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# A Call for Community-Based Suicide Prevention in South Korea

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In this paper, we reviewed the community-based approaches to suicide prevention and national strategies for the decrement of suicide rate, and made some suggestions to decrease the suicide rate in South Korea. Until now, efforts to understand and prevent suicide have been pursued singularly by specialized interest groups such as psychiatrists, psychologists, mental health practitioners, and private organizations with little interaction between them, resulting in narrow approaches toward suicide that existed in relative isolation to one another and that have been largely ineffective. To decline the suicide rate in South Korea, the people lived in Korea community ought to have enough knowledge related to suicide and have to cooperate with other people. Through these efforts, Korea community would have established social safety networks to improve the community 's mental health. The most important factor in suicide prevention and declining the suicide rate is reducing the stigma and increase the self-help seeking behaviors associated with suicide and mental health. Therefore, suicide is not an individual problem solved by suicidal patient, but a community's problem solved by community in recognizing, managing and preventing suicide.

*Key words : Suicide, Suicide Prevention, Community based approaches, Safety network*

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South Korea's high rate of suicide in Asia and worldwide makes it necessary that effective suicide prevention strategies be developed in South Korea. This paper examines the phenomenon of suicide in South Korea, reviews general community based strategies for suicide prevention that have been successfully utilized in other countries and discusses ways that a community based suicide prevention program might be implemented in South Korea to educate South Korean citizens about suicide, provide increased suicide-focused services as well as access to them, and ultimately reduce the incidence of suicide in South Korea.

Suicide is a serious public health problem and a leading cause of death in many developing countries worldwide (Motto & Bostrom, 2001), including Korea. In the Asia Pacific region, Korea has a higher suicide rate than any other countries, and one that continues to rise, increasing from 6.96 per 100,000 in 1991 to 26 per 100,000 in 2008 (NSO, 2009). Overall, South Korea has the 4 $^{th}$ highest suicide rate and highest rate of suicide increase in countries comprising the Organization Economic Cooperation and Development (OECD, 2009), and death by suicide is the 4$^{th}$ leading overall cause of death for South Koreans (NSO, 2009). Among the countries in the OECD, South Korea has posted the highest growth in suicides rates since 1982. Consistent with most other countries' patterns, suicide rates in South Korea are higher for males than for females (Shin, Suh, Rhee, Sung, & Kim, 2004), and between 1991 and 2000 the suicide rates for men were two to three times higher than that for women (Cho, 2003).

Since 1998, suicides in South Korea are explained by the economic crisis that has affected family structure and employment rates (Shin, Suh, Rhee, Sung, & Kim, 2004). Two months after South Korea's 1998 economic depression, the number of suicides increased by 190 per month (Kim, Song, Yi, Chung, & Nam, 2004), and overall mental and behavioral disorder morbidity increased over 300% (Kim, Chung, Song, Kang, Yi, & Nam, 2003). Other risk factors for suicide in South Korea include depression, female gender, academic stress, hostility and substance abuse (Juon, Nam, & Ensminger, 1994), as well as the stigma associated with mental health disorders and suicide. Psychiatric disorders in South Korea have long been subject to stigma, and discussion of mental health problems and suicidal thoughts and behaviors, and their treatment has been avoided. The cultural view on suicide in South Korea, however, is somewhat counterintuitive. Although the dominant religion of Confucianism prohibits suicide, there has typically been an acceptance and compassion for suicide in South Korea as an escape from life's hardships (Cho, 2003). A recent survey by the Korea Institute for Health and Social Affairs (KIHASA, 2005) revealed a more conservative attitude toward suicide by Korean citizens, although some people

support for suicide by individuals with incurable illness.

Because of the relatively low base-rate of occurrence of suicide (Moscicki, 1995) and its multi-factorial etiology (Shneidman, 1993), pathogenesis and expression (Silverman & Maris, 1995), suicide prevention is a complex and difficult task (Glanz, Haas, & Sweeney, 1995). This difficulty is exacerbated by the association of suicide with depression and high levels of psychological distress (Bostwick & Pankrats, 2000; Brent, et al., 1988; Goldston et al., 1998; Gould et al., 1998), and the fact that relatively few people seek help when psychologically distressed or suicidal (Ono et al., 2001), particularly in Korea where the stigma associated with psychiatric disorders is prohibitive.

From a prevention perspective, stigma associated with mental health problems and suicide may often preclude help seeking behavior at the individual level (Tadros & Jolley, 2001), resulting in the increased likelihood of a poor outcome and, since others may not be aware of a person 's difficulties, a lack of social support and community level assistance. Further, if a behavior or disorder is stigmatized at the community level, there is less desire to subsidize care or provide resources (U.S. Public Health Service, 1999; Pompili, Mancinelli, & Tatarelli, 2003).

For suicidal individuals, failure to seek and attain treatment places them at high risk for suicide completion, whereas people who receive appropriate help and advice when they experienced suicidal problems are likely to decrease their level of risk and distress (Capp, Deane, & Lambert, 2001). Therefore, if suicidal individuals are able to access appropriate assistance, suicide rates might be reduced.

## Current Mental Health and Suicide Prevention Efforts in South Korea

South Korea had experiences many changes in the areas of economy, culture, life style. Some people have problems in adjusting to changed society but South Korea had no enough mental health service system a few years ago. Among the psychological problems South Korea experienced, suicide is a very severe problem. As a result of the dramatic increase in suicide rates over the last two decades, the South Korean government has recently begun to recognize the significant public health problem of suicide; however, it has historically avoided the issue of suicide and mental health in general, having only recently, in 1995, established a national mental health program. According to the World Health Organization's report, Korea does have a mental health policy, budget allocations for mental health programs, and mental health benefits and treatments for individuals with psychiatric disorders. Unfortunately, there has not been a specific focus on suicide and no enough financial supports, and there has not been a

decrease in Korean suicide rates since the inception of that countries'national mental health program (De Leo & Evans, 2003). Unlike many developing countries, South Korea does not have a specialized government entity or organization focused specifically on understanding and prevention of suicide, and relies instead on the existing infrastructure of public and private hospitals, and regional and community clinics. In September 2004, the South Korean Ministry of Health and Welfare (MOHW) revealed a five-year plan to reduce the number of suicides in the country by 20% by the year 2010. The government's suicide prevention efforts will include the establishment of an additional 120 mental health centers across the country, as well as life campaign, improved early intervention and treatment of at-risk individuals and suicide attempters, and the establishment of phone and internet suicide prevention systems (Hun, 2004). Suicide prevention public service announcements were televised for two months on Korea's three nationwide networks, and a telephone hotline was placed in service in January 2005 (Korea Update, 2005). In 2004, a joint venture by the Korean Association for Suicide Prevention, Journalists Association of Korea, and the Health and Welfare Ministry resulted in the establishment of reporting guidelines for suicide, calling for restraint in mentioning methods and locations of suicides in an attempt to de-romanticize suicide and contain potential contagion effects (Hun, 2004).

In addition to the efforts of the Korean Suicide Prevention Centre, a private organization, which was established in 2003, has aims of research, public education and the prevention of suicide. Teenscreen, a screening program originating at Columbia University, to ensure that all youth are offered a voluntary mental health check-up before leaving high school is also in place in South Korea (Teenscreen, 2004). Further, some provinces in Korea are forging ahead with anti-suicide campaigns on their own. The region of Suwon, began a program entitled Safe Community Suwon to address developmental concerns, as well as domestic violence and suicide prevention (Suwon Safe Community Council, 2003). Safe Community Suwon has conducted a regional study on causes of suicide and methods used, distributed informational pamphlets, assigned a trained crisis social worker in a hospital emergency department to assess risk and make referrals, and have established a crisis hotline for suicidal individuals.

While noteworthy, these efforts are not enough to sufficiently reduce the problem of suicide in South Korea. South Korea has no public or professional education programs focused on suicide, no national prevention or intervention programs, and very few mental health professionals who are specifically trained in crisis intervention or suicide prevention. And there is no centralized or standardized data collection on death by suicide in South Korea. The government does collect some epidemiological

data and requires submission of a death certificate to the Korean National Statistical Office (Song & Byeon, 2000). But, data on death by suicide are often incomplete (Kim, 1990). A physician conducts death certification in South Korea in only about 30% of all deaths and more often in urban than rural areas and in locations where there are large hospitals (Suk, 1992). Further, the police, rather than a coroner, investigate deaths from external causes (e.g., accidental injury, poisoning and suicides), and more reliable data about the incidence of suicide might be obtained from the National Police Headquarters.

Overall, it is clear that the South Korean government, and many health care professionals, academic researchers and community members have begun to understand the severity of the public health problem of suicide within their community, and have begun to investigate what can be done to prevent suicide in the future. In order to achieve government goals in suicide prevention, it is very necessary to understand the nature of suicide in South Korea. So, government officials and related people keep interests in basic suicidal studies continuously. Without basic data in South Korean suicide, probably we will not achieve positive results in suicide prevention These burgeoning efforts require some direction and will benefit from a collaborative spirit involving government officials and organizations, researchers and clinicians and the general public. In order to achieve this goal, we propose that a community-based approach to suicide prevention will be an important and effective tool in the efforts to reduce suicide in South Korea Community.

## Community-Based Prevention Perspectives

In 2003, the World Health Organization issued its first *World Report on Violence and Health*, in which it called for strengthening community-based efforts to prevent suicide. Among its recommendations were: 1) development and evaluation of community prevention programs; 2) improvement of the quality of existing services; 3) increased government funding and support for prevention centers, support groups and programs focused on the reduction of social isolation; 4) establishing partnerships and collaborations between organizations interested in reducing suicide; and, 5) development of educational programs aimed at preventing suicide. Further, the World Health Organization (WHO, 2001) has identified a framework for the reduction of mental illness that can readily be applied to community suicide prevention efforts and that calls for: 1) development of policies to improve mental health at the population level; 2) universal provision of and assurance of access to cost-effective mental health and provision services; 3) assessment and tracking of the mental health of at-risk communities, including vulnerable populations such as children and the elderly 4) reduction of

risk factors and promotion of healthy lifestyles; and, 5) promotion of research focused on the etiology and treatment of mental disorders and suicide.

The breadth of such a charge invokes the need to address suicide at the need to address suicide at the group, environmental and social levels (Klassen, Mackay, Moher, Walker, & Jones, 2000) while, at the same time, respecting the shared aims, values and actions of its constituents (Judy, 1999). Because of the oft-stigmatized and privatized perception of suicidal individuals in Korea, little has been done to address the phenomenon of suicide at the community level.

In Korea, particularly in the field of suicidology in general, suicide prevention efforts have historically targeted individuals in crisis or assessed to be at risk for suicide (Sanddal, Sanddal, Berman, & Silverman, 2003), and attempts to intervene occur during or after a suicidal event. This approach places much of the burden of suicide prevention on clinician attempting to treat suicidal individuals, rather than allowing the at-large community to participate in suicide prevention efforts. The aforementioned WHO community prevention model (2001, 2003), as well as prevention terminology proposed by the Institute of Medicine (2004), advocate a multi-level strategy of mental health treatment, including universal, selective and indicated prevention efforts. Universal prevention strategies occur at the population level and attempts to reduce risk through community or nation-wide initiatives, whereas selective prevention strategies target individuals or groups at high risk via community or group level tactics and indicated strategies intervene at the level of the at-risk or symptomatic individual.

In Korea, efforts to address suicide have typically adhered to the indicated and selective approaches, only identifying vulnerabilities and risk factors or treating the suicidal individual once they come to the attention of medical or psychiatric professionals. Further, Korean suicide prevention efforts have adopted very few, if any, of the stances advocated by the World Health Organization. We assert that such adoption of policy, procedure, treatment and research are precisely what needs to occur in Korea in order for some change to be effected in the incidence and prevalence of suicide.

It has been suggested that suicide prevention programs model their efforts af ter successful cardiovascular disease (CVD) prevention programs (Knox, Conwell, & Caine, 2004), which made the transition from being largely clinically -focused to becoming integrated community-wide (Eisenberg, 1994; Eisenberg, Pantridge, Cobb, & Geddes, 1996). Additionally, for a community suicide prevention program to be effective, it must engage members of and stakeholders invested in diverse sub-groups of the community, particularly those gauged to be at high-risk for suicide, such as the elderly, the homeless,

adolescents, and the severely and persistently mentally ill. It is this type of integrative population approach that addresses risk factors and at-risk community members that will result in more effective prevention of suicide (Knox et al., 2004).

Until recently, efforts to understand and prevent suicide have been pursued singularly by specialized interest groups such as psychiatrists, psychologists, mental health practitioners, and private organizations, with little interaction between them, resulting in narrow approaches toward suicide that exist in relative isolation to one another and that have been largely ineffective (Stillion & McDowell, 1996). Such a reductionistic approach is an ineffective methodology for understanding the complex social problem of suicide (Checkland, 1981; Lazlo, 1972).

In contrast, the community approach offers a multidisciplinary guiding framework for exploration of the complex factors leading to suicidal behavior and the application of scientific methods to discern effective and efficacious means of preventing suicide. In turn, an increased understanding of potential suicide risk and protective factors allows clinicians and researchers to construct and assess a greater range of appropriate prevention strategies which, with widespread implementation, hold promise for saving lives that might have been prematurely lost to suicide (Hammond, 2001).

A community-based suicide prevention model in South Korea would seek to emphasize health promotion and disease prevention via the modification of lifestyle and development of effective policies regarding the detection, treatment and prevention of suicide (Stone et al., 1997). In many ways, this type of prevention framework fits well with the existing public and private health infrastructure already in place in the Republic of Korea, which provides basic medical and psychiatric services for all South Korean citizens via a National Health Insurance System. Private insurance is also available, and there is also a Medical Aide program, which is a government -subsidized public assistance program for the poor and medically indigent (Kim, Chung, Song, Kang, Yi, & Nam, 2003). Each major city and county has a public health center whose task it is to promote health through education, management of infectious diseases, and provision of public health services and visiting nurse services (Lee, et al., 2003). Private secondary and tertiary hospitals and medical clinics also provide care.

An additional benefit of a community -based approach to suicide for Korea is that such a perspective would attempt to address the often-condemnatory attitudes toward mental and help-seeking behaviors that many South Koreans hold. What an individual, as well as the larger community, knows and believes about risk factors and causes of suicide, the availability and acceptability of seeking professional help, and their attitudes toward intervention, play a large

role in whether or not a community-based intervention will be successful (Jorm, 2000). At a community level, this may mean the improvement of mental health literacy through provision of information that assists a community in recognizing, managing and preventing mental health problems. At the level of the individual, mental health literacy translates to the ability of an individual to access, understand and utilize information regarding and influencing their personal health (Jorm et al., 1997; Nutbeam et al, 1993).

Efforts to increase mental health literacy at the community and national level may consist of increased media exposure aimed at educating the community-at-large, high-risk groups and helping professionals about psychiatric disorders, and their symptoms and treatment, and (Jacobs, 1995; Paykel, Hart, & Priest, 1998; Regier et al., 1988), with a goal of stigma reduction and increased help-seeking behavior (Johannessen, 1998). One strategy is to initiate community education about early recognition of mental illness and signs of suicidal behavior, as well as dissemination of knowledge on factors that contribute to poor mental health and suicide, such as the role of acute and chronic stressors or substance abuse in the development of psychopathology and the importance of factors that might be protective, including social support, coping strategies, healthy eating and sleeping habits and exercise (WHO, 2002).

## Global Approaches to Community-Based Suicide Prevention

Throughout the world, nations are recognizing the impact of suicide on their communities, and many have taken steps to develop and implement at least some form of community education or prevention program, even if in simple form. Following the implementation of educational and social action plans to prevent suicide, several countries worldwide have experienced declines in suicide rates. France and the United Kingdom (Jorm, Korten, & Jacomb, 1997; WHO, 2002) manifested greater than 10% declines in suicide rates after implementation of their national suicide prevention programs, between 1989 and 1996. The suicide rate in Finland decreased 18% between 1990 and 1996 after the launch of that country's national suicide prevention strategy (Upanne, Hakenen, & Rautava, 1999). Campaigns to decrease suicide and the stigma associated with suicide have also been implemented successfully in Norway (Rettersol, 1995), Sweden (Rutz et al., 1989) and the USSR (Varnik, 1998), although there is no available data yet to support the effectiveness of these programs.

In fact, this is a common problem worldwide. Many countries have become interested in the prevention of suicide, but the state of the suicide prevention field is somewhat novice. There have been very few controlled

examinations of prevention programs intended to assess efficacy and effectiveness (U.S. Public Health Service, 1999), and the studies that have been conducted have suffered from methodological limitations, including small sample size, that make results difficult to interpret (Arensman et al., 2001; Breton et al., 1998). Thus, it is difficult to ascertain whether the decreases in suicide rates experienced by many countries are the result of one specific intervention.

This section examines details from some of the more comprehensive community-based programs that we feel might be applicable to South Korean suicide prevention efforts, including intervention strategies from Australia, Canada, England, and the United States, as well as recent trends in these countries' suicide rates. We feel that the examples of these model programs, in consultation with South Korean officials and community leaders and constituents, provide a basis for immediate action, although the ongoing, rigorous evaluation of what works for the South Korean people must remain a priority.

### Australia

To address high rates of suicide in rural and Aboriginal communities, researchers and clinicians in Australia developed an early intervention community gatekeeper training program (Capp et al., 2001). The initial and, perhaps, most crucial stage involved identification of stakeholders and community members interested in suicide prevention who were willing to share their knowledge and attitudes toward suicide in their community, perceived barriers to provision of or access to care. A second stage involved training community members to become gatekeepers, increasing their ability and, in turn, that of the community as a whole, to identify individuals at risk for suicide, build and activate both formal and informal community helping networks, and facilitate help-seeking behavior. Success of the project was felt to hinge on the integration of local individuals and information and cultural elements as determined by focus groups, including use of community-based statistics, recognition of risk factors and stressors specific to Aboriginal people and their community, and identification of specific and existent personal and community resources that could be accessed when gatekeepers came into contact with a suicidal individual.

Although Australia experienced a peak increase in suicides of 9% from 1996 to 1997, suicide rates have been declining incrementally since the early 1990's. In 2003, age-standardized suicide rates were 5% lower than in 2002, and were 24% lower than for the peak year of 1997 (Australian Bureau of Statistics, 2003). Declining suicide rates in Australia between 1996 and 2000 were associated with increased SSRI antidepressant prescriptions (Mitchell, 2004). Mitchell and colleagues, however, felt that antidepressants alone could not explain the

decrease and posited that antidepressant prescriptions were a proxy marker for additional psychosocial and pharmacological treatments at the level of the community.

### Canada

Canada is one of the few industrialized nations that does not have a national strategy for the prevention of suicide (Yackel, 2004); however, by the 1990s, there were over 100 community crisis or suicide prevention centers in country, in addition to numerous hospital and community-based mental health programs that also addressed suicide. Many of these programs are established according to the Center for Disease framework (CDC, 1992), and include general education, peer support, means restriction, school and community gatekeeper training, screening, crisis centers, and postvention as core characteristics. This breadth corresponds to the view by most suicide research and prevention experts, that suicide is a multi-determined problem and its prevention must incorporate sociological, psychological, and biological perspectives in order to be successful (Leenaars, 1996).

Although the suicide rate in Canada declined between 1979 and 1998, after 1984 the rate of decline in suicide rates was significantly correlated with the number of suicide prevention centers (Leenaars & Lester, 2004), suggesting that their presence was of benefit to the reduction of suicide rates. A review of the literature on Canadian and United States community prevention programs, however, suggests that despite the proliferation of school-based programs, as well as many community and hospital-based programs, there is no evidence for their effectiveness in reducing suicide (McNamee & Offord, 1994).

### England

Suicide rates in England decreased 14% for males and 22% for females, from 1990 to 1997 (McClure, 2000), and in 2003 suicide rates were at their lowest for both males and females since 1973 (Office for National Statistics, 2003). This decline may be partially attributed to an emphasis on improved services for suicide prevention implemented by the Royal College of Psychiatrists, which included a more proactive stance by care providers and the initiation of suicide and depression prevention programs (McClure, 2000).

Mehlum (2004) suggested that successful community-based approaches in England should be evidence based, include interdisciplinary involvement and cooperation between community authorities, organizations and individuals, and that suicide prevention measures must be specific, practical, and pertinent to the particular population being targeted. Steps indicated as necessary to reduce suicide in England include: 1) increase safety for high-risk groups, particularly persons involved with mental health services, and decrease the number of suicides in

the year following an incident of deliberate self-harm; 2) promotion of mental well-being in the general population; 3) reduction of the availability and lethality of suicide methods; 4) improvement in media reporting of suicidal behavior; 5) promotion of research on suicide and suicide prevention; and, 6) improvement of epidemiological monitoring of suicides.

### United States

Suicide rates for the general population of the United States have fluctuated over the last several decades, with differences in reduction or increase of rates between gender, ethnic and age groups. Overall, the suicide rate decreased 10% between 1990 and 1998 (Kochanek, et al., 2002); however, this is not attributable to any particular suicide prevention effort. Prescption of SSRI antidepressants and other individual groups of antidepressants is associated with decreased suicide rates at the county level, between 1996 and 1998, although collectively antidepressants are not associated with a reduction of suicide rates (Gibbons, Hur, Bhaumik, & Mann, 2005).

In the United States, Middlebrook, et al. (2001) reviewed current youth suicide prevention programs, summarizing their characteristics according to a framework developed by the U.S Department of Health and Human Services Secretary 's Task Force on youth suicide (1989), and found that more successful programs include emphases on: 1) data development; 2) risk factors for youth suicide; 3) evaluation of interventions to prevent youth suicide; 4) suicide prevention services; 5) community information and education; and 6) broader approaches to preventing youth suicide (Duclos & Manson, 1994). Although primarily focused on youth suicide prevention, these observations are useful in understanding necessary components of community -based approaches.

The United States is also host to the largest effective community level intervention effort, the United States Air Force (USAF) suicide prevention program. In 1996, the USAF implemented a community-based prevention program to reduce risk and enhance protective factors, and which included strategies such as: 1) enhancing understanding of mental health in the larger community; 2) decreasing stigma; 3) facilitating help seeking; 4) enhancing social networks. Institutionalization of training and support, as well as changes in policy, helped to ensure the effectiveness of this multi-layered program. After implementation, there was a 33% risk reduction for completed suicide (Knox. et al., 2003).

## Discussion

Suicide is a serious public health problem worldwide and, it is beginning to be similarly recognized in South Korea, a few work has been done to understand and prevent suicide in this country. As rates of suicide in South Korea

continue to rise, it is imperative that data is collected and efforts be made at the individual and community levels, so that more precise treatment programs may be developed.

The suicide prevention movement in South Korea consists of a small number of clinicians and researchers with minimal resources, isolated interest groups, and stand-alone health clinics that approach suicide from either indicated or selected prevention perspectives. Unfortunately, the majority of clinicians, researchers, clinics and, particularly, the general population, are not familiar with the concept of community-based approaches to suicide prevention. We feel that an initial introduction to this perspective and a description of how a community-based approach might be implemented in South Korea is the beginning step toward development of a comprehensive plan of action to prevent suicide in South Korea. This can be more readily accomplished by importing some of the elements, guidelines and frameworks of successful suicide prevention programs from other nations.

In South Korea, clinicians and researchers must essentially start at the beginning, by collecting data on the incidence and prevalence of suicide, on risk and protective factors, and on community attitudes toward mental health and suicide. The establishment of community, as well as nation-wide, data sets to track suicidal activity will provide a more accurate description of the extent of suicide in South Korea, which at this point is likely an underestimate of the true prevalence.

Further, South Korean mental health professionals must begin to develop, test and implement community information and education campaigns and suicide prevention programs. Strategies utilized by other successful prevention programs have included efforts to educate community members on the myths and facts surrounding suicide, the association of stress to suicide, ways in which to recognize warning signs of suicide, how to communicate and offer help to someone who is ing suicidal, and acquainting community members with local support networks and referral sources. Training of community gatekeepers can be an important and helpful strategy, as it provides an early warning system able to detect suicide related behaviors and warning signs at many different levels of the community, such as schools and universities, clinics and hospitals, and community assistanc e agencies.

There are numerous barriers to the implementation of a community-based suicide prevention program in South Korea, not the least of which and, perhaps, the most important, the lack of involvement and integration of the South Korean government in any suicide prevention efforts. The South Korean government's current policy toward mental health, suicide and their treatments are one of detached concern. Continuous governmental interest and support on political, administrative and financial levels are necessary for any

community-based approach to succeed, including the resources and cooperation of ministries, national and regional health institutes, and service agencies, in addition to nongovernmental organizations such as help-lines and psychiatric and psychological associations (WHO, 2002).

Stigma is another significant barrier to an effective suicide prevention program. In South Korea, an understanding of suicide within a cultural context of illness and health, as well as help-seeking, must be developed. We must study attitudes and behaviors towards suicide, at both the individual and community levels, through consulting, stakeholder meeting, focus groups and community education sessions, garnering formal and informal feedback on the knowledge of and attitudes toward suicide in a community, as well as the barriers that prevent community members from seeking or offering help(Capp, et al., 2001).

In conclusion, suicide is a serious public health problem that, in South Korea, is compounded by a lack of enough education regarding suicide, as well as sociocultural stigma about mental health. We have outlined the current state of suicide prevention efforts in South Korea, and the many barriers that make it difficult to address suicide in that country. It is recommended that interested communities, organizations and individuals in South Korea review the community-based suicide prevention strategies that have been successfully implemented in other countries and attempt to apply them to South Korean prevention efforts. Although specific strategies tailored to South Korean societal norms and cultural beliefs can be developed over time, utilization of existing guidelines and ideas will allow the Republic of South Korea to begin serious prevention efforts sooner rather than later.

## References

Arensman, E., Townsend, E., Hawton, K., Bremner, S., Feldman, E., Goldney, R., et al. (2001). Psychosocial and pharmacological treatment of patients following deliberate self-harm: The methodological issues involved in evaluating effectiveness. *Suicide and Life-Threatening Behavior. 31,* 169-180.

Australian Bureau of Statistics. (2003). *Suicides: Recent trends; No. 3309.* Australian Bureau of Statistics, Canberra.

Bostwick, J. M., & Pankratz, V. S. (2000). Affective disorders and suicide risk: A reexamination. *The American Journal of Psychiatry, 157(12),* 1925-1932.

Brent, D. A., Kupfer, D. J., Bromet, E. J., et al. (1988). The assessment and treatment of patients at risk for suicide. In Francis, A. J. and Hales, R. E. (eds). *American Psychiatric Press Review of Psychiatry*, Washington: American Psychiatric Press.

Breton, J. J., Boyer, R., Bilodeau, H., Raymond, S., Joubert, N., & Nantel, M. A. (2002). Is evaluative research on youth suicide programs

theory-driven? The Canadian experience. *Suicide and Life Threatening Behavior, 32(2),* 176-90.

Capp, K., Deane, F., & Lambert, G. (2001). Suicide prevention in aboriginal communities: Application of community gatekeeper training. *Australian and New Zealand Journal of Public Health, 25(4),* 315-321.

Centers for Disease Control. (1992). *Youth suicide prevention programs: A resource guide.* Atlanta, GA: U. S. Department of Health and Human Services, Public Health Services, National Center for Injury Prevention and Control, Epidemiology Branch.

Checkland, P. (1981). *System thinking, system practice.* Chichester, England: Wiley.

Cho J. P. (2003). Suicide in Korea. In L. Vijayakumar (Ed.), *Suicide prevention*-Meeting the challenge together, pp.231-238. Andhra Pradesh, India: Orient Longman.

De Leo, D., & Evans, R. (2003). *International suicide rates: Recent trends and implications for Australia.* Canberra, Australia: Australian Government Department of Health and Ageing.

DuClos, C. W., & Manson, S. M. (Eds.). (1994). *Calling from the rim: Suicidal behavior among American Indians and Alaskanative adolescents* (Vol. 4). Boulder, CO: University of Colorado Press.

Eisenberg, M. S. (1994). Improving out of-hospital resuscitation. *Lancet, 344,* 561 -562.

Eisenberg, M. S., Pantridge, F. J., Cobb, L. A., & Geddes, J. S. (1996). The revolution and evolution of prehospital cardiac care. *Archives of Internal Medicine, 156,* 1611-1619.

Gibbons, R., Hur, K., Bhaumik, D., & Mann, J. (2005). The relationship between antidepressant medication use and rate of suicide. *Archives of General Psychiatry, 62(2),* 165-172.

Glanz, L. M., Haas, G. L., & Sweeney, J. A. (1995). Assessment of hopelessness in suicidal patients. *Clinical Psychology Review, 15,* 49-64.

Goldston, D. B., Daniel, S., Melton, B., Reboussin, D., Kelly, A., & Frazier, P. (1998). Psychiatric disorders among previous suicide attempts, first-time attempters, and repeat attempters on an adolescent inpatient psychiatry unit. *Journal of American Academy Child & Adolescents Psychiatry, 40,* 91-99.

Gould, M. S., King, R., Greenwald, S., et al. (1998). Psychology associated with suicidal ideation and attempts among children and adolescents. *Journal of American Academy Child & Adolescents Psychiatry, 37,* 915-923.

Hammond, W. R. (2001). Suicide prevention: Broadening the field toward a public health approach. Suicide and *Life-Threatening Behavior, 32(supplement),* 1-2.

Hendin, H. (1995). *Suicide in America.* New York: W.W. Norton.

Hun, K. (2004, July 29). *Guidelines for suicide reporting are born.* Chosun Ilbo. Retrieved on 05/10/05, from http://english.chosun.com/w21data/html/news/200407/200407290040.html

Institute of Medicine. (2004). *Reducing risks for mental disorders: Frontiers for preventive intervention research.* Washington, D.C.: National Academy Press.

Jacobs, D. G. (1995). National depression screening

day: Educating the public, reaching those in need of treatment, and broadening professional understanding. *Harvard Review of Psychiatry, 3,* 156-159.

Johannessen, J. O. (1998). Early intervention and prevention in schizophrenia: Experiences from a study in Savager, Norwat, Seishin Shinkeigaku Zasshi. *Psychiatria et Neurologia, 100,* 511-522.

Jorm, A. F. (2000). Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry, 177,* 396-401.

Jorm, A. F., Korten, A. E., Jacomb, P. A., et al. (1997). Mental health literacy: A survey of public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia, 166,* 182-186.

Judy, P. (1999). *Researching health needs: A community-based approach.* London, England: Sage.

Juon, H., Nam, J., & Ensminger, M. (1994). Epidemiology of logy oal behavior among Korean adolescents. *Journal of Child Psychology and Psychiatry, 35,* 663-676.

Kim, Tai-Hun (1990). *Mortality Transition in Korea 1960-1980.* Seoul, Korea: Population and Development Studies Center, Seoul National University.

Kim, H., Chung, W., Song, Y., Kang, D., Yi, J., & Nam, C. (2003). Changes in morbidity and medical care utilization after the recent economic crisis in the Republic of Korea. *Bulletin of the World Health Organization, 81,* 567-572.

Kim, H., Song, Y., Yi, J., Chung, W., & Nam, C. (2004). Changes in mortality after the recent economic crisis in South Korea. *Annals of Epidemiology, 14,* 442-446.

Klassen, T., Mackay, J., Moher, D., Walker, A., & Jones, A. (2000). Community -based injury prevention interventions. *Future Child, 10,* 83-110.

Knox, L. K., Conwell, Y., & Caine, E. D. (2004). If suicide is a public problem, what are we doing to prevent it? *American Journal of Public Health, 94(1),* 37-45.

Knox, K. L., Litts, D. A., Talcott, G. W., Feig, J. C., & Caine, E. D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal, 327,* 1376-1380.

Kochanek, K. D., Murphy, S. L., Anderson, R. N., & Scott, C. (2004). *Deaths: Final data for 2002.* National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120.

Korea Institute for Health and Social Affairs. (2005). *Thirty-five percent of Koreans have considered suicide.* Ministry of Health and Welfare, Republic of Korea.

Lazlo, E. (1972). *The systems view of the world: The natural philosophy of the new developments in the sciences.* New York: G. Thomas.

Lee, C., et al. (2003). A comparative study of the health care delivery system of Korea and Thailand. *Nursing Outlook, 51,* 115-119.

Leenaars, A. A. (1996). Suicide: A multi-

dimensional malaise. *Suicide and Life-Threatening Behavior, 26,* 221-236.

Leenaars, A. A., & Lester, D. (2004). The impact of suicide prevention centers on the suicide rate in the Canadian Provinces. *Crisis, 25(2),* 65-68.

McClure, G. M. G. (2000). Changes in suicide in England and Wales, 1960-1997. *British Journal of Psychiatry, 176,* 64-67.

McNamee, J. E., & Offord, D. R. (1994). Prevention of suicide. In Canadian Task Force on the Periodic Health Examination. Canadian Guide to Clinical Preventive Health Care, 456-467. Ottawa: Health Canada.

Mehlum, L. (2004). A suicide prevention strategy for England. *Crisis, 25(2),* 69-73.

Middlebrook, D. L., LeMaster, P. L., Beals, J., Novins, D. K., & Manson, S. M.(2001). Suicide prevention in America Indian and Alaska Native communities: A critical review of programs. *Suicide and Life -Threatening Behavior, 31 (supplement),* 132 -149.

Moscicki, E. K. (1995). Epidemiology of suicidal behavior. *Suicide and Life-Threatening Behavior, 25,* 22-35.

Motto, J., & Bostrom, A. (2001). A randomized controlled trial of postcrisis suicide prevention, *Psychiatric Services, 52(6),* 828 -833.

National Statistical Office, Republic of Korea. (2009). Vital data. Daejon, Republic of Korea: NSO.

National Statistic Office, Republic of Korea. (2004). Vital data. Daejeon, Republic of Korea: NSO.

Nutbeam, D., Wise, M., Bauman, A., et al. (1993). Goals and targets for Australia's health in the year 2000 and beyond. Canberra: Australian Government Publishing Service.

Office for National Statistics. (2003). Suicide rates in England and Wales, 2000 to 2003. London, England: ONS.

Ono, Y., Tanaka, E., et al. (2001). Epidemiology of suicidal ideation and help-seeking behaviors among the elderly in Japan. *Psychiatry and Clinical Neurosciences, 55,* 605-610.

Organization for Economic Cooperation and Development. (2009). Health Data 2009. Washington, D.C.: OECD.

Pompili, M., Mancinelli, I., & Tatarelli, R. (2003). Stigma as a cause of suicide. *The British Journal of Psychiatry, 183(2),* 173-174.

Paykel, E. S., Hart, D. & Priest, R. G. (1998). Changes in public attitudes to treatment of depression: Result of opinion poll for Defeat Depression Campaign just before its launch. *British Medical Journal, 313,* 858-859.

Reiger, D. A., Hirschfeld, R., Goodwin, F., et al. (1988). The NIMH depression awareness, recognition, and treatment program: Structure, aims and scientific basis. *American Journal of Psychiatry, 145,* 1351-1357.

Rettersol, N. (1995). The national plan for suicide prevention in Norway. *Italian Journal of Suicidology, 5,* 19-24.

Rutz, W., Von Knorring, L., & Walinder, J. (1989). Frequency of suicide on Gotland after systematic post-graduate education of general practitioners. *Acta Psychiatrica Svcandinavica, 80,* 151-154.

Sanddal, N. D., Sanddal, T. L., Berman, A., &

Silverman, M. (2003). A general system approach to suicide prevention: Lessons from cardiac prevention and control. *Suicide and Life-Threatening Behavior, 33(4),* 341-352.

Shneidman, E. (1993). Suicide as psychache. *Journal of Nervous and Mental Disease, 181,* 147-149.

Shin, S., Suh, G., Rhee, J., Sung, J., & Kim, J. (2004). Epidemiologic characteristics of death by poisoning in 1991-2001 in Korea. *Journal of Korean Medical Science, 19,* 186-194.

Silverman, M. M., & Maris, R. W. (1995). The prevention of suicidal behaviors: An overview. *Suicide and Life-Threatening Behavior, 25,* 10-21.

Song, Y., & Byeon, J. (2000). Excess mortality from avoidable and non-avoidable causes in men of low socioeconomic status: A prospective study in Korea. *Journal of Epidemiological Community Health, 54,* 166-172.

Stillion J. M., & McDowell E. E. (1996). *Suicide Across the Life Span,* 2nd ed. Washington, D.C.: Taylor and Francis.

Stone, E. J., Pearson, T. A., Fortmann, S. P., & McKinlay, J. B. (1997). Community-based prevention trials: challenges and directions for public health practice, policy and research. *Annual of Epidemiology, 7,* 113-120.

Suk, Jae-Ho. (1992). Suicidal behavior in Korea. In Kok Lee Peng & Wen-Shing Tseng (eds.) Suicidal Behaviour in the Asia-Pacific Region, 41-57. Singapore: Singapore University Press.

Suwon Safe Community Council. (2003). Application to become a member of the Safe Community Network. Retrieved on 05/08/05, from http://www.phs.ki.se/csp/ safecom/suwon.htm

Tadros, G., & Jolley, D. (2001). The stigma of suicide. *The British Journal of Psychiatry, 179,* 178.

Teenscreen. (2004). *Adolescent suicide and mental health screening programs.* Retrieved on 05/11/05, from http://www.teenscreen.org

Upanne, M., Hakanen, J., & Rautava, M. (1999). Can suicide be prevented? The suicide project in Finland 1992-1999: Goals, implementation and evaluation. Helsinki: STAKES National Research and Development Centre for Welfare and Health.

U. S. Public Health Service. (1999). The Surgeon General's call to action to prevent suicide. Washington D.C.: U. S. Department of Health and Human Services.

Varnik, A. (1998). Suicide in the former republics of the USSR. *Psychiatric Fennica, 29,* 150-162.

World Health Organization. (2001). The world health report. Geneva.

World Health Organization. (2002). Suicide prevention in Europe. Geneva.

World Health Organization. (2003). World Report on Violence and Health. Geneva.

Yackel, D. (2004). Canada needs a national strategy for suicide prevention. Published excerpts from an invited presentation to The Standing Committee on Social Affairs, Science and Technology. Ottawa, Canada: Centre for Suicide Prevention.

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# 한국의 자살예방을 위한 지역공동체 접근

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본 논문에서는 자살예방을 위한 지역공동체 기반의 접근과 자살률 감소를 위한 국가전략에 대해 고찰하고 한국에서의 자살감소를 위한 제안을 하였다. 한국의 경우 여전히 자살의 이해와 예방에 대한 노력은 정신과의사, 심리학자, 정신건강관련기관, 개인기관 등과 같은 특수한 목적을 가진 집단에 의해 상호협조 없이 단독으로 이루어지고 있으며, 각 집단이 개별적으로 활동하고 있기 때문에 궁극적으로는 자살예방에 있어서 별다른 효과가 나타나지 않고 있는 상황이다. 한국에서의 자살을 예방하고 감소시키기 위해서, 지역공동체의 구성원들은 자살과 관련된 충분한 지식을 갖고 다른 영역의 전문가나 기관들과 적극적으로 협력해야 한다. 이러한 노력을 통해, 지역공동체는 정신건강을 증진시킬 수 있는 네트워크를 구축할 수 있게 된다. 자살을 예방하고 자살률을 감소시키는 가장 중요한 요소는 자살과 정신건강에 대한 오명을 제거하고, 도움추구 행동을 증가시키는 것이다. 자살은 자살하려는 사람이 해결할 수 있는 개인적인 문제가 아니라 자살의 인식, 관리 및 예방에 있어 지역공동체가 해결해야 되는 지역공동체의 문제다.

주요어 : 자살, 자살예방, 지역공동체 기반의 접근, 안전네트워크