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Lena Bucatariu, Babu George

CUSTOMER RELATIONSHIP MANAGEMENT PRACTICES TO PROMOTE MENTAL HEALTH SERVICES: A STUDY IN HO CHI MINH CITY, VIETNAM

Abstract. Given the reported high incidences of depression related suicides in Ho Chi Minh City (HCM City) Vietnam, a phenomenological case study was conducted to assess the profiles of mental health providers and their customer relationship practices. The study presents findings from eight in-depth interviews with Mental Health (MH) doctors and marketers at public and private facilities about activities used to attract and retain customers, their effectiveness, and the challenges encountered. The trade publications and also the scholarly literature would indicate progressively increasing use of marketing skills at both public and private MH providers, through social marketing campaigns, anti-stigma and MH awareness, social media marketing, Search Engine Optimization (SEO), digital platforms, and tech-enabled Customer Relationship Management (CRM), despite the fact that there is a recurring undersupply of mental health care services. In somewhat of a contrast, findings from interviews for the HCM City showed that government-affiliated providers were reactive, dependent on direct transfers and unconcerned about retention or CRM. Investments in CRM and marketing in general were limited and non-strategic in the State sector; marketing communication materials were of limited effectiveness and quality, even among mid-tier private providers. In contrast, upscale private clinics used a repertoire of tools including Facebook Business pages, YouTube.com clips, content-rich websites, blogging, toll-free numbers and workshops. Through innovation and client-focus, upscale private MH clinics derived a major source of business from Word of Mouth (WOM). Some challenges to MH usage that we identified were stigma, gender roles, unethical doctor behaviors, poor quality of MH education, and practice. Also, many providers had a difficult time educating individuals about the symptoms and treatment of mental illness, and outreaching with the MH service delivery to induce trial.

Keywords: Digital marketing, mental health, consumer behavior, CRM (Customer Relationship Management), psychology, psychiatry, Ho Chi Minh City, Vietnam.

Introduction

In a period of unprecedented economic growth following Vietnam's reform, WTO membership, and TPP signing [Dezan & Das 2017], there is increased pressure on Vietnam's youth and workforce to perform in a global economy [Le 2018]. As a result, a host of mental health indexes are at dangerous levels, including record-high suicide rates, depression, anxiety, addiction (especially alcohol, tobacco, and gambling), personality disorders, and other mental afflictions [WHO 2014]. The World Health Organization ranked suicides as the second most pervasive cause of death among people aged 15—29 [WHO 2014], with the highest suicide rates in low-middle income countries, especially in South East Asia [WHO 2014]. By 2013, over 16 % of Vietnamese teenagers of 13 to 17 had expressed suicidal thoughts or intentions [WHO 2014]. By comparison, results from Cambodia were one third at 6 % [WHO 2014], and Thailand's rate was two thirds at 12 % [WHO 2014], respectively.

To make matters worse, supply and quality of mental health care offerings are often inadequate [WHO 2014], an issue further exacerbated by low awareness and poor customer attraction and

marketing skills of most existing providers [Le 2017]. To illustrate, according to most recent data available, Vietnam had only 59 mental health outpatient facilities, or 0.07 per 100,000 population and only 32 mental hospitals or 0.04 per 100,000 people. Also, there were only 1,01 psychiatrists (and an additional 0.3 in training) available per 100,000 people and 0.03 trained psychologists per 100,000 people [WHO 2014]. By comparison, Russia had 4,173 mental health outpatient facilities or 2.97 per 100,000 people, 11.61 % psychiatrists per 100,000 citizens and 5.42 psychologists per 100,000 people [WHO 2014]. Even among its Asian peers, Vietnam's mental health workforce lags far behind SE Asia average of 4.8 and global average of 9. In contrast, the highest supply is in Europe, at 43.5 mental health workforce per 100,000 population [WHO 2014].

The problem identified for this study is low usage of Mental Health (MH) services, which manifests as high rates of suicide and depression affecting the Vietnamese workforce [WHO 2014], low awareness and knowledge of MH services among patients [Le, 2017], and limited variety and effectiveness of marketing activities used by MH providers [Tran, 2017].

According to the literature, the decision-making process for mental health services follows the key stages highlighted by Schiffman and Kanuk (2010) reproduced in Figure 1:

Fig. 1. Stages in the consumer decision-making process.
Source: [Schiffman & Kanuk 2010]

However, unlike routine business-to-consumer services such as car washing or getting a haircut, *Problem/Need identification* stage in mental health is less salient due to the intangible, subjective nature of the service outcome, and *Evaluation of alternatives* stage is less immediate due to lack of pre-established criteria [Belch & Belch 2012; Kotler & Armstrong 2010].

More developed economies are characterized by high awareness and understanding of MH due to past social awareness campaigns [Chapman Walsh & Rudd 1993] supported by large budgets both in the public and private sectors [Brohan 2017]. In Western markets, MH marketing communications are mainly driven by digital, online, and mobile initiatives such as social media, AdWords, and are predominantly "mobile-first" [Hawn 2009]). Customer Relationship Management (CRM) activities are well-established and often take advantage of web/mobile delivery of service [Mook 2011]. Thirdly, service seeking is often patient-initiated as prospects feel empowered [Calfee 2002] and more likely to display self-help behaviors [Chang 2005].

Specifically for Vietnam, the mental health industry is plagued by the traditional view as "illness" not wellness [Manderscheid et al. 2010], state monopoly, focus on severe cases [Tran 2017], and limited marketing activity in both public & private MH care [Le 2017]. Gaps in the literature include prevalence of medical-focused studies and a dearth of marketing-related studies (Burgess, 2015; Lipscomb et al., 2004), with studies skewed to quantitative methods and coming mostly from developed economies Mainly in Western or developed countries [Boehnlein 2006; Bright 2017; Carr 2009], and almost none from Vietnam [Tran 2017]. Since awareness and knowledge of service are key drivers to increase consumption [Schiffman & Kanuk 2010], by conducting this study and deriving market insights it is hoped to partly attenuate the problem. Thus, increased usage of MH can help to strengthen Vietnam's labor force plagued by 40,000 suicides/year, of which 75 % from depression [WHO 2014], reduce the rate of 86 % workers that have occupational stress [Thanh 2016], while enriching the body of research for MH from a marketing — not medical — angle, uniquely tailored for MH industry in Vietnam and provide best practices to MH clinics/hospitals [Sigall 2004].

The research questions we address in this paper are: 1) Which are the key activities used for marketing mental health services among Vietnamese in HCMC? 2) Which marketing activities are most effective in attracting and retaining customers for mental health services among Vietnamese in HCMC? 3) What are some key challenges to marketing mental health services among Vietnamese in HCMC? To answer these questions, the study employs a phenomenological qualitative approach to show "how we as humans make sense of the world" [Saunders et al. 2012: 137]. Based on the interpretivist philosophy, the article uses text as a proxy for experience [Creswell 2007] and inductive reasoning to "explore phenomena, identify themes and patterns" [Ibid 2012: 144]. Qualitative in-depth interviews were conducted with 8 experts in MH marketing & delivery (doctors, counselors, lecturers, clinic owners). Themes were derived through open coding and in vivo codes using respondent's natural key words [Saunders et al. 2000], followed by focused coding and axial coding to establish relationships [Saunders et al. 2000].

Methods

To estimate the total population of potential interviewees, the following numbers were considered: 900 currently employed psychiatrists, 20 post-graduate professors of Psychology and Psychiatry, 120 practicing psychologists, 35 state sector MH hospitals and state-affiliated MH clinics, 16 public clinics of psychology in HCM City, and 32 private psychology and mental health clinics in HCM City — to ensure fair representation of both public and private sector respondents. The population excluded 950 medical doctors with non-psychiatric training, 400 trained psychiatric doctors that changed to non-MH careers, and all 6 international MH wards that treated expatriates in HCMC. The initial contact list was created by combining direct respondent contact details (doctor's or marketer's) with organizational type of contact data (hospital's or clinic's general contact details).

To maximize the richness of the sample, the researcher used a combination of snowballing and heterogenous purposive sampling strategy to help uncover differing themes between the perspectives of public v. private MHC specialists. Since snowballing was more likely to yield experts that had the desired inclusion characteristics and openness towards being interviewed, this strategy was employed to supplement the sample from the professional networks of:

— Vice-Dean at the Faculty of Psychology & Psychiatry, Pham Ngoc Thach University of Medical Sciences, HCM City (mainly to reach doctors and psychologists in private clinics);

— Research Director at MAP Research, HCM City (mainly for MH respondents with sales & marketing experts);

— local recruitment agency Karla Recruitment Services, HCM City (mainly to reach doctors in the public sector and some niche respondents).

A pre-screener questionnaire was administered over the phone to ensure participants met the inclusion criteria:

— for doctors: minimum 5 years of relevant work experience in the field of psychology, psychiatry, and/or counselling, with minimum 20 % of their time dedicated to marketing activities, e.g. participation at MH awareness events, talks at MH conferences, free consultations for volunteering, etc.;

— for marketers: minimum 2 years of work experience in a marketing or sales position for a mental health care practice located in HCMC, state or private, e.g. hospital of psychology/psychiatry, MH clinic, wellness and counselling clinic, NGO/charity for MH.

Eight was found to be a suitable number since smaller sample sizes of 3 to 10 subjects have been recommended for phenomenological studies [Creswell 2007]; saturation became visible after

around 6 participants, when answers started to converge [Saunders, Lewis, & Thornhill, 2000]. As a result, eight face-to-face qualitative in-depth interviews were conducted with experts involved in marketing of mental health, among which psychology professors, trained psychologists, psychiatric doctors, sales and marketing experts at public and private mental health institutions. Demographically, the 8 experts interviewed were 2 female and 6 male aged 30—60+ with a spectrum of relevant backgrounds: one owner of a state clinic focused on criminal psychology, two doctors at two state hospitals of which one is also a psychology lecturer, that had private evening clinics, one owner of a premium clinic treating local celebrities, one younger doctor at an LGBT clinic operating mainly through B2B (business-to-business) referrals, one HR consultant in occupational psychology, one published book author who owns a child psychology center, and one public speaker and counselor specializing in marriage counseling).

Care was taken to minimize the incentive's downsides, e.g. inconsistent reduction in non-response errors, changing the sample composition (all respondents that did not meet inclusion criteria were simply not contacted, not included in the sample, and therefore not incentivized), or the possibility of data fabrication by validating the respondents through visit at office (hospital, clinic) and performing a spot check on the activities claimed. Each respondent signed an IRB approved Consent form to confirm voluntary participation in the study. The researchers' understanding of and personal or professional experience with mental health needed to be considered when investigating potential biases in qualitative studies. The services of bi-lingual local Vietnamese research assistants were used to provide additional explanations and clarifications on less salient meanings and cultural realities, e.g. prejudice and superstitions.

Findings

To ensure that findings "lead to actionable and evidence-based recommendations" that MHC providers would be able to readily apply [Guest et al. 2013: 77], data analysis for this study relied on "description of the experiences of participants" [Creswell 2007: 59] with minimal introduction of the researcher's interpretation.

The key themes pervasive in MH sphere in Ho Chi Minh City, Vietnam have been found are:

1) MH need is unrecognized or misunderstood by the consumer as there is 2) low profile of MH education and practice compounded by 3) complacent, reactive marketing in the state sector. However, there is a growing consumption of MH services among the more affluent segments encouraged by 4) more proactive and developed marketing in the private clinic sector. In the following sub-sections, these themes are substantiated by highlighting relevant excerpts from interviews.

Theme 1: *It* refers to the patient's inability to recognize need or to incorrectly label the need, as the patient does not have sufficient understanding of what mental illness and mental wellness mean, how they manifest themselves and how they affect one's ability to function cognitively and emotionally. The following are a sample of respondent quotes to support this theme:

- *"A disorder like psychosis triggers loss of insight, that means they don't know they're ill, they don't have self-awareness". (Psychiatrist at private clinic and psychology lecturer);*
- *"In Vietnam, older people in low-income families still think that mental illness is a curse, karma for the mistakes of the parents". (Owner at child psychology center, book author);*
- *"Some patients think that mental health service is a scam for doctors to get rich". (Owner at state clinic on criminology).*

Theme 2: It refers to the lower importance and emphasis placed on MH as an area of study and training as well as an area of medical practice. This situation results in lax entry barriers to both

the education and industry of MH, as well as leaving opportunities for unethical practices. The following are a sample of respondent quotes to support this theme:

- *"There are many life-and-death specialties — Oncology, Cardiology, Surgery for trauma — they are the stars." (Psychiatrist at state hospital);*
- *"When I failed the university entrance exam into Journalism, my friend recommended going for Psychology: there was less competition and I can enter with a lower score." (Psychologist counselor at a private clinic);*
- *"In Vietnam, there is no standardization, no government body to control." (Marriage counselor).*

Theme 3: It refers to market realities in the public sector, where patients lack choice as a result of limited affordability and dependence on social health insurance, hospitals are congested due to transfers from non-MH department or lower-tier medical institutions, and most providers have limited or no marketing budget and manpower. The following are a sample of respondent quotes to support this theme:

- *"I feel sorry for some [patients] — they live as far as half a day away, they take a 4 AM bus from another province to come see me because only this hospital offers SHI [social health insurance] reimbursement for their illness." (Psychiatrist at state hospital);*
- *"We already have too many patients. We don't need to market to get any more." (Owner at state clinic on criminology);*
- "*Communications about MH are about 1 in 10 and not very effective: they [state agencies] put up banners on Suicide Prevention Day, and published a few PR articles but far between." (Psychiatrist at private clinic and psychology lecturer).*

Theme 4: It refers to the presence of a wider repertoire of basic and advanced media and communication tools among private MH care providers, especially high niche players, with some elements of segmentation, IMC strategy, some integration of digital offline channels that follow the consumer's journey and readiness stage. The following are a sample of respondent quotes to support this theme:

- *"We do psychological assessments for LGBT (...), only adults though." (Psychologist counselor at a private clinic);*
- *"Our website will rank high because we invest in SEO and we have many visitors and page views." (Private counseling clinic focused on celebrities);*
- *After I speak on TV or radio shows, I get a lot of Facebook inquiries from people who need my advice." (Marriage counselor);*
- *"From the very first step, everything is kept private. The client rings the doorbell and is invited in, like a guest in a rich man's home."(Private counseling clinic focused on celebrities);*
- *"We always keep track of our clients' progress."(Private counseling clinic focused on celebrities).*

Still, mid-market private providers are more likely to struggle:

- *"We cannot afford a skilled full-time marketer on our payroll." (Owner at a child psychology center, book author).*

Discussion

In answer to the research questions, the study unveiled some complex market realities. For the spectrum of marketing activities used in research question 1) there is a major gap in both intensity and quality of marketing activities between new versus established providers as well as between public versus private institutions. In detail, new, private providers use word of mouth and refer-

rals from networking with personal, academic, and professional contacts, and some B2B outreach efforts. More established, private influential experts rely on the publication of books, TV and radio shows, and offline events to promote themselves. Individual doctors migrate from state hospital daytime jobs to home evening clinics, and private clinics with higher budgets use Facebook ads and cured content, youtube.com demonstration clips, and Search Engine Optimization tools (SEO). State providers are all well-established and benefit from direct patient transfers from non-MH specialties, and from lower-tier clinics. The Ministry of Health maintains limit and basic communications on MH on the official online channel www.t4G.vn. Few state hospitals do basic communications of MH on their website, and there have been occasional government awareness campaigns about suicide through offline posters and fliers.

For the effectiveness of marketing activities in research question 2) Attraction & Retention activities are skewed to private providers, which attract users through trust-building activities and human connection and retain them based on meaningful follow-ups. In detail, state hospitals do not appear interested in attracting new patients, as they already experience patient overload from transfers and lower-income segments tied to social health insurance (SHI). Private clinics make efforts to attract users, and the most effective tools are word of mouth, helpline, trust-building and demonstration activities e.g. Facebook live stream of talk shows, proprietary youtube.com clips of the simulated counseling session, targeted/segmented communications on digital platforms, e.g. google keywords, website call-to-action. For retention, the most effective tools include communication through interactive platforms with frequent reminders e.g. face-to-face conversations at workshops, doctor's reply on Facebook Messenger, outbound calls and SMS to remind of the next appointment, and structured long-term treatment plans centered around the patient's growth.

For challenges to marketing MH services in research question 3) Lack of awareness and/or the consumer misunderstanding the MH service is the key challenge for all providers new or established, public or private. The second and third top challenges i.e. limited marketing investment and unethical service affect mainly state providers and some mid-range private clinics. In detail, institutions are affected by product and customer challenges such as the fact that MH patients are unaware of illness due to loss of insight, there is little mass communication from government, the inability of the providers to tangibilize the benefit, and for a minority of patients, the issue of past experience with unethical doctors. On a macro level, MH poses difficult cultural barriers such as stigma, traditional gender roles (it is not acceptable for men to show signs of weakness), and superstitions e.g. mental illness is seen as being possessed by a demon. At the industry level, institutions are affected by limited communication and investment from central government, limited self-funded budgets for private providers, MH higher education that is uncompetitive and outdated to prepare new doctors, as well as lax legislation and oversight. As a result, the industry is plagued by unethical behaviors of unqualified doctors entering the workforce and providing inadequate care to cash-strapped, undiscerning users.

Implications for practice

By compiling data from all respondents and re-grouping them, three profiles of MH institutions have been identified, with suitable marketing recommendations given for each: 1) The Complacent, 2) The Constrained, and 3) The Advanced. In detail, the Complacent tend to be state hospital or state-owned clinic, serving low-income users; this profile has a monopoly on patient transfers, use limited online communications such as website, and do not invest in activities to attract or retain users. For this provider profile, it is recommended that the policy-maker a) invests in a national Mental Health Fund [Le 2017] to sponsor high-scale social campaigns as is the case in more deve-

loped countries, and b) to tighten entry criteria into MH education & practice. Second, The Constrained profile is more likely to be private-operated, have a broad "mass" consumer target, with a limited marketing budget and skill, as well as some investment in Customer Relationship Management (CRM) via encouraging follow-up visits, but weak long-term retention due to lack of regular communications. For this profile, it is recommended to utilize freely available marketing materials such as white papers and YouTube.com tutorial videos in the local language, as well as seeking pro bono training from local marketing associations and/or schools. Third, The Advanced provider group tends to be niche clinics with a suitable marketing budget and skill, using Integrated Marketing Communications (IMC), monitored through Key Performance Indicators (KPI). This profile group are more client-focused, supported by strong online content for the attraction (SEO, social media, Livestream), high-conversion from offline activities (workshops), and a dedicated CRM system for long-term retention. For this provider group, the recommendations are to hire external consultants such as from PACE Institute of Management to fine-tune in-house skills on digital media, customer service.

Recommendations for future research

The current study has a number of limitations; namely it was conducted in one location, employing the qualitative approach which means that findings cannot be generalized. For inclusion criteria, only 8 experts were interviewed, derived through purposive sampling and snowballing, and no patients were surveyed, which results in a lack of "customer voice". To atone for the limitations identified above, it is recommended that future research on the topic include users of mental health services or at least a survey on the general public's opinion; insight from policymakers e.g. Ministry of Health on anti-stigma campaigns and HR recruiters to better gauge the impact of stigma in staff hiring and retention; and an extended geographic area to include other regions e.g. North Vietnam and second-tier towns or rural areas for a more comprehensive view of challenges. To take the investigation one step further, future studies could include discourse analysis in the form of detailed investigation of themes in the execution of marketing communications for MH e.g. a comparison between PPC ads, Facebook posts, and YouTube.com videos from various providers; or perform testing and experiments to gauge the effectiveness of alternative marketing materials for MH awareness and prevention.

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Authors:

Bucatariu Lena, Lecturer, RMIT Vietnam, Ho Chi Minh City, Vietnam, School of Communications and Design. ORCID: 0000-0001-6015-9054. E-mail: lena.bucatariu@gmail.com

George Babu, Ph.D. (Management), Associate Professor, Fort Hays State University, United States, College of Business and Entrepreneurship. ORCID: 0000-0002-2791-828X. E-mail: bpgeorge@fhsu.edu

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Лена Букатариу, Бабу Джордж

ПРАКТИКА УПРАВЛЕНИЯ ОТНОШЕНИЯМИ С КЛИЕНТАМИ В ЦЕЛЯХ СОДЕЙСТВИЯ ИХ ПСИХИЧЕСКОМУ ЗДОРОВЬЮ: ИССЛЕДОВАНИЕ В Г. ХОШИМИНЕ, ВЬЕТНАМ

Аннотация. В связи с информацией о большом числе самоубийств, связанных с депрессией, в г. Хошимине было проведено феноменологическое тематическое исследование для оценки профилей лиц, оказывающих психиатрическую помощь, и их практики отношений с клиентами. В исследовании представлены результаты восьми углублённых интервью с врачами и маркетологами в государственных и частных учреждениях, занимающихся вопросами психического здоровья, о деятельности по привлечению и удержанию клиентов, её эффективности и возникших проблемах. Публикации по вопросам торговли, а также научная литература свидетельствуют о постепенном расширении использования навыков маркетинга как государственными, так и частными поставщиками услуг в области психического здоровья путём проведения кампаний социального маркетинга, повышения осведомлённости о стигматизации и охране психического здоровья, маркетинга в социальных сетях, оптимизации поисковых систем, использования цифровых платформ и управления отношениями с клиентами (УОК) с использованием технических средств, несмотря на то, что постоянно наблюдается нехватка услуг по охране психического здоровья. В то же время результаты опросов, проведенных в г. Хошимине, свидетельствуют о том, что государственные поставщики услуг не были заинтересованы в управлении отношениями с клиентами. Инвестиции в УОК и маркетинг в государственном секторе в целом являлись ограниченными и нестратегическими; информационные материалы по маркетингу имели небольшую эффективность и невысокое качество даже среди частных поставщиков услуг среднего звена. В отличие от этого крупные частные клиники использовали разнообразные методы, включая страницы Facebook Business, клипы YouTube.com, информационно насыщенные сайты, блоги, бесплатные номера и семинары. Благодаря инновациям и ориентированности на клиентов частные клиники психического здоровья с более высоким уровнем развития приобрели важный источник бизнеса из Word of Mouth (WOM). К числу выявленных авторами проблем в охране психического здоровья относится стигматизация, гендерные роли, неэтичное поведение врачей, низкое качество образования и практики в области психического здоровья. Кроме того, многие лица, оказывающие медицинские услуги, испытывают трудности с информированием людей о симптомах и лечении психических заболеваний, а также с пропагандой услуг в области охраны психического здоровья с целью привлечения пациентов для лечения.

Ключевые слова: цифровой маркетинг, психическое здоровье, поведение потребителей, управление отношениями с клиентами, психология, психиатрия, г. Хошимин, Вьетнам.

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Авторы:

Букатариу Лена, преподаватель, Университет РМИТ Вьетнам, г. Хошимин. ORCID: 0000-0001-6015-9054. E-mail: lena.bucatariu@gmail.com

Джордж Бабу, к.н. по менеджменту, доцент, Государственный университет Форт-Хейс, США. ORCID: 0000-0002-2791-828X. E-mail: bpgeorge@fhsu.edu

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