Review Article

Psychiatry in South Korea

Seon-Cheol Park, M.D., Ph.D.[1,2]*

[1]Department of Psychiatry, Hanyang University College of Medicine, Seoul, [2]Department of Psychiatry, Hanyang University Guri Hospital, Guri, Korea

Abstract

Background: Although the history of psychiatry has been relatively short, psychiatry has been progressively developed through Westernization to assimilate into the psychiatric practices and research of developed countries. Psychiatry in South Korea has followed the above-described rule. In this review, I am describing the picture of psychiatric practice in South Korea for the readership of *the Taiwanese Journal of Psychiatry*. **Methods:** In this review, I am planning to introduce a brief history of psychiatry in South Korea first, to describe the current status of mental health-care services, and to highlight special programs to deal with special psychiatric issues in South Korea. **Results:** A three-layer hierarchical system (including [a] the Ministry of Health and Welfare, [b] the Metropolitan City or Province, as well as [c] the City, County, or District), has been organized in South Korea. With the complete revision of *the Act on Mental Health and Welfare* in 2016, the processes and requisites of psychiatric hospitalization or admission have been complicated. As a result, based on the Penrose hypothesis, deinstitutionalization has been regarded as one of the causative factors for "trans-institutionalization." Thus, it has been suggested that the policies for the treatment and prevention of psychiatric persons should be controlled at a national level. South Korea has presented herself to have the highest suicide death rate in 2021 among the Organization for Economic Cooperation and Development (OECD) countries. Hence, "Suicide CARE" has been originally developed as a gatekeeper program in Korea. Furthermore, the economically weak have undergone more severe psychiatric difficulties, even after the COVID-19 pandemic. Thus, proactive care measures to secondary emotional reaction of the COVID-19 pandemic have been required in Korea. Finally, renaming the Korean terms for terminology in psychiatry, epilepsy, and schizophrenia has been done in an attempt to reduce stigma associated with persons of the mentally ill and denote more essential characteristics of mental health fields. Furthermore, it is expected that the detailed description of anger syndrome and fear of interpersonal relationship can enrich the cultural conceptualization of distress in *the DSM-5*. **Conclusion:** Despite existences of several problems of the mental health-care system, psychiatry has been progressively developed and steadily established its own originality in South Korea.

Key words: COVID-19 pandemic, mental health, stigma, suicide
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Introduction

South Korea (Republic of Korea) is located in the southern portion of the Korean Peninsula in East Asia (Figure 1). South Korea shares a national land border with North Korea (Democratic People's Republic of Korea) to the north, and another national sea border with China and Japan, to the west and to the east, respectively. A three-year Korean War began in 1950 when the armed forces of North Korea attacked South Korea. As a result, the division between South and North Korea has continued. Over the past several decades, rapid and vigorous social, economic, and political changes have occurred in South Korea. South Korea's agrarian society in the 1960s and the 1970s was converted into an industrial society in the 1980s, followed by an information society in the 1990s. This paper is planning to review the brief history of psychiatry and to update the current status of psychiatric practices and mental health-care services in South Korea [1].

Brief History of Psychiatry in South Korea

As an ancient history book of Korea described that bitter but good advice can cure man's anxiety in A.D. 630 [2], the Korean traditional culture could have an abundant background for psychiatric care. But in modern psychiatry

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[1]*Corresponding author. 153, Gyeongchun-ro, Guri, Gyeonggi 11923, South Korea.
E-mail: Seon-Cheol Park <psc76@hanyang.ac.kr>

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Figure 1. A map of Republic of Korea (Political Map of the Republic of Korea (South Korea) - Nations Online Project).

in Korea, the history has been rather short [3]. Its impacts were not significant in Korea in the 18th century, although Galen's neuroanatomical and neurophysiological theory that had been introduced and quoted by a scholar of the Realist School of Confucianism, being questioned the scholars of the Conservative School of Confucianism the mind–body theory of Korean folk medicine [4, 5].

The dawn of modern psychiatry in Korea began in the late 19th century [6]. In 1886, *Jaejungwon*, which was the first Western medical institution in Korea, published an annual report of clinical practice patterns for diseases of the nervous system, including diagnoses of chorea, delirium tremens, hysteria, globus hystericus, idiocy, insanity, mania, dementia, melancholy, and insomnia [7]. In 1910, the first lecture on "mental diseases" in Korea was given at Daehan Hospital, a modern hospital founded by the order of the emperor of the Korean Empire in 1907.

In 1913, the first psychiatric ward and department of psychiatry in a modern hospital of Korea were established during the forced Japanese annexation of Korea [8]. In 1913, Charles Inglis McLaren (1882–1957), a medical missionary from the Australian Presbyterian Church, started to give lectures on psychiatry and neurology at Severance Union Medical School, and continued to deliver lectures on psychiatry and neurology as well as treating psychiatric and neurological patients [9, 10]. The Korean people, who had superstitious beliefs about mentally ill persons, accepted the relatively modern approach to treat the patients [5].

In September 1945, the Korean Neuropsychiatric Association (KNPA) was first founded among several academic meetings of special clinical medicine in Korea. At that time, the KNPA was composed of about 20 members, limited to internists and psychiatrists. In 1950, the Korean War had devastating consequences and offered the opportunity to

advance psychiatry in South Korea. Many young psychiatrists recruited as military medical officers visited military hospitals in the United States of America during the war. The first returning group of Korean civilian psychiatrists who had been in the United States for residency training and further study after serving military duties became forerunners of contemporary Korean psychiatry. Thus, education and training in psychiatry in South Korea have changed from a German to an American psychiatry-based system [6]. In 1953, the first psychoanalytic psychotherapy in South Korea was given to a patient with a psychogenic headache [11]. In 1955, antipsychotic drugs, including reserpine and chlorpromazine, were introduced into psychiatric practice in Korea [12].

Psychiatry in Korea has progressed through Westernization and modernization to catch up with and to assimilate psychiatry in developed countries. Based on the influences of the indoctrinated circumstances of psychoanalytic psychiatry in the U.S. at the end of World War II, the first-generation psychiatric group in South Korea principally studied psychodynamic psychiatry. In the 1970s, psychotherapy and cultural psychiatry in South Korea contributed to the establishment of related academic meetings, including the Korean Academy of Psychotherapists (1974), the Korean Society for Analytical Psychology (1978), and the Korean Association of Psychoanalysis (1980). In the 1980s, progress in biological psychiatry was started in South Korea owing to the influence of biology-based research in psychiatry in the U.S. [5, 6]. In the 1990s, biological psychiatry was developed with the evolution of basic science, including molecular biology, genetics, electrophysiology and neuroimaging, as well as the introduction of various diagnostic and treatment skills in South Korea. Thus, neuroimaging, genetics, and other psychiatric disciplines are being actively investigated. In the 2020s, digital health care, virtual care, and ecological momentary assessment with digital phenotype have been studied in the realm of psychiatry in South Korea.

Mental Health Service System

Since the enactment of *the Mental Health Act* in 1995, mental health services have advanced in South Korea. Under the influence of legislation, the focus on mental health services has shifted from institutionalization- to community-based mental health care, which stressing psychosocial rehabilitation for the patients [13]. Consistent mental health-care planning at the national level was supported by *the Amendment of the Mental Health Act*, in which central and local governments regulate the establishment of mental health service plans every five years. Mental health promotion services include treating psychiatric illnesses in mental medical institutions, community-based psychosocial rehabilitation, and housing, occupational, and economic support. Treatments in mental health institutions include psychiatric examinations, drug treatment, and rehabilitation conducted by national, public, and private mental health institutions. In addition, community-based psychosocial rehabilitation includes the management of chronic persons of the mentally ill and prevention of mental health problems in the general population. As shown in Figure 2, mental health service delivery in South Korea is organized in three hierarchical systems: (a) the Ministry of Health and Welfare, (b) the Metropolitan City or Province, and (c) the City, County, or District.

According to the 2021 National Mental Health Statistics [14], between 2017 and 2021, the total number of mental health institutions was increased 1.31-fold (from 1554 to 2,038), the total number of psychiatric hospital beds was decreased 0.92-fold (from 81,734 to 75,474), and the total number of inpatients was decreased 0.88-fold (from 67,441 to 58,412, Figure 3). But the number of psychiatric hospital beds per 1000 persons was increased 1.05-fold (from 1.18 to 1.24) between 2014 and 2019. Moreover, the number of psychiatrists per 1,000 persons was increased 1.14-fold (from 0.07 to 0.08) between 2014 and 2020. By the end of 2013, mental medical institutions consisted of 247 mental hospitals, 388 hospitals with mental health units (218 general hospitals and 70 hospitals), and 1494 psychiatric clinics. In addition, the community rehabilitation centers consisted of 346 social rehabilitation facilities, 260 mental health welfare centers (16 regional, 244 local), 50 addiction management centers, and 6 suicide prevention centers. As of 2021, the total number of people using mental health welfare centers and addiction management centers was 79,446 and 7, 636, respectively. The numbers of lifetime and one-year prevalence of mental disorders have been reported to be 27.8% and 8.5%, respectively. In 2021, the population of South Korea was 51,301,193.

Involuntary Hospitalization or Admission

The Mental Health Act, enacted in 1995, included involuntary hospitalization or admission with the receipt of

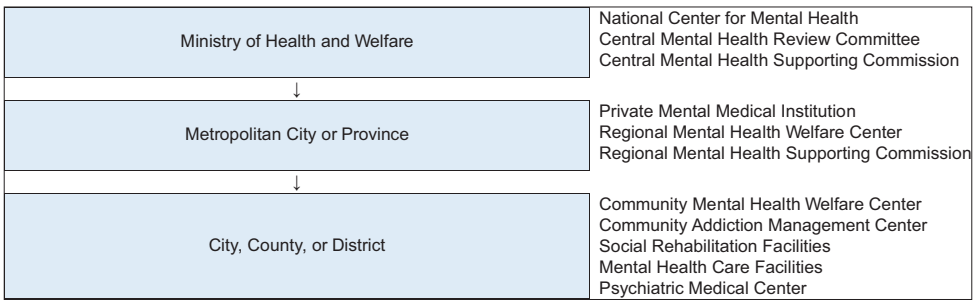

Figure 2. Mental health service delivery system in Korea.

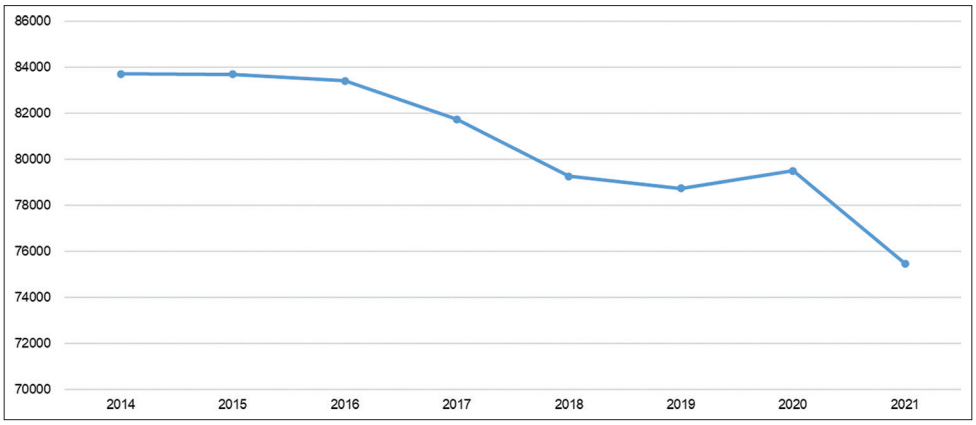

Figure 3. Total number of psychiatric hospital beds from 2014 to 2021.

an application from one legal guardian. But with increased concern about human rights in South Korea society, issues of involuntary admission or admission processes and prerequisites have been continually raised. In 2016, the clause on involuntary hospitalization or admission of *the Mental Health Act* was decided as "uncomfortable to constitution" by the Constitutional Court of in South Korea.

After the complete revision of the *Act on the Improvement of Mental Health and the Support for Welfare Services for Mental Patients* (abbreviation: *Act on Mental Health and Welfare*) in 2016, the prerequisites for involuntary hospitalization or admission of a patient with mental illness have become stricter and more rigorous. Table 1 summarizes the types of psychiatric hospitalizations or admissions under *the Act on Mental Health and Welfare* in South Korea. These are mainly divided into voluntary and involuntary hospitalizations. The processes and prerequisites have become more complicated in all types of hospitalization or admission of the mentally ill than before the 2016 revision. Most importantly, in terms of hospitalization with legal guardians, receiving an application from two or more legal guardians but not one guardian (before the complete revision of *the Act on Mental Health and Welfare* in 2016) is inevitably required. A legal guardian of the mentally ill denotes a guardian or a person under duty to provide support under the Civil Act in South Korea. It also requires a psychiatrist's diagnostic decision that a person suffers from a psychiatric disorder to require hospitalization or admission at a mental medical institution or mental health sanatorium and has a likelihood to harm their health or safety or that of another person. In addition, continuous hospitalization or admission can be conducted under a consensus between two or more psychiatrists who work for different mental institutions within a specific initial hospitalization period not exceeding two weeks. Furthermore, by the hospitalized or admitted person's intention to apply for a direct investigation, the "Committee for Examination" as to Legitimacy of Admission examines whether the case of hospitalization or admission is legitimate. Upon noticing the illegitimacy of hospitalization by the Committee, the head of a mental health institution or mental health sanatorium should promptly notify the person. The Committee consists of members including psychiatrists, judges, public prosecutors, licensed attorneys-at-law, mental health professionals who work for mental health welfare centers, family members of the mentally ill, and others. As shown in Table 1, despite several specific differences, other types of involuntary hospitalizations or admissions, including hospitalization with consent; hospitalization with a Special Self-governing City Mayor, Special Self-governing Province Governor, or head of City, County, or District; and emergency hospitalization, have shared the processes and prerequisites of hospitalization with legal guardians.

The complete revision of *the Act on Mental Health and Welfare* in 2016 has the following problems:

First, in South Korea, the Penrose hypothesis can be actualized that, although psychiatric rehabilitation institutions or residential facilities are insufficient for the the mentally ill in the community society, the enactment of deinstitutionalization contributes to an increased number of homeless people and inmates at correctional institutions [15]. Thus, deinstitutionalization is sometimes regarded as one of the several factors that can induce "trans-institutionalization." In Korea, the total number of psychiatric beds in 2017 was decreased by 23.5% compared to that in 2011, whereas the number of inmates at correctional institutions in 2017 was increased by 35.2% compared to that in 2011. Unfortunately, two psychiatrists died from accidents associated with the the mentally ill in 2018 and 2020 [16]. Those tragedies impacted in South Korea society, and psychiatrists requested a complete revision of *the Act on Mental Health and Welfare* to provide adequate treatment for the mentally ill. But no revisions to the Act have been implemented in South Korea.

Second, the Committee of the Rights of People with Disabilities in the United Nations (UN) has recommended abolishing hospitalization with legal guardians, an alternative decision-making system for involuntary hospitalization. In clinical practice, to define the appropriateness of legal guardians for the mentally ill is difficult. In addition, as the order of priority for legal guardians has not been defined by the Civil Act, it may be defined by legal decisions of the Court of Family Affairs in South Korea. In the absence of documentary evidence from legal guardians, involuntary hospitalization or admission is

Table 1. Types of the psychiatric hospitalization or admission under the *Act on the Mental Health and Welfare* in South Korea

	Psychiatric evaluation	Consent of the legal guardian(s)	Specific hospitalization period
Voluntary hospitalization	A mentally ill person or other person who has a mental disorder	Not required	A prompt discharge upon receipt of an application for discharge from a person who has been voluntarily hospitalized and an inability to be continuously hospitalized with another type of hospitalization or admission
Hospitalization with consent†	An application for hospitalization with the head of the mental medical institution	Consent of the legal guardian	A prompt discharge upon receipt of an application for discharge from a person who has been voluntarily hospitalized or an ability to refuse to honor the application for discharge for not exceeding 72 hours
Hospitalization with legal guardians‡	A psychiatrist's diagnosis that the mentally ill person meets each of the following criteria: (i) where a mentally ill person suffers a mental disease of a degree or nature requiring hospitalization or care at a mental medical institution; (ii) where a mentally ill person needs hospitalization or admission because the person is likely to harm their own health or safety or that of another person	Receipt of an application from two or more legal guardians	A specific period not exceeding two weeks A following continuous hospitalization with a consensus among two or more psychiatrists who work for different mental medical institutions or a prompt discharge
Hospitalization with Special Self-Governing City Mayor, Special Self-Governing Province Governor, or head of City, County, or District	A psychiatrist's discovering that it is necessary to examine in more detail a person who is suspected to be mentally ill, because of the person's likelihood to harm his or her own health or safety or that of another person.	Request of Special Self-Governing City Mayor, Special Self-Governing Province Governor, or head of Si, Gun, or Gu	A specific period not exceeding two weeks. Following continuous hospitalization with a consensus among two or more psychiatrists who work for different mental medical institutions or a prompt discharge
Emergency hospitalization†	A person discovering any person presumed to be mentally ill and highly likely to harm themselves, risking their own health or safety or that of another person, lacks time to hospitalize the person in a mental medical institution.	Consent of a medical doctor and a police officer	A period not exceeding three days (excluding holidays) A continuous hospitalization with another type of hospitalization or admission (i.e., voluntary hospitalization, hospitalization with legal guardians, hospitalization with Special Self-Governing City Mayor, Special Self-Governing Province Governor, or head of Si, Gun, or Gu) or a prompt discharge

†Involuntary hospitalization or admission

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unacceptable, regardless of patients' severity level of delusion, hallucinations, or other symptoms and the likelihood of harming their health, safety, or other symptoms. Problematic discrepancies between *the Act on Mental Health and Welfare* and clinical psychiatric practice have frequently been observed.

Therefore, to get a compromise plan among self-determination for persons of the mentally ill is needed to protect the rights to treatment and social safety in making an option substituting for the current processes and prerequisites for involuntary hospitalization or admission in Korea. The options substituting for involuntary hospitalization have five choices [16]:

- to unify the diverse types of involuntary hospitalization or admission is needed under the regulation of a judging committee.
- to reject the processes of involuntary hospitalization or admission, which are mainly dependent on the social burden of legal guardians.
- to regulate the involuntary hospitalization of admissions is needed based on the decisions of a nationally organized agency.
- to legally establish psychiatric beds for the acute phase of mental illness is needed to overcome the limitations of current processes and prerequisites for emergency hospitalization or admission.
- to widely accept that the nation, but not the legal guardian can order the subject of treatment and protection for mentally ill persons in Korean society.

"Suicide CARE" as the Gatekeeper Training Program

As shown in Figure 4, Korea has reported 24.1 suicide deaths per 100,000 persons, the highest rate in 2021 or the latest available data among OPED countries. Therefore, suicide is the most important public mental health concern in South Korea. Between 2012 and 2021, the age-standardized suicide rate per 100,000 persons per year in South Korea ranged from 24.3% to 28.5%, which was much higher than the average rate of 10.7 among OECD countries in 2021 (Figure 5). Between 2012 and 2021, the total number of suicide completions per year ranged from 12,463 to 14,427. The "National Suicide Prevention Action Plan" of the Ministry of Health and Welfare of South Korea was established in 2022, to decrease the suicide rate to less than 20 per 100,000 persons per year and total completed suicides of <10,000 persons per year.

The psychological autopsy interview report between 2015 and 2018 [17], published by the Korea Psychological Autopsy Center, presented the characteristics of 391 Korean suicide completers based on interviews with their family survivors. Among 391 suicide completers, 92.3% reported warning signals before suicide completion, whereas 6.1% did not report any warning signals. In addition, 1.5% of respondents were unaware of any warning signals. Of the 361 suicide completers reported reporting some warning signs, including alterations in verbal expression, behaviors, and emotions before death, 77.0% of them had not recognized them, whereas only 20.5% did. The psychological autopsy interview reports have classified suicide warning signals into two groups: verbal/behavioral and situational. First, descriptive analyses of the verbal/behavioral signals of 249 suicide completers were conducted. The verbal signals have been classified into seven categories, including frequent mentions of suicide, homicide, or death (52.2%), somatic complaints (48.2%), expression of self-criticism (42.6%), questioning on how to commit suicide (12.0%), writing about death in letters, notes, or others (16.1%), expression of longing for the afterlife (12.0%), and talking about people who committed suicide (7.6%). The behavioral signals have been classified into 11 categories, including alterations in sleep (65.9%), alterations in appetite (53.4%), decreased concentration or indecisiveness (32.9%), indifference to appearance management (32.9%), disposing of the belongings (30.1%), self-destructive behaviors or substance abuse (25.3%), striving to improve interpersonal relationships (18.1%), planning suicide (17.3%), aggressive or impulsive behaviors (17.3%), giving others the things they usually valued (7.6%), and excessive collecting of poems, music, and movies related to death (12, 4.8%). Second, descriptive analyses of situational signals were conducted for 103 suicide completers. The situational signals for suicide were classified into eight categories: mental health problems (84.5%), occupational stress (68.0%), economic problems (54.4%), family-related stress (54.4%), interpersonal relationship-related stress (38.8%), spousal stress (34.0%), physical health problems (33.0%), lover-related stress (13.6%), and learning-related stress (13.6%). In life cycle classification, the suicide warning signals of young adults are related to learning, family- and lover-related stress, loneliness, and the absence of close relationships. In addition, middle-aged adults' warning signals are related to associate with economic stress and debt problems. Finally, the warning signals of the elderly included chronic physical diseases, unspecified somatic symptoms, and the absence of interpersonal relationships. As shown in Figure 6, based on the findings, the three pathways to suicide completion for job seekers, self-employed persons, and retirees have been conceptualized to enhance the understanding of suicide completers.

Based on psychological autopsy interview reports from 2015 to 2018 [18], a standardized suicide prevention program for gatekeeper intervention was originally developed in Korea since the gatekeeper training program has been regarded as an evidence-based suicide prevention strategy. As shown in

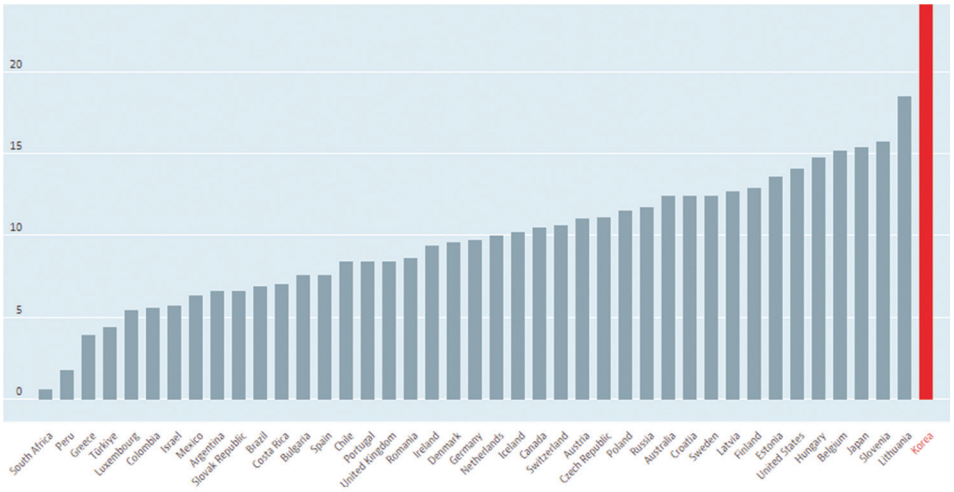

Figure 4. Suicide rates per 100,000 persons among OECD countries. Adapted from OECD data. Suicide rates per 100,000 persons, 2021 or latest available (Internet). Paris: Organization for Economic Cooperation and Development (OECD); c2023, according to the Creative Commons license.

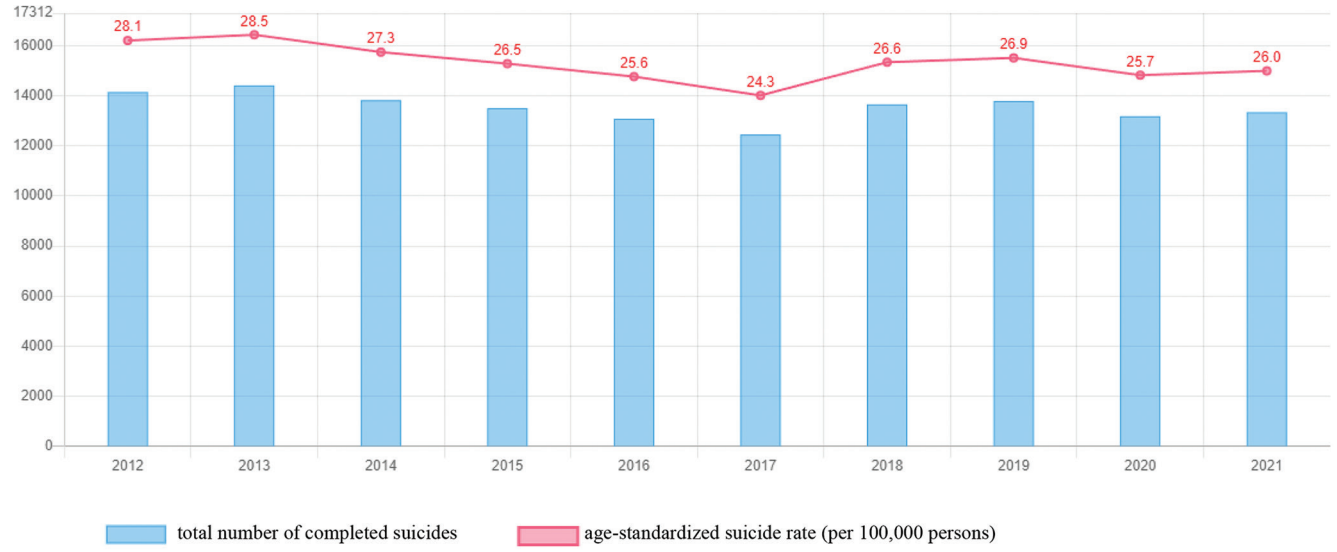

Figure 5. Suicide status over the past 10 years. Adapted from the Korean Foundation for Suicide Prevention. Suicide status over the past 10 years (Internet). Seoul: Korea Foundation for Suicide Prevention; c2023, according to a Creative Commons license.

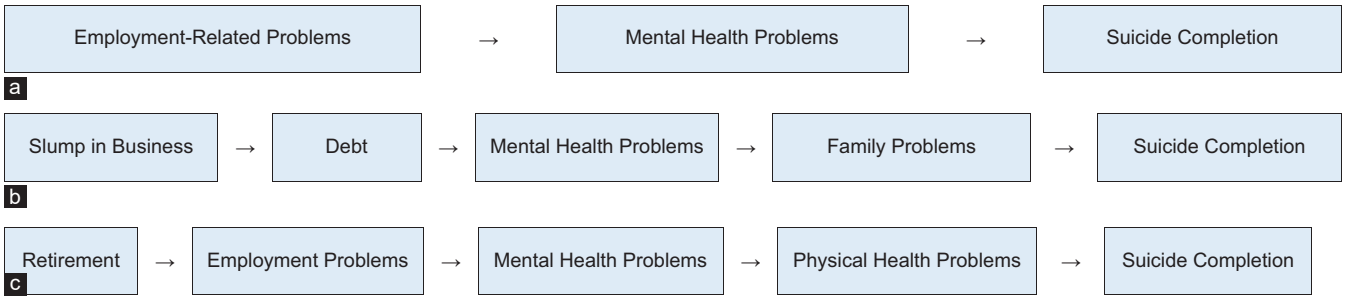

Figure 6. Pathways to suicide completion. Adapted from Park et al., 2020, with permission to reprint from Korean Neuropsychiatric Association. (a) Pathway of job seekers to suicide, (b) Pathways for self-employed persons leading to suicide, (c) Pathways of retirees to suicide [18]. These pathways were proposed based on psychological autopsy interview reports collected between 2015 and 2018.

Figure 7, the gatekeeper training program has been popularly referred to as "Suicide CARE" (meaning careful observation, active listening, risk evaluation, and expert referral). "Suicide CARE" provides guidelines regarding gatekeeper interventions for people at high risk of suicide. In addition, the program has been divided into three parts according to the name: "Careful observation" covers the detection of verbal and nonverbal signals of suicidal intent [18, 19]. "Active listening" is to hear the cause of suicidal intention, and "Risk evaluation and Expert referral" involve referring suicidal persons to psychiatric professionals. In addition, based on the three pathways to suicide completion, "Suicide CARE" has been distinctively specified by the three age groups, including young-aged, middle-aged, and old-aged adult groups. It is the specialized versions that have also been developed for soldiers, firefighters, teachers, middle and high school students, and North Korean defeaters [20, 21]. Any person can complete the "Suicide CARE" free of charge through the education program of the community mental health welfare centers. The instructors are mental health professionals with more than two years of suicide prevention work experience. Instructors are provided with instructor manuals with detailed content information, and gatekeepers were provided with workbooks, video clips, and role plays. By 2019, 1.2 million persons had completed the "Suicide CARE" program. It is expected that more popular use of "Suicide CARE" can reduce the suicide rate in South Korean society.

Mental Health-care Measures during the COVID-19 Pandemic

After the spread of COVID-19 from Wuhan, China, to South Korea by a patient was first reported, community-based spread occurred in Korea. It has been suggested that confirmed and suspected patients with COVID-19 may fear the consequences of this infection. Furthermore, quarantined individuals may experience boredom, loneliness, and anger. Infectious disease outbreaks commonly cause anxiety, fear, uncertainty, and stigmatization, which medical and psychiatric treatments can prevent or minimize [22, 23]. The "primary emotional reaction" during the COVID-19 pandemic could be regarded as the fear or anxiety of the physical disease itself or the "contagion" myth directly related to infectious

Figure 7. "Suicide CARE" as an evidence-based gatekeeper training program in Korea. Adapted from the Korea Association for Suicide Prevention. "*Suicide CARE, Version 2.0*." Seoul: Korea Association for Suicide Prevention; c2020, according to a Creative Commons license. The Korean characters refer to careful observation, active listening, risk evaluation, and expert referrals.

diseases. It is presumed that this primary emotional reaction might have been shared worldwide during the pandemic. In primary emotional reactions, mental health care should focus on patients in isolation, individuals in quarantine, and health-care workers who treat patients with COVID-19 infection. The care for the primary emotional reaction to COVID-19 is relatively well prepared and provided in South Korea. National hospitals and mental health welfare centers across the country were prepared to provide mental health-care services to individuals in isolation or quarantine because of the COVID-19 outbreak. In addition, leaflets promoting mental health care related to distress due to the infectious disease pandemic were distributed by the National Center for Disaster Trauma. The "secondary emotional reaction," beyond the anxiety of the physical disease or the contagion myth, might be considered the other psychological consequence of the COVID-19 pandemic [24, 25]. The secondary emotional reaction may involve an indirect psychological response to the COVID-19 pandemic, showing the public's repressed emotional problems that might be deeply influenced by specific sociocultural factors.

About 25% of the workers in South Korea are self-employed, which is much higher than the figure of 15% in OECD countries. Even after the end of the COVID-19 pandemic, most self-employed workers in South Korea experienced severe economic difficulties. The difficulties the economically weak population faced in South Korea worsened during the COVID-19 outbreak. Based on previous findings, Korea tends to experience increased suicide rates during crises like the 1997 financial crisis. As mentioned previously, the psychological autopsy interview reports have shown that economic problem is the main cause of stress for more than 60% of suicide completers. Furthermore, the unemployment rate and income inequality are proportional to the suicide rate. Most importantly, economic problems greatly affect suicide among older adults. Even after the COVID-19 pandemic, to strengthen the social welfare support system and suicide prevention programs is necessary for the economically weak [26, 27].

Renaming the Korean Terms for Psychiatry, Epilepsy, and Schizophrenia

As a way to reduce the stigma of psychiatry and persons of the mentally ill, the South Korean terms for psychiatry, epilepsy, and schizophrenia were renamed in the last few years [28]: Most of all, the Korean term for psychiatry, which denotes "*shin-eui-hak* (medicine of mental health)," was sometimes mistaken for "the field for treating insane people." Thus, the South Korea Neuropsychiatric Association changed the term for psychiatry into the new name, which reflected "*jung-shin-geon-gang-eui-hak* (medicine of mental health promotion and wellbeing)," in 2010. The renaming has been aimed at reducing the negative connotations related to the South Korea term for mind or spirit (*jung-shin*) and denoting a paradigm shift from symptomatic management to mental health promotion in psychiatry [29-31].

In addition, the Korean Epilepsy Society and Korean Epilepsy Association renamed the Korean term for epilepsy from "*gan-jil* (sometimes mistaken for insanity)" to "*noi-jeon-jeung* (cerebroelectric disorder)" in 2010 to reflect the essence of the disease pathogenesis and reduce the stigma associated with epilepsy [32, 33].

Finally, the Korean Neuropsychiatric Association and Korean Society of Schizophrenia Research changed the Korean term for schizophrenia from "*jung-shin-bun-yeol-byung* (mind splitting disorder)" to "*jo-hyeon-byung* (attunement disorder)" in 2011. *Jung-shin-bun-yeol-byung* refers to the Korean pronunciation of "*seshin-bunretsu-byo*," which was approved as a formal Japanese translation for schizophrenia in 1937 by the Japanese Society of Psychiatry and Neurology. In 2002, *seshin-bunretsu-byo* was renamed "*togo-shitcho-sho* (integration disorder)." *Jo-hyeon* is quoted from a Korean Buddhist text that "studying is similar to tuning the string instrument, in which tightness and looseness should be balanced." Thus, using *jo-hyeon-byung*, schizophrenia has been metaphorically defined as "a disease characterized by inadequate tuning of the neural network." Furthermore, attunement disorder, the English translation of *jo-hyeon-byung*, denotes the disintegration of intersubjectivity and confusion regarding the certainties of the self and the world from the viewpoint of phenomenological psychopathology [34-36]. In addition, in 2012, using *jo-hyeon* as a prefix, the Korean terms for schizophreniform disorder, schizoaffective disorder, schizotypal (personality) disorder, and schizoid personality disorder changed [37]. It can be concluded that renaming the

Korean terms for psychiatry, epilepsy, and schizophrenia has commonly been aimed at reducing the social stigma associated with psychiatric and neurological disorders and reflects the essential characteristics of the mental health field or disease pathogenesis. Moreover, since renaming the Korean term for dementia (*chi-mae*) is being discussed by academic societies, several alternative terms have been suggested.

Korean Contributions in *DSM-5*

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (*DSM-5*), emphasizes the cultural conceptualization of distress with reference to Korea [38, 39]. As shown in Table 2, South Korea has been mentioned five times in *DSM-5*. "*Hwa-byung* (anger syndrome)" and "*taein-kong-po* (fear of interpersonal relations)" were introduced in the section on cultural concepts of distress.

First, in *DSM-5*, *hwa-byung* is predominantly regarded as one of the *khyâl cap* (wind attack)-related conditions in other cultural contexts, whereas the clinical characteristics of *hwa-byung* have not been described at all. *Hwa-byung* has been prevalent among older married women and etiologically associated with anger repression arising from familial conflicts attributed to the patriarchal Korean social system. But *hwa-byung* has merely been used as a folk term to describe the "consequences of repressed anger or accumulated rage and sorrow." But it has been discussed that its uniqueness is not sure about "a culture-bound syndrome specific to Korean culture [40-43]." "*Shin-byung* (divine illness)" has been listed as a culture-bound syndrome in *DSM-IV*, whereas it has been excluded from *DSM-5*. Along with the change, few Korean patients present themselves with "dissociation and possession by ancestral spirits," or *shin-byung* [44]. Second, the translated Chinese term for fear of interpersonal relationships is pronounced differently in Korean (*taein-kong-po)* and Japanese (*taijin-kyofusho)*. An offensive subtype of *taein-kong-po* (*taijin-kyofusho*) had initially been defined as a "Japanese culture-specific diagnostic label" and has been clinically characterized by the fear of offending others or making them uncomfortable by staring inappropriately, making rude and improper facial expressions. It has been proposed that the offensive version of *taein-kong-po* is not a culture-bound syndrome [45-47]. Third, Internet addiction is regarded as one of the most serious public mental health problems among South Korean children aged 6–19 years because of its high prevalence and association with pharmacotherapy and/or hospitalization. An epidemiological study reported that patients with Internet gaming addiction in South Korea are characterized by high frequencies of suicidal ideation, planning, and attempts [48-51]. A detailed description of *hwa-byung*, *taein-kong-po*, and Internet gaming disorders in South Korea may enrich the cultural conceptualization of distress in *DSM-5* [52].

Conclusion

Although Korean traditional culture has been suggested to have a background for psychiatric care, history of modern psychiatry is relatively short. After division of South and North Korea, psychiatry in South Korea has been progressively developed through Westernization and modernization to assimilate the psychiatry of developed countries. Thus,

Table 2. Korean contributions in *DSM-5*

Page	Diagnosis or Chapter	Content
p. 205	Social anxiety disorder	"The syndrome of *taijin kyofusho* (e.g., in Japan and 'Korea') is often characterized by social-evaluative concerns, fulfilling criteria for social anxiety disorder, that are associated with the fear that the individual makes *other* people uncomfortable (e.g., "My gaze upsets people so they look away and avoid me"), a fear that is at times experienced with delusional intensity."
p. 495	Alcohol use disorder	"Polymorphisms of genes for the alcohol-metabolizing enzymes alcohol dehydrogenase and aldehyde dehydrogenase are most often seen in Asians and affect the response to alcohol. When consuming alcohol, individuals with these gene variations can experience a flushed face and palpitations, reactions that can be so severe as to limit or preclude future alcohol consumption and diminish the risk for alcohol use disorder. These gene variations are seen in as many as 40% of Japanese, Chinese, 'Korean,' and related groups worldwide and are related to lower risks for the disorder."
p. 797	Internet gaming disorder	"The prevalence of Internet gaming disorder is unclear because of the varying questionnaires, criteria and thresholds employed, but it seems to be highest in Asian countries and male adolescents 12-20 years of age. There is an abundance of reports from Asian countries, especially China and 'South Korea,' but fewer from Europe and North America, from which prevalence estimates are highly variable. The point prevalence in adolescents (ages 15-19 years) in one Asian study using a threshold of five criteria was 8.4% for males and 4.5% for females."
p. 834	Cultural concepts of distress: *Khyâl Cap*	"Related conditions in other cultural contexts: Laos (*pen lom*), Tibet (*srog rlunggi nad*), Sri Lanka (*vata*), and 'Korea (*hwa byung*).'"
p. 837	Cultural concepts of distress: *Taijin Kyofusho*	"The distinctive symptoms of *taijin kyofusho* occur in specific cultural contexts and, to some extent, with more severe social anxiety across cultures. Similar syndromes are found in 'Korea' and other societies that strongly emphasize the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. *Taijin kyofusho-like* symptoms have also been described in other cultural contexts, including the United States, Australia, and New Zealand."
		"Related conditions in other cultural contexts: *Taein kong po* in 'Korea.'"

DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [39]

psychodynamic psychiatry, biological psychiatry, and digital health care have been the main areas of research in the 1970s, 2000s, and 2020s, respectively. In South Korea, mental health-care delivery system has been established with a three-layered system including the Ministry of Health and Welfare, Metropolitan City or Province, and City, County, or District. According to the 2021 National Mental Health Statistics, the total number of mental medical institutions is 2038, the total number of psychiatric hospital beds is 75,454, and the number of psychiatrists per 1,000 persons is 0.08. After the complete revision of *the Act on Mental Health and Welfare* in 2016, the processes and prerequisites of psychiatric hospitalization or admission have been more sternly complicated. Thus, according to the Penrose hypothesis, deinstitutionalization might be the significant contributing factor to trans-institutionalization.

South Korea has been reported the highest suicide deaths in 2021 among OECD countries. Hence, based on the psychological autopsy interview report, "Suicide CARE" has been originally developed as an evidence-based gatekeeper training program in South Korea. Even after the COVID-19 pandemic, the difficulty of the economically weak population has worsened. The mental health-care measures to secondary emotional reaction of COVID-19 have necessarily required. In the psychopathological issues, the Korean terms for psychiatry, epilepsy, and schizophrenia have been renamed to reduce social stigma associated with mental disorders and reflect the essential characteristics of mental health field. In *DSM-5*, anger syndrome and fear of interpersonal relationships have been introduced in the cultural concept of distress. Despite the several problems of mental health-care system, psychiatry has been progressively developed and steadily established its own originality in South Korea.

Data Availability Statement

Data sharing is not available in this review as no datasets were generated or analyzed during the current study.

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Conflicts of Interest

The author declares no potential conflicts in writing this review.

References

1. Lee MS, Park YC, Park SC: South Korea. In: Bhugra D, Tse S, Ng R, Takei N, (eds): *Routledge Handbook of Psychiatry in Asia*. London, United Kingdom: Routledge, 2012: 183-95.
2. Kim YS: The actual status in poem of historical sings on the loyal advices and the meaning of the praise and censure. *Daedonghanmunhak* 2004; 21: 127-60.
3. Chang SC, Kim KI: Psychiatry in South Korea. *Am J Psychiatry* 1973; 130: 667-9.
4. Lee NM, Rhi BY: The introduction of the Western psychiatry into Korea: From the mid seventeenth century to 1911, the time of Japanese forced annexation of Korea. *Uisahak* 1999; 8: 233-68.
5. Rhi BY: Hundred years' psychiatry in Korea (1899-1999). *Uisahak* 1999; 8: 157-68.
6. Lee HY: Past, present and future of Korean psychiatry. *Psychiatry Investig* 2004; 1: 13-9.
7. Park HW, Yeo IS: The first annual report of the Korean Government Hospital. *Yonsei J Med Hist* 1999; 3: 1-44.
8. Chung W, Lee N, Rhi BY: The introduction of Western psychiatry into Korea (II). psychiatric education in Korea during the forced Japanese annexation of Korea (1910-1945). *Uisahak* 2006;15:157-87.
9. Yeo IS: The establishment of SUMC (Severance Union Medical College) Psychiatry Department and the formation of humanistic tradition. *Uisahak* 2008; 17: 57-74.
10. Min SK: Professor Charles I: McLaren, MD (1): His life and medical philosophy. *J Korean Neuropsychiatr Assoc* 2011; 50: 172-86.
11. Hur CH: Examining Korea's first case of psychoanalytic psychotherapy: A brief psychotherapeutic treatment on a patient with psychogenic headache. *Korean J Psychother* 2009; 23: 60-4.
12. Kim JK, Rhi BY: Psychiatric care in Korea between 1945-1955. *J Korean Neuropsychiatr Assoc* 1996; 35: 342-55.
13. Roh S, Lee SU, Soh M, et al.: Mental health services and R&D in South Korea. *Int J Ment Health Syst* 2016; 10: 45.
14. National Mental Health Welfare Center: *2021 National Mental Health. Statistics*. Seoul, South Korea: National Mental Health Welfare Center, 2022.
15. Wild G, Alder R, Weich S, et al.: The Penrose hypothesis in the second half of the 20th century: investigating the relationship between psychiatric bed numbers and the prison population in England between 1960 and 2018-2019. *Br J Psychiatry* 2022; 5: 295-301.
16. Lee HY: Se-Won Lim and standardized suicide prevention program for gatekeeper Intervention in Korea (Bogo Deudgo Malhagi, Suicide CARE). *Psychiatry Investig* 2020; 17: 1045-7.
17. Korea Psychological Autopsy Center: *Psychological Autopsy Interview Report 2015-2018*. Seoul, South Korea: Korea Psychological Autopsy Center, 2018.
18. Park SC, Na KS, Kwon SJ, et al.: "Suicide CARE" (standardized suicide prevention program for gatekeeper intervention in Korea): an update. *Psychiatry Investig* 2020; 17: 911-24.
19. Korea Association for Suicide Prevention: *Suicide CARE: Version 2.0.* Seoul: Korea Association for Suicide Prevention, c2020.
20. Park SC: "Suicide CARE" Is proactively required to reduce the suicide death rate in the identified hotspots in South Korea. *Alpha Psychiatry* 2023; 24: 56-7.
21. Park SC: Why "suicide CARE" is required for North Korean defectors in South Korean Society? *Psychiatry Investig* 2023; 20: 391-2.
22. Yoo JH: The fight against the 2019-nCoV outbreak: an arduous march has just begun. *J Korean Med Sci* 2020; 35: e56.
23. Park SC, Park YC: Mental health care measures in response to the 2019 novel coronavirus outbreak in Korea. *Psychiatry Investig* 2020; 17: 85-6.
24. Park SC, Park YC: Secondary emotional reactions to the COVID-19 outbreak should be identified and treated in Korea. *J Korean Med Sci* 2020; 35: e161.
25. Ofri D: The emotional epidemiology of H1N1 influenza vaccination. *N Engl J Med* 2009; 361: 2594-5.
26. Han C: How to approach to suicide prevention. *J Korean Med Assoc* 2019; 62: 79-84.
27. Kim SW, Jhon M, Kim M, et al.: A social psychiatric approach to suicide prevention. *J Korean Med Assoc* 2019; 62: 93-101.
28. Park SC: Trends in renaming the Korean terms for psychiatry, schizophrenia, and epilepsy. *Acta Psychopathol* 2016; 2: 26.
29. Ahn DH: Special issue. *J Korean Neuropsychiatr Assoc* 2010; 49: 533-7.
30. Park JI, Oh KY, Chung YC: Psychiatry in Korea. *Asian J Psychiatr* 2013; 6: 186-90.
31. Lee HK, Choi WS, Paik JW, et al.: The future report for the innovative advance of Korean psychiatry in 2030. *J Korean Neuropsychiatr Assoc* 2014; 53: 75-86.
32. Kim HD, Kang HC, Lee SA, et al.: Changing name of epilepsy in Korea; cerebroelectric disorder (Noi-Jeon-Jeung,뇌전증,): My epilepsy story. *Epilepsia* 2014; 55: 384-6.
33. Li S: Comments in response to the changing name of "epilepsy" in

Korea. *Epilepsia* 2014; 55: 387.
34. Lee YS, Kim JJ, Kwon JS: Renaming schizophrenia in South Korea. *Lancet* 2013; 382: 683-4.
35. Lee YS, Park IH, Park SC, et al.: Johyeonbyung (attunement disorder): Renaming mind splitting disorder as a way to reduce stigma of patients with schizophrenia in Korea. *Asian J Psychiatr* 2014; 8: 118-20.
36. Jeong SH, Son JW, Kim YS: Understanding of attunement disorder from phenomenological- anthropological perspective: inquiring into the use of the term attunement in psychiatric literature. *J Korean Neuropsychiatr Assoc* 2013; 52: 279-91.
37. Park SC, Lee YS, Kwon JS: Special issue. *J Korean Neuropsychiatr Assoc* 2011; 49: 533-7.
38. Park SC, Park YC: Korea in the diagnostic and statistical manual of mental disorders, fifth edition. *J Korean Med Sci* 2020; 35: e6.
39. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*. Washington, DC: American Psychiatric Association, 2013.
40. Park YC: Hwabyung: Symptom and diagnosis. *Psychiatry Investig* 2004; 1: 25-8.
41. Min SK, Suh SY, Song KJ: Symptoms to use for diagnostic criteria of Hwa-Byung, an anger syndrome. *Psychiatry Investig* 2009; 6: 7-12.
42. Lee BT, Paik JW, Kang RH, et al.: The neural substrates of affective face recognition in patients with Hwa-Byung and healthy individuals in Korea. *World J Biol Psychiatry* 2009; 10: 552-9.
43. Rhi BY: Hwabyung: An overview. *Psychiatry Investig* 2004; 1: 21-4.
44. Yongmi Yi K: Shin-Byung (divine illness) in a Korean woman. *Cult Med Psychiatry* 2000; 24: 471-86.
45. Clarvit SR, Schneier FR, Liebowitz MR: The offensive subtype of Taijin-Kyofu-Sho in New York city: the phenomenology and treatment of a social anxiety disorder. *J Clin Psychiatry* 1996; 57: 523-7.
46. Vriends N, Pfaltz MC, Novianti P, et al.: Taijin Kyofusho and social anxiety and their clinical relevance in Indonesia and Switzerland. *Front Psychol* 2013; 4: 3.
47. Lee SH, Park YB, Oh KS: Comparative study of social phobic symptoms between early 80's and 90's. *J Korean Neuropsychiatr Assoc* 1996; 35: 107-13.
48. Block JJ: Issues for DSM-V: Internet addiction. *Am J Psychiatry* 2008; 165: 306-7.
49. Kim DJ, Kim K, Lee HW, et al.: Internet game addiction, depression, and escape from negative emotions in adulthood: a nationwide community sample of Korea. *J Nerv Ment Dis* 2017; 205: 568-73.
50. Koo HJ, Kwon JH: Risk and protective factors of internet addiction: a meta-analysis of empirical studies in Korea. *Yonsei Med J* 2014; 55: 1691-711.
51. Heo J, Oh J, Subramanian SV, et al.: Addictive internet use among Korean adolescents: a national survey. *PLoS One* 2014; 9: e87819.
52. Tseng WS: Culture and psychopathology: General view. In: Bhugra D, Bhui K, (eds): *Textbook of Cultural Psychiatry*. Cambridge: Cambridge University Press, 2007: 95-112.