JOURNAL OF SCIENCE, Hue University, N^0 61, 2010

ACCESSIBILITY TO MENTAL HEALTH CARE AND PERCEPTIONS OF MENTAL HEALTH IN THUA THIEN HUE PROVINCE, VIETNAM

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SUMMARY

This study assesses perceptions of mental health and mental health care in Vietnam through explorative research among adults in four quarters of Hue city in Central Vietnam. Methods included questionnaires (200) and focus group discussions (eight). Respondents were often unable to name specific mental illnesses, but recognised more when suggested. The most frequently mentioned symptoms of mental illness were talking nonsense, talking/ laughing alone and wandering. Pressure/ stress and studying/ thinking too much were often identified causes of mental illness. Most respondents showed a preference for medical treatment options, often in combination with family care. Important obstacles for relatives of mentally ill people were a lack of drugs and financial resources and the burden of providing care at home. The results revealed a need for educational and awareness programs on mental health so that people are better able to understand mental illness and seek help when they need it.

***Keywords**: mental health, mental health care, perceptions, help-seeking behavior*

1. Inroduction

Mental disorders affect one out of four people during their lives, changing the functioning and thinking processes of the individual and often greatly reducing his social role and productivity in the community. Because mental illnesses are disabling and may last for many years, they also place a huge burden on the emotional and socio-economic capacity of the family members who care for the patient (WHO, 2001). The global burden of disease of mental illness is high and is expected to rise (Mathers & Loncar, 2006). At present, anxiety and mood disorders are the most common mental problems worldwide (WHO World Mental Health Consortium, 2004) and it has been predicted that unipolar depressive disorders will be the second leading cause of burden

of disease in 2030 (Mathers & Loncar, 2006). Most people suffering from mental health problems live in developing countries, where they often do not receive the treatment they need even though it may be available and generally inexpensive (Patel et al. 2006). In these countries, mental illness is more often associated with stigma than in more developed countries (WHO, 2001). Up to today, mental health remains a neglected topic. Interventions aimed at decreasing the burden of mental disease are limited, especially in low and middle-income countries (Jacob et al. 2007).

As a consequence of rapid demographic and socioeconomic changes, Vietnam is in an epidemiological transition. There is a double burden, with decreasing but still high rates of infectious diseases along with increasing rates of non-communicable diseases including mental disorders (Giang, 2006). The burden of mental health problems is high and appears to be rising, but the health system still pays little attention to mental health. Access to mental health care is limited and few health policies address mental health (Harpam & Tuan, 2006). For a long time the national plan of action focused only on the treatment of schizophrenia and epilepsy in hospitals. Since 2004, the national plan proposed to incorporate screening for mental illness among women and children to implement early detection and treatment. Research on mental health in Vietnam is limited and few studies have been published about the prevalence of mental disorders. Fisher et al. (2006) found that 33% of the women attending general health clinics in Ho Chi Minh City were depressed after giving birth and 19% of them explicitly acknowledged suicidal thoughts. Giang (2006) found a prevalence of 5.4% of mental distress in a rural area in Vietnam. Only 42% of those people, however, received treatment for their problems and only 5% sought treatment at official mental health facilities. Help-seeking behavior of the Vietnamese is influenced by Vietnamese concepts of mental illness and health, which are based on a mix of traditional and modern beliefs (Nguyen, 2003; Phan & Silove, 1999). Information is lacking on the perceptions about mental health in Vietnamese communities, and its effect on help-seeking behavior. The aim of this study was therefore first to describe the perceptions of community members and health workers in an urban setting in Vietnam about mental health, then to look at the influence of those perceptions on help-seeking behavior by patients and families facing mental health problems.

2. Methods

2.1. Study design: This study used an explorative design.

2.2. Study area:

The study was carried out in Hue city, the capital of Thua Thien Hue province in central Vietnam, which has more than 300,000 inhabitants. Hue Central Hospital has a psychiatric ward serving nearly one million people in Thua Thien Hue province, and providing inpatient care. The Provincial Psychiatric Department provides outpatient

care in the province and has a network to the community level. Primary health care doctors, who provide community based care in Community Health Centers (CHCs) in the 25 quarters and communes in Hue city, are also involved in this network.

From the 25 quarters and communes, four were randomly selected as the study areas, by picking them from a phonebook: Phu Binh, Phu Hau, Vinh Ninh and Truong An, with populations of respectively 11,124, 10,415, 9,084 and 14,441. The target population included adults 18 years and older from these four quarters.

2.3. Study methods

Questionnaire

From each of the four quarters, 50 respondents were selected, which provided a total sample size of 200 adults. The selection of respondents was done randomly by selecting one adult from every 5^{th} household on the registration lists in the health centers (which listed all households in a their quarter).

People's perceptions and attitudes towards mental health were investigated using a four-part, semi-structured questionnaire. The questionnaire included both open and closed questions. The first part collected demographic data about the respondents. The second part addressed awareness and knowledge of respondents about mental illness, its symptoms, causes and treatment options; these questions were based on the content of questionnaires used in previously published studies on mental illness (Kabir et al. 2004; Deribew & Tamirat, 2005). The third part explored attitudes towards people with mental illness and perceived severity by using vignettes describing four cases, each representing one mental illness (major depression, alcohol dependency, generalized anxiety disorder and schizophrenia) and one representing a physical illness (diabetes). For each illness attitudes were measured by obtaining total scores of five items with a 5-point Likert scale. The perceived severity of each illness was measured by one item using on a 5-point Likert scale. The vignettes and items were based on the "Attitudes to Mental Illness Questionnaire" (AMIQ) (Luty et al. 2006) but adapted to the local context. The fourth part of the questionnaire inquired about personal experiences with mental illness.

The questionnaire was developed with the help and advice of local mental health experts. It was constructed in English, translated into Vietnamese and checked for consistency of translation by a third person. A pilot study with 8 respondents was carried out before finalisation of the questionnaire. The data were collected by interview, which was done by a group of 12 master students of Hue Medical University who had been trained for one day on the questionnaire and on interview techniques. The respondents were asked for their informed consent before the interview. The collected data were translated into English, entered in Epi-Info 6.0® and converted for analysis in SPSS-13.

In the presentation of the results, distinction is often made between the responses obtained using open and closed questions. This is important because in the open questions, which came first, the respondents had to come up with the information themselves, while in the closed questions, we presented possibilities and they could choose among them. When the results were similar in the two cases, the likelihood that the perception was strongly rooted is high, whereas responses that were only given when elicited by the closed questions might be less obvious or familiar to the respondents.

Table 1. *Demographic data of the 200 questionnaire respondents*

Age (M)	**46.0 (SD=15.7)**					
Sex	**Male = 50%**			**Female = 50%**		
Marital status	Married = 81%		Single = 16.5%		Widowed/divorced = 2.5%	
Occupation	Sales = 21%	Civil servant = 15%	Housewife = 13.5%	Retired = 13.5%	Worker = 6%	Student = 6%
Education	Illiterate = 5%	Reading & writing = 4.5%	Primary school = 15.5%	Secondary school = 26.5%	High school = 28.5%	University / over = 20%
Religion	Buddhist = 70%		Catholic = 4.5%		Not religious = 25.5%	

Focus Group Discussions

Eight focus group discussions (FGD) were held, four with people unrelated to any patient with a mental health problem, and four with relatives of mental health patients. These participants were selected by convenience sampling through the health centers of the four quarters.

In the discussions with the four patient-unrelated groups, a first exercise addressed the identification of symptoms of mental illness. During the second exercise, the participants were asked to discuss a case story describing one of the following mental illnesses: major depression, generalized anxiety disorder or schizophrenia. The case stories were based on those used in a study by Deribew and Tamirat (2005) but adapted to the local context. In the four patient-related FGD, the first exercise included a similar discussion about one of the same three case stories. The second exercise for these groups addressed the identification of perceived obstacles in the accessibility to mental health care.

The first FGD was considered a pilot session. However, because only minor changes were then made in the guidelines, the data were included in the final analysis.

All FGD took place in the Community Health Centers of the four quarters and all were attended by one moderator and one observer. The moderator was a PhD student at Hue Medical University, who had been trained and carefully instructed in using the structured guidelines. At the start of each session, the participants were informed about the purpose of the discussion and were asked for their consent, also for the use of a tape recorder. The FGD results were analysed after manual coding by a "summarizing content analysis" method (Flick et al. 2004).

Table 2. *Demographic data of the FGD Participants*

	Patient unrelated				**Patient related**				**Total**
	FGD 1	**FGD 2**	**FGD 3**	**FGD 4**	**FGD 5**	**FGD 6**	**FGD 7**	**FGD 8**	
N	10	9	10	8	10	7	10	12	76
Male	7	2	1	2	2	5	0	4	23 (30.5%)
Female	3	7	9	6	8	2	10	8	53 (69.5%)
Age (M)	54.1	53.7	44.8	61,3	49.4	47.7	45.5	56.6	51.6 (SD=14.7)

Analytical framework

An analytical framework, integrating aspects of the Behavioral Model (Anderson, 1995) and the Health Belief Model (Rosenstock, 1988), was used to identify the concepts that were addressed by the questionnaire and the focus group discussions and to structure the analysis of the results. The Behavioral Model describes a range of environmental, population and individual-related variables associated with decisions to seek care. Most relevant in this context were the population variables, which included factors related to attitudes and beliefs, family and community resources and perceptions and evaluations of illness. The Health Belief Model can be used to explain health behavior by focusing on perceptions. The most relevant components of the Health Belief Model are 'perceived severity' and 'perceived barriers'. The factors addressed by these two models reflect important aspects of perceptions of mental health in relation to help-seeking behavior.

The study was approved by the Research Committee of the Hue Medical College for both its scientific planning and the ethical aspects related to the research. There are no known conflicts of interest and all authors certify responsibility for the manuscript.

3. Results

Attitudes and beliefs

Mental Illnesses

Table 3 shows that more than half of the respondents could not identify a mental illness in response to the open questions in the questionnaire. Schizophrenia was overall the most frequently identified mental illness. Depression was the most identified illness in the closed questions, while it was seldom identified by the open questions and the vignettes. Anxiety was often recognized as a mental illness in the vignettes, but seldom in response to the open and closed questions. Other mental illnesses regularly recognized by the respondents were psychosis or nerve problems, stress, epilepsy and alcoholism. Participants in the focus group discussions often recognized correctly the case describing schizophrenia, while the case story presenting a case of depression was mostly associated with psychosis or nerve problems. The case story describing a person with anxiety disorder was usually referred to as a condition of 'thinking too much'.

Table 3. *Mental illnesses identified by respondents*

Rank	Open questions		Closed questions		Vignettes	
	Response	**(%)***	**Response**	**(%)***	**Response**	**(%)***
1	Do not know	32.0%	Depression	63.0%	Schizophrenia	85.5%
2	Mad/ insane	31.0%	Schizophrenia	55.5%	Anxiety	44.5%
3	Abnormal mental status	18.0%	Stress	51.5%	Alcoholism	28.5%
4	Schizophrenia	14.5%	Epilepsy	43.0%	Depression	7.0%
5	Psychosis/nerve problem	10.5%	Anxiety	33.0%	Diabetes	1.0%

*Multiple responses were recorded; percentages represent proportions of respondents per response.

Symptoms

Table 4 shows that overt abnormal behavior was, what was most people identified as a symptom of mental illness. In the open questions, respondents often referred to strange or unusual behavior in general. The most commonly identified symptoms were related to abnormal talking and laughing followed by wandering. Other symptoms of mental illness often identified in both open and closed questions were aggression or violence and loss of memory or recognition. Imagining things was a symptom that only appeared in the closed questions. The participants of the focus group

discussions also identified several clusters of symptoms. The symptom cluster 'unconscious behavior' was most often associated with strange behavior, talking or laughing alone, improper dressing and abnormal eating behavior, while the symptom cluster 'sad or unhappy' was mostly associated with abnormal facial expressions and avoiding contact or isolation.

Table 4. *Perceived symptoms of mental illness*

Rank	Open questions			Closed questions	
	Response	**(%)***		**Response**	**(%)***
1	Talking nonsense	39.5%		Talking/laughing alone	90.5%
2	Wandering	35.5%		Wandering	89.9%
3	Strange/unusual behavior	25.5%		Loss of memory	82.5%
4	Aggression/violence	18.5%		Imagining things	70.4%
5	Loss of memory/recognition	16.5%		Talkativeness	49.0%
6	Talking/laughing alone	16.0%		Aggression	43.2%

*Multiple responses recorded. Percentages represent proportions of respondents.

Causes

Table 5 shows that when respondents were asked about the causes of mental illness, they usually mentioned stress or tension and studying or thinking too much. Other prevalent explanations were often related to emotional problems and included psychological or emotional shock, emotional distress and internal emotional problems. Respondents also came up with biological causes, naming genetic and congenital conditions and brain disturbance. The environment could also cause mental illness, according to the responses in both open and closed questions, in particular family and marital conflicts. The closed questions led to identification of accident or injury as causes but these did not appear in the open questions. During the focus group discussions about the case stories, the schizophrenia case was mostly associated with the causes genetics, work and love. The case story describing a case of depression was usually associated with family problems, while financial problems were considered as the most likely cause in the anxiety case story.

Table 5. *Perceived causes of mental illness*

Rank	Open questions			Closed questions	
	Response	**(%)***		**Response**	**(%)***
1	Stress/tension	31.0%		Accident/injury	82.7%

2	Thinking/Studying too much	23.0%		Thinking/studying too much	81.9%
3	Psychological/sentimental shock	22.0%		Emotional distress	80.4%
4	Genetic/congenital	18.5%		Brain disturbance	80.3%
5	Family events/conflict	18.5%		Conflict in marriage or family	59.6%
6	Internal emotional problems	17.0%		Worrying too much	56.5%

*Multiple responses recorded. Percentages represent proportions of respondents.

Treatment

Table 6 reveals that in response to the both open and closed questions, the majority of the respondents preferred medical treatment options, such as psychiatric hospital or psychiatrist, hospital or doctor and drugs. Besides medical care, many participants also expected results from the support of family and friends and care at home. Only a minority of respondents considered treatment by traditional healers as a possibility and only in the closed questions. For the vignettes describing cases of depression, anxiety and schizophrenia, medical treatment was the most common recommendation, followed by family care. For the alcoholism vignette, giving up drinking was the most common response, followed by medical treatment. When the focus groups discussed the case stories, support from family and friends was considered the most appropriate way to deal with all kinds of mental illness, although often in combination with medical treatment options.

Table 6. *Preferred treatment for mental illness*

Rank	**Open questions**			**Closed questions**	
	Response	**(%)***		**Response**	**(%)***
1	Psychiatric hospital/psychiatrist	50.5%		General hospital/CHC	98.0%
2	Hospital/doctor	47.0%		Mental health ward	97.0%
3	Drugs	28.5%		Drugs	95.0%
4	Support family/ friends	20.0%		Family	64.5%
5	Treatment at home	17.5%		Local traditional healer	34.5%

*Multiple responses recorded. Percentages represent proportions of respondents.

Attitudes

Respondents showed the most negative attitude towards the person depicted in the alcoholism vignette (M = 17.66) followed by the schizophrenia vignette (M = 17.09). The most positive attitude was expressed towards the person with a physical illness (M = 10.49). People with lower education levels had significantly more positive attitudes towards mental illness in general than did those with higher education levels (t = 1.978, df = 178.760, p = 0.049). Those who named their religion as Buddhism also had more positive attitudes towards mental illness than non-Buddhists (t = 3.410, df = 130.269, p = 0.001).

Perceived severity

Of the four vignettes describing mental illnesses, the respondents considered the schizophrenia vignette to be the most severe (M= 3.33) followed by the alcoholism vignette (M=2.55), while anxiety (M=2.25) and depression (M=2.24) were considered the least severe. Respondents with lower education levels perceived schizophrenia and anxiety disorder as significantly more severe than did those with higher education levels (respectively t = 2.456, df = 178.729, p = 0.015 and t = 2.564, df = 194, p = 0.011). Looking at the symptom clusters identified during the focus groups, the symptom cluster 'unconscious behavior' was thought to be most severe followed by the cluster 'sad or unhappy'. Other symptom clusters that respondents rated among the most severe were 'aggression or violence', 'wandering' and 'agitation or bad temper'. Only in case of the four most severe symptoms, people suggested that the patient should seek care in a psychiatric hospital or mental institution, while support from family or friends was thought to be appropriate for all symptom clusters.

Perceived barriers

During the FGDs, patient relatives identified several obstacles in the delivery of mental health care to patients. The most commonly identified obstacles were a lack of drugs (usually identified as vitamins), financial problems and the burden of taking care of the patient. Drugs specific for the illness were sometimes lacking or supplied with delay. The lack of financial support and poverty were also important obstacles. Family members have to give up their jobs to take care of the patient and lose income, while the family has extra expenses for drugs and other materials for the patient. The burden of care by a family member was an important obstacle, specifically the emotional burden, the difficulties in patient management and potentially, aggression from the patient. The following comment reflects the emotional part of the burden: "*Sometimes I get so tired and angry that I secretly hope the patient dies, but I do not really want this and I will always worry about him*". Discussing the topic of aggression from patients a mother said about her schizophrenic son: "*My son controls me with aggression, he threatens me and sometimes he beats me when I cannot meet his demands*".

4. Discussion

This study looked at perceptions of mental health and their influence on help-seeking behavior in Vietnam. The results identify several aspects, which have an important influence on these concepts. The following section discusses the relevance of the identified lack of knowledge, attitudes and beliefs, help-seeking behavior and the burden of giving care by families and the relationship between these concepts.

Lack of knowledge

The results reveal a general lack of knowledge on mental health among this population of relatively well-educated urban residents in Central Vietnam. The lack of knowledge appears to reflect the lack of effective mental health educational programme, which only recognizes epilepsy and schizophrenia as "social illnesses'' and patients get free care and medications. Most people could not spontaneously name any mental illness and used the words mad and insane to describe this condition. Nguyen (2003) indicates that this terminology is common in Vietnam in the context of mental illness. The most common actual mental disorder identified by our respondents was schizophrenia. Depression was identified as a mental illness using some methods but not for all, while anxiety disorder was hardly recognized as a mental illness. In line with these findings, the respondents ranked schizophrenia as the most severe condition, while depression and anxiety were considered the least severe. Deribew and Tamirat (2005) reported similar findings from a study in Ethiopia and found that people only recognized severe psychotic conditions as mental disorders. Similarly, we found that behaviors such as talking nonsense, wandering, strange behavior and aggression or violence were the most frequently mentioned symptoms of mental illness in the questionnaire. Results from the focus group discussions showed that the symptom clusters of 'unconscious or strange behavior', 'aggression' and 'wandering' were ranked as the most severe problems. These findings are in agreement with those from studies carried out in Africa (Kabir et al. 2004; Deribew and Tamirat, 2005), suggesting that overt psychotic behavior that attracts public attention and is socially disruptive is associated with mental illness, in any society. These results suggest that perceptions of the severity of mental illnesses are strongly related to the recognition of those illnesses and related symptoms, and that both are strongly influenced by a lack of knowledge and awareness.

Attitudes and beliefs

Respondents attitudes and beliefs concerning mental health are influenced by a lack of knowledge as well as a mix of traditional and modern views. Respondents often identified 'stress' and 'nerve problems' as mental illnesses. When respondents were asked about the causes of mental illness, those most frequently mentioned were 'stress or tension' and 'excessive studying or thinking'. Nguyen (2003) documented similar

perceived causes of mental illnesses among Vietnamese people in Ho Chi Minh City and mentions that it is a common belief in Vietnam that people can fall mentally ill from studying or thinking too much. These findings point at culture specific perceptions of mental health in relation to stress and mental overload. There were incongruent findings for the recognition of depression and anxiety in this study. Although the lack of knowledge is likely to play a role in this, culture specific explanations can also be found in the literature. Wagner et al. (2006) found that Vietnamese people did not differentiate clearly between the terms 'stress', 'depression' and an ordinary 'anxiety', which are used as different words for a single psychological construct. It is notable that participants in our study sometimes gave traditional explanations for mental illnesses, but much less frequently than modern explanations. A possible explanation for this finding is that respondents answered in a socially desirable way in which modern views of mental health would be more socially desirable than traditional views. However, it is more likely that modern views on mental health were in fact more dominant in our study population. The study was done with a relatively well-educated urban population, which is more likely to have a modern view and to prefer natural causes over supernatural causes than might less educated and more rural populations (Nguyen et al. 2003).

Attitudes towards the different mental illness vignettes in the questionnaire were most negative for the alcoholism vignette, followed by the schizophrenia vignette. These results suggest that people have the most negative attitudes towards mental illnesses associated with socially disruptive behavior, which is in line with findings from Deribew and Tamirat (2005). The finding that people with low education levels had a more positive attitude towards schizophrenia than did respondents with higher education levels is in contradiction with findings from two studies on perceptions of mental health in Africa (Kabir et al. 2004; Deribew and Tamirat, 2005). However, Lauber et al. (2004) suggested that more knowledge about mental illnesses and especially schizophrenia may increase the social distance.

Help-seeking behavior

Modern medical treatment was preferred by a majority of the study population. Similar preferences were found in other studies on perceptions of mental health (Deribew & Tamirat, 2005; Kabir et al. 2004). A considerable number of people also recommended family support and care at home. It is plausible that both treatment approaches are often used together and differences in preference might occur according to differences in the perceived severity of a mental disorder. The results show that only for the four most severe symptom clusters did the respondents suggest seeking care in a psychiatric hospital or mental institution, while support from family and friends was mentioned for all symptom clusters. Apparently, people prefer to take care of persons with a mental illness in the family, but will bring the patient to a psychiatric hospital if

the condition is very severe, which is consistent with the findings by Nguyen et al. (2003) and Wagner et al. (2006). The fact that people seldom mentioned other treatment options besides family care for mental illnesses other than schizophrenia indicates that in many cases the Vietnamese population is unlikely to use mental health care services. The lack of knowledge about and the attitudes and beliefs towards mental health care services are also likely to influence the help-seeking behavior of the Vietnamese. James et al. (2002) found a strong relationship between health seeking behaviors, perceptions of the local population and the use of mental health care services in India and Pakistan. Social stigma towards mental illnesses could also play a role in reducing the number of people willing to seek treatment for mental health problems (Corrigan, 2004)

Family burden

Patient relatives identified the heavy burden of giving care as an important barrier to providing care for a relative with mental health problems. Caregivers experienced financial burdens, emotional burdens, disruptions to family routines and difficulties in dealing with aggression by the patient. Wong (2004) confirmed the strong positive relationship between family burdens and distress among caregivers and suggested that culturally specific health beliefs influence the way caregivers experience the family burden of care and that this is related to help-seeking behaviour. Because family members only help patients to seek medical treatment in severe cases and usually take care of patients at home until the situation becomes intolerable, they find themselves confronted with a huge burden on the family. With a lack of financial resources and limited knowledge of mental illnesses, caregivers find it hard to deal appropriately with their situation.

5. Conclusions

This study gives unique insights into the perceptions of mental health among an urban population in Central Vietnam, and their influence on help-seeking behavior. The results demonstrate a need for educational and awareness programs about the nature and symptoms of mental illnesses and in particular about neglected common illnesses like mood and anxiety disorders. Programs should address the different treatment options and people should be encouraged to seek help in an early stage of illness. In developing such programs culture-specific notions of mental illness should be taken into account. The importance of the family should de acknowledged and efforts should be made to understand the needs of families, in order to provide them with support and skill training and to help them organize family groups and associations. More research is needed on prevalence rates of mental disorders, the availability and accessibility of mental health care services and stigma in Vietnam, especially in rural areas. For programs and research on mental health, it is important to have support from national and regional authorities. The current trend in which we see a broadening of policies on mental health could create opportunities for development of successful mental health programs.

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