

Behavioral and Psychiatry Curriculum
Resources
There are major differences from pro
gram to program regarding how each plans
to implement behavioral medicine and psychiatry curricula. The faculty members at some of the programs feel that a patient-centered approach to care is difficult for the Vietnamese people, who expect their physician to be the expert who tells the patient what to do. Faculty members at other programs are actively teaching the patient-centered method using interactive teaching techniques. The experience of the faculty in terms of knowledge and skills in communication, mental health issues, and family systems varies from program to program.

Some residency programs have active plans for incorporating behavioral medicine curricula with involved psychiatric faculty. Thai Nguyen family medicine residents alternate months spent at the program with months spent in practice at their rural health centers seeing patients. At our spring visit, the residency program was just about to embark on its 1st monthlong psychiatry rotation. All residents were to be placed only on inpatient psychiatry units. In Thai Nguyen there is no psychiatry presence in the family medicine ambulatory clinics.

In Ho Chi Minh City the program, to date, has relied on the U.S. consultants' annual visits to teach the behavioral medicine curriculum. A psychiatrist sees patients 1 half day per week at each of the four outpatient family medicine training sites. At this point in time, he does not see patients with family medicine residents, nor does he conduct teaching sessions in the program. In Hanoi, the program has relied on faculty development workshops for this curriculum.

The Department of Social Medicine may play an important role in the teaching of medical students or residents around communication issues. At the Hue Medical School, the Department of Social Medicine is responsible for teaching communication, biostatistics, community prevention, epidemiology, philosophy, and health psychology. Department faculty use role play, videotaped interviews, small group feedback, and other active teaching methods in their medical school classes. The Can Tho medical school has a communication skills lab that is used for medical students and family practice residents. Although skills labs may be available at the other medical schools, they are not being used for training the family medicine residents. The medical libraries have few up-to-date books or journals about behavioral medicine, psychiatry, or family medicine. In Ho Chi Minh City, the latest family medicine references are journals left by a 2003 tour from our delegation. Most of the texts are written in either English or French. Use of computers and access to the World Wide Web for scholarly activity are limited. Barriers include the cost, slow modem speeds, and limited availability to computers.

**Work Plan**

Because of the cultural differences between the United States and Vietnam, the U.S. consultant team has emphasized that the Vietnamese faculty begin to apply behavioral medicine principles in ways that honor their ideas, values, and philosophies. This is part of finding common ground, so that the Vietnamese begin to own the behavioral medicine curriculum rather than have outsiders come and teach. There are many talented teachers at each program who understand the commonalities between the practice of family medicine and the need by this new type of physician to have a clear understanding of behavioral and mental health issues. This project has the potential to develop behavioral medicine leaders and to clarify how this new curriculum will be taught at the respective schools, using the resources from within the schools' departments and professional communities. As a result of the 2004 visit, a project and timeline has been developed. Future work will include

1. continued annual visits by consultants to teach and provide support and
feedback to the behavioral medicine curriculum development;
2. collaboration by U.S. and Vietnamese faculty on a monograph to detail the applications of behavioral medicine in Vietnam;
3. incorporation of behavioral medicine faculty meetings into future national family medicine conferences to discuss program successes, struggles, and learning points;
4. advocacy for systems change to recruit other in-country disciplines to teach behavioral medicine;
5. publication of a directory of names, addresses, and phone numbers of psychiatrists and primary care physicians at the different levels of health care willing to collaborate in clinical care to promote continuity of care;
6. assessment of the feasibility of a 2-year master's-level psychology training program at the University of Hanoi to provide behavioral specialists for clinical care and teaching;
7. development of knowledge and teaching skills for family medicine faculty to support the behavioral medicine curriculum; and
8. provision of resources to the family medicine training programs on behavioral medicine, such as compact discs, Web site information, and publications.

DISCUSSION

It is not surprising to discover that the different family medicine residency programs have different ideas about teaching behavioral medicine and psychiatry. Residency programs in different geographical regions of Vietnam have unique cultures. We hope to provide all family medicine faculty and residents with the tools to apply to their own system. Teaching will be informed by international consensus guidelines on doctor-patient communication and on teaching behavioral medicine in family medicine training programs (Bayer-Fetzer Conference, 2001; Makoul & Schofield, 1999). Mutual understanding is needed about behavioral medicine concepts. Reciprocal exchanges between Vietnamese programs will facilitate the teaching of concepts in different programs. Sociocultural exchanges between Vietnam and the United States will facilitate collaborative projects and plans for each site.

The immediate need for Vietnamese faculty to develop basic knowledge of behavioral medicine concepts is juxtaposed against the long-term need to identify the best teachers for a behavioral medicine curriculum. A mutual agenda must be clarified at each step in the consultation process.

Barriers to the consultation include the cultural and economic differences between Vietnam and the United States. Despite these differences, there are some common health care values and beliefs. English is consistently taught and spoken in Vietnam, but language can still be a barrier. Behavioral medicine concepts are not generally taught or understood in public or medical schools.

The effectiveness of implementing a behavioral medicine curriculum in Vietnamese family medicine residency programs remains to be seen. A final measure of our success will be the incorporation of a curriculum in behavioral medicine, sustained by the resources within each residency program in the Vietnam training network. Success will also be measured by the ability of the family medicine faculty to teach the new content area and the investment of key stakeholders, from the Ministry of Health and medical school deans to the family medicine residents.

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COMMENTARY

Cross-Cultural Strategies:
A View Through the International Lens

DONALD A. BLOCH, MD

Two articles contrasting efforts in Vietnam and Finland to promote family and systemic approaches to health care are reviewed (J. M. Schirmer, C. Cartwright, A. J. Montegut, G. K. Dreher, & J. Stovall, 2004; P. Larivaara et al., 2004). Considering them together permits a deeper understanding of the consultation process in differing cultural and historical conditions. Analogies with systemic treatment can be noted as well.

Two articles in this international issue of Families, Systems, and Health contrast with each other in a way that may help us identify productive dimensions of the cross-cultural consultation and teaching process. Both articles report on projects, one in Finland, the other in Vietnam. The goal in both instances is to advance a model of health care practice that is systemic and family based and that uses intervention techniques loosely drawn from the playbook called "family therapy." The first article, "A Collaborative Needs Assessment and Work Plan in Behavioral Medicine Curriculum Development in Vietnam," by Schirmer, Cartwright, Montegut, Dreher, and Stovall (2004), describes the work of a U.S. medical teaching group collaborating with a Vietnamese counterpart group to establish a family medicine model in that country. An essential element of the family medicine teaching program the authors have proposed is the inclusion of a mental health and behavioral medicine orientation in the practice model. A linchpin concept of the model is that some aspects of psychiatry are located as a part of general practice. Often called behavioral medicine, this model is currently promoted as a part of general or family practice in the United States.

The second article, "Family-Oriented Health Care in Finland: Background and Some Innovative Projects," by Larivaara et al. (2004), describes a long-term effort by a loosely constituted Finnish group to essentially change the same structures—that is, the medical schools and health care delivery system—in a systemic and family-oriented direction. The difference between the two efforts is based on their position vis-à-vis the system they are trying to change and in the consistency of their focus on a general systems theoretical orientation. Larivaara et al. are indigenous to Finland and have had durable collaborative rela...
tions with systemic family therapists from other countries. Their approach is long term, programmatic, and based on local knowledge of resources, recent history, sociocultural changes, and pressing current and evolving health care needs. Essentially, their program represents change from within the Finnish culture, with one medical school and district as the lead location for the effort. We might think of this strategy as advancing a theoretical orientation: the biopsychosocial paradigm, a term used by these writers but not Schirmer et al.

One might look at the Vietnamese and Finnish programs as being at differing points on a historical continuum, but it would be, in my view, an error to think of other Western models as being fully evolved or even more advanced. Under the impact of U.S. managed care, for example, the struggle to establish models of complete psychosocial health care has become more difficult and regressive and has slid backwards in recent years in most locations. There are, for example, strong economic incentives from the pharmacological industry for psychoactive drugs to become more and more a part of the general practice armamentarium. New diagnoses are invented (e.g., social anxiety syndrome) to be treated with antidepressants prescribed by family practitioners. This is a far cry from the biopsychosocial paradigm, indeed.

The countries that the articles under consideration address are vastly different from each other in regard to language, history, culture, and location; in addition, if there is a final common pathway toward the development of what I call systemic health care, they are at quite different places on that pathway. Vietnam, an ancient and highly advanced culture in Southeast Asia, is at the beginning of this particular path, importing consultants from the United States to help set up family medicine training programs and to imbed behavioral medicine within those programs. Conversely, Finland is much more in the Western mode politically and culturally, with a long and complex history of work in a Western medical orientation. The country has long had an informal group of senior clinicians and researchers that guides the work toward a family and biopsychosocial orientation.

Vietnam resonates in the consciousness of the English-speaking world, particularly the North American division. It resides there as a costly, painful, and vainglorious failure of U.S. military and political policy. There is still much residual guilt about this adventure and some effort at reparation. The program described in Schirmer et al.'s (2004) article began in 1996 as a collaboration between the Division of International Family Medicine of the Maine Medical Center and the Ministry of Health, Socialist Republic of Vietnam. It began with a needs assessment: "The outcome of the initial needs assessment was a recommendation by the U.S. consultant team to develop the specialty of family medicine in Vietnam. In 2000, the specialty was established" (p. 410). As of spring 2004, three of the eight Vietnamese medical schools have first-degree family medicine specialist training programs, and the Ministry of Health has requested the expansion of the program to the other five medical schools. Each developing residency program in Vietnam is affiliated with a U.S. family medicine residency program.

The words bear repeating: "a recommendation by the U.S. consultant team to develop the specialty of family medicine in Vietnam." The model is to establish a specialty. It is the medical model, and it de. ploys a new specialty.

Behavioral medicine was introduced early on as part of the curriculum of this new specialty; the Vietnamese touring the Philippines and the United States "were introduced to the importance of behavioral! medicine, family systems, and psychiatry! to family medicine" (p. 411). Schirmer et al (2004) offered a World Health Organi'l zation report from 2001 as a foundation,
stone: "a report confirming the need to integrate the assessment and treatment of mental health disorders into primary care" (p. 411). Allowing for differences of language, custom, and medical and political history, it sounds much like the development of a new program of family medicine in the United States.

In the Discussion section of the article, Schirmer et al. (2004) noted that

teaching will be informed by international consensus guidelines on doctor-patient communication and on teaching behavioral medicine in family medicine training programs. A final measure of our success will be the incorporation of a curriculum in behavioral medicine, sustained by the resources within each residency program in the Vietnam training network. (p. 417)

In the section labeled Cultural Implications, the authors began with an exemplary statement: "Cross-cultural issues are paramount with relation to behavioral medicine curriculum development in another culture. What works in the United States does not necessarily apply in a country that has a very different history and culture" (p. 411).

The problematic aspect of this statement is the notion that we know and can explicate, let alone reproduce for export, "what works in the United States." How this translates into Vietnamese is not known. Mental health, mental disorders, behavioral medicine, the family in family medicine, and the biopsychosocial model share much, but they are not identical by any means. Nor do we know the referents in Vietnamese culture and religion, although some similar-sounding concepts can be found. Indeed, it is not easy to know in the United States itself how these are best defined—therefore, caution is called for when the model is packaged for export.

Schirmer et al. (2004) noted that "our model for this cross-cultural curriculum consultation takes as its theoretical approach a collaborative learner-centered model, similar to the patient-centered model of doctor-patient communication or the learner-centered model of teaching" (p. 413). This is an excellent and laudable goal—but perhaps not so easy to achieve.

To my mind, it appears that something might be amiss. In regard to the 2004 spring visit, the U.S. faculty found that

despite numerous E-mails back and forth prior to the visit to develop collaborative goals for the visit, when we arrived, we were scheduled to spend most of that time teaching residents and faculty about behavioral medicine concepts and interactive teaching models. (p. 414)

Perhaps someone was tapping the brakes to slow down the vehicle, at least temporarily.

All in all, the project described in Schirmer et al. (2004) is a daunting task, and we cannot help but admire the courage and tenacity of the teaching and consultation group. We must remember that the program is taking place in a country that is slowly recovering from a devastating war, where the picture of psychiatric illness and treatment is reminiscent of much earlier times in the West—for example, in the United States preceding World War II—if it is comparable at all. At this juncture, one wonders if funded research teams, transported this significant distance in time, space, and cultural difference, assigned the task of inculcating a predetermined model of care delivery that is still struggling to be adapted in the country of origin, are not being encouraged in an unequal struggle. Future reports, at the same level of candor as this, will help us know.

THE FINNISH EXPERIENCE

Pekka Larivaara and his colleagues live and work in Finland. Their article begins by setting the macro context that has influenced the health care needs of the population. It recapitulates the changes that
have taken place in Finnish society since World War II and relates these to the evolution of the health care system, with particular emphasis on programs with a family and biopsychosocial orientation. This provides context for the programs Larivaara et al. (2004) advocate; a description of these programs provides the bulk of the article. Space limitations of a journal article restrict the description-Larivaara et al. have provided something more in the nature of an hors d'oeuvre. Particularly missing is a description of the work of the informal planning group over the years.

Since the middle of the 20th century, the Finnish population has been under steady pressure to adapt to large population shifts and changes in the economic base of the country with the steady movement of younger people to the urban centers and, consequently, an aging rural population and diminution of stable family support systems. Larivaara et al. noted that these changes in the population structure, internal migration, emigration, and return of population, as well as regional changes in population age structure, have led to major changes in traditional family structures. A large part of the population has been uprooted within a relatively short period of time. . . . This has given rise to insecurity, loneliness, and exclusion. . . as well as psychiatric and psychosocial problems. (p. 396)

Noting the high proportion of diagnosable mental illness, Larivaara et al. (2004) observed, "In many cases the support networks consisting of family and relatives have been replaced by networks of officials" (p. 396). Social capital has diminished and is only slowly being restored.

Despite these difficulties, there has been a consistently high-level, well-informed building of professional and community structures to offset and mitigate these losses. These programs have been constructed somewhat piecemeal but seem, as well, to have been informed and guided by a commitment to family systems work and the biopsychosocial paradigm. Of particular interest is the following response to a reviewer's query regarding whether the movement process has been directed by a specific group. Larivaara et al. (2004) noted that during the last 15 years there has been an unofficial steering group, which has created many strategies for getting biopsychosocial and interprofessional ideas in the curriculum at the medical school. Since 1999 there has been a professorship of systemic family medicine in the Faculty of Medicine at Oulu University.

Thus, a sophisticated, theory-driven effort has gone on over the years-a significant feature of which has been the close contact that was being maintained and strengthened with leading family and systemic therapists in other countries (Lyman Wynne, Susan McDaniel, and Tom Campbell, among many others). These contacts have been cross-fertilizing, so that the contributions of Finnish researchers, clinicians, and teachers to the work of others outside of the country has been steady. This combination of an indigenous steering group, either formal or informal in nature; a manageable work and population unit; a history of national social responsibility; and a practical awareness of the relevant historical, macroeconomic, and political forces seems especially suited to steadily guiding and facilitating change. Above all, there is a commitment to the biopsychosocial paradigm. It guides and organizes choices and structural decisions. I particularly recommend that the reader pay attention to the description of the 2-year interprofessional family-oriented education program for professionals working with families in the field of health care and social welfare organized in the Province of Oulu. I could not help wondering how such a sector approach might be adapted to work in larger, more heterogeneous countries.
In the early days of family therapy, a naive, evangelical attitude characterized our teaching, particularly in other countries. Our forefathers and foremothers, such folks as Nathan Ackerman and Virginia Satir, among a ball devoted band, were out on the hustings, showing in case presentations and family interviews that they could do the clinically impossible. The invitation was for a live clinical demonstration, the case chosen the most intractable, the results (almost) just short of miraculous. In a way, we were tricksters, and, in a way, geniuses, as even our primitive methods of family interviewing were capable of producing a major shift in focus and associated change in many conditions.

To a considerable degree we were technique driven—the magic ingredient was family. But an awareness of the importance of the biopsychosocial paradigm informed the entire undertaking.

This all indicated our assumption that the particular model of a "healthy" family-working father, stay-at-home mother, and two and a half children—that we longed for in our own culture was appropriate to all racially and ethnically diverse family systems in the Western world.

Viewing these programs through that lens can be useful. As well, it may lead us to ask again what we really do and how it can—or whether it should—be exported. Larivaara et al. (2004) deserve our thanks for providing such rich material for future discussions. We will learn much from future reports, especially if the same high degree of candor can be achieved.

REFERENCES