Korean-Canadian Immigrants' Help-Seeking and Self-Management of Suicidal Behaviours

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ABSTRACT

Suicidal behaviours are intricately connected to culture, oftentimes reflecting traditional norms and attitudes to health help-seeking and self-management. To describe Korean-Canadian immigrants' help-seeking and self-management for their suicidal behaviours, 15 participants completed individual semistructured in-depth interviews. Using constant comparison analysis, participants' narratives were analysed to inductively derive two themes: 1) resisting professional help; and, 2) developing effective self-management strategies. The study findings suggest that most participants preferred and opted for self-management strategies rather than seeking professional help. Most participants' reluctance to seek professional or peer help was underpinned by a fear of the stigma associated with traversing cultural norms by harbouring a mental illness and seeking help for that ailment. In addition, a lack of knowledge about available professional health care services, along with language and cultural barriers, led some participants to perceive mental health services as ineffectual. Participants' determination to self-manage their suicidality was influenced by cultural norms around honouring and protecting family, and a range of spiritual and religious beliefs also emerged to counter impulses for acting on suicidal thoughts. By shedding light on Korean-Canadian immigrants' experiences with suicidal behaviours, the findings offer some guidance toward developing culture-sensitive suicide prevention programs.

Keywords: suicide, Korean-Canadians, immigrants, help-seeking, mental health, stigma

RÉSUMÉ

Les comportements suicidaires sont associés de façon complexe à la culture, et reflètent souvent des normes et des attitudes traditionnelles face à la recherche d'aide et à l'autogestion de ces comportements. Afin de décrire l'attitude des Canadiens issus de l'immigration coréenne dans ce genre de situation, nous avons demandé à 15 personnes de cette communauté de participer à des entrevues approfondies semi-structurées. En utilisant la méthode d'analyse comparative constante, nous avons analysé les témoignages des participants et nous en avons tiré de façon inductive deux thèmes : 1. la difficulté d'accepter l'aide de

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professionnels de la santé; et 2. l'élaboration de stratégies d'autogestion. Nos résultats indiquent que la plupart des participants, préférant gérer eux-mêmes ces comportements, choisissaient cette approche plutôt que de demander de l'aide professionnelle. Leur réticence à demander de l'aide à des professionnels ou à leurs pairs s'appuyait sur la crainte d'être stigmatisés s'ils devaient avouer qu'ils souffraient d'une maladie mentale, transgressant ainsi des normes culturelles. De plus, le manque de connaissances sur les services de santé mentale disponibles, de même que des barrières liées à la langue et à la culture, ont conduit des participants à estimer que ces services ne pouvaient pas offrir de résultats satisfaisants. La détermination des participants à gérer eux-mêmes leurs comportements suicidaires était influencée par des normes culturelles liées au devoir d'honorer et de protéger leur famille; diverses croyances spirituelles et religieuses pouvaient également les empêcher d'agir quand ils songeaient à le faire pour contrer leurs pensées suicidaires. En mettant en lumière l'expérience de Canadiens d'origine coréenne en matière de comportements suicidaires, notre étude offre des éléments qui pourront contribuer à la création de programmes de prévention du suicide qui tiennent compte des spécificités culturelles.

Mots clés : suicide, Canadiens d'origine coréenne, immigrants, recherche d'aide, santé mentale, stigmatisation

INTRODUCTION

Global suicide rates are steadily increasing (World Health Organization, 2014), a trend evident in Canada where suicide is one of the leading causes of death (Statistics Canada, 2014). Recognizing suicide as a serious public health issue, in November 2012, the Government of Canada passed Bill C-300, an Act legislating the development of a federal suicide prevention framework. This was key to improving public awareness and promoting effective, evidence-based practices for the prevention of suicide (Albrecht, 2012).

Given its far-reaching impact, suicide has been widely studied, and various epidemiological profiles and risk factors have been proposed. Within this work, it is important to carefully examine diverse subgroups to distill culture-specific suicide risks and protective factors, attitudes and perceptions toward suicide, and help-seeking behaviours and management strategies. Culture encompasses several working definitions across various disciplines, and in the current article, the term *culture* is used to represent a shared set of meanings, assumptions, values, and patterns of behaviour distinctive to a specific heterogeneous group of people (Spradley, 1980). Similar to other human behaviours, suicidal behaviours are embedded in cultural contexts, reflecting and disrupting normative cultural standards and attitudes (Colucci & Lester, 2013). For example, prevalence and risk factors for suicidal behaviours vary significantly across geographies and ethnicities, and are intricately linked to culture (Hjelmeland, 2013). Indeed, in Western countries, depression has been highlighted as a prevalent suicide risk factor (Cavanagh, Carson, Sharpe, & Lawrie, 2003); while the link between depression and suicide in East Asia is less evident (Yang, Phillips, Zhou, Wang, Zhang, & Xu, 2005; Cheng, Fancher, Ratanasen, Conner, Duberstein, Sue, & Takeuchi, 2010). Such cultural variations underscore the importance of understanding suicidal behaviours, especially in light of the high global migration rates (Organisation for Economic Co-operation and Development (OECD), 2013). In particular, in a multicultural nation such as Canada where 20.6% of the total population are foreign-born and/or visible minorities (Statistics Canada, 2011), taking cultures into consideration is essential. In fact, immigration has been highlighted as the key contributor to Canadian population growth, and immigrants from Asian countries

account for almost 60% of recent Canadian immigrants (Statistics Canada, 2011). Also, a steady growth in Korean-Canadians has occurred over the last two decades, particularly between 1996 and 2001 (Park, 2012), and the Korean-Canadian community is the fourth largest visible minority group in British Columbia, and the seventh largest non-European ethnic group in Canada (Statistics Canada, 2007; Lindsay, 2007).

In the context of East Asian immigrants (i.e., Chinese, Japanese, Korean, and Taiwanese) (Holcombe, 2001), the literature indicates that this subgroup tends to deny psychological distress and suicidal ideation (Aubert, Daigle, & Daigle, 2004; Noh, Kaspar, & Wickrame, 2007), internalize thoughts of suicide (e.g., withdrawing from others, being anxious and worried) (Lau, Zane, & Myers, 2002), and exhibit fewer depressive or anxiety symptoms than the population in general (Cheng et al., 2010). To explain this phenomenon, Noh and colleagues (2007) pointed to East Asians' tendency to deal with stress and problems through self-blame, self-destruction, and risk-taking behaviours. They also argued that East Asians tend to resist help-seeking and avoid self-disclosure about experiencing distress because of the shame associated with mental illness and the importance of family honour in East Asian cultures (Noh et al., 2007). Hence, recognizing these cultural norms amid considering other sociocultural contexts, including the importance of family cohesion stemming from collectivist and interdependent cultural orientations, is central to developing targeted suicide intervention/prevention programs.

While it is ever clear that suicide among immigrants has significant social, economic, and political implications in Canada, only a few studies have examined suicide among immigrants. Moreover, most of these studies tend to aggregate immigrants as a single group, forgoing contextual cultural insights (Han, Oliffe, & Ogrodniczuk, 2013a). By shedding light on Korean-Canadian immigrants' help-seeking for and self-management of suicidal behaviours, the current study offers some guidance towards developing culture-sensitive suicide prevention programs.

METHODS

The findings presented in this article are drawn from a study of 15 first-generation Korean-Canadian immigrants. The 15 participants resided in the Greater Vancouver area in British Columbia and had experienced suicidal behaviours; of these, two had attempted suicide in the past. In this article, the term *suicidal behaviours* entails and is classified into three subsequent categories: 1) suicidal ideation; 2) suicide plan; and 3) suicide attempt (Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008). Ethics approval was obtained from the University of British Columbia. Recruitment strategies included posters and on-line advertisements (in both English and Korean) in weekly Korean newspapers and Web sites. Also bilingual recruitment flyers were posted at various sites including Korean supermarkets and restaurants, and college and university campuses. Participants had lived in Canada for one to 25 years (M=10.7 years; SD = 7.8) and self-identified as first-generation Korean-Canadian immigrants. The sample comprised 11 women and four men between the ages of 20 and 62 (*M= 32.6*). All 15 participants had experienced suicidal behaviours, and four had sought professional help (i.e., psychiatrist, psychologist, counselling) for mental illness issues and/or their suicidality. Of these four participants who sought professional help, one had attempted suicide and had begun seeking professional help prior to the attempt. Table 1, Participant Demographics, provides additional details.

Table 1
Participant Demographics

Demographics	
Age	
20–29	8
30–39	4
40–49	1
50–59	1
60–69	1
Mean	32.6
Range	20–62
Gender	
Male	4
Female	11
Religion	
Atheist	1
Buddhist	2
Catholic	6
Christian	2
Protestant	2
Spiritual	1
None	1
Marital Status	
Single/never married	7
Married	5
Common-law	1
Separated	2
Divorced	
Living Status	
Alone	1
Roommates	5
Parents	2
Spouse/partner	2
Spouse/partner and children	4
Spouse/partner, children, and other extended family	1
Years in Canada	
0–5 years	5
6–11 years	3
More than 11 years	7

... continued

Table 1
(Continued)

Demographics	
Highest Education	
College diploma	1
University student, undergraduate	6
University, bachelor's degree	5
University, master's degree or PhD	2
Not specified	1
Current Occupation	
Student	7
IT industry	2
Service industry	2
Homemaker	1
Employed, but not specified	1
Not specified	2
Previously Sought Treatment(s)	
Yes	4
No	11
If yes, type(s) of treatment	
Psychiatrist	1
Psychologist	1
Medication	1
Other counselling	2

The key points of focus in the current study were to capture participants' subjective experiences, attitudes, perceptions, and understandings about help-seeking and self-management for suicidal behaviours. In that sense, the qualitative approaches, including semistructured individual interviews, were chosen to access the participants' ideas, thoughts, and memories and to understand their connections to behaviours (De Laine, 1997). In addition, individual interviews were conducted to facilitate conversations about potentially sensitive or taboo issues and to distill contextual insights about participants' experiences by emphasizing depth, nuance, complexity, and roundedness in their narratives (Mason, 2002). The participant interviews, lasting 30 to 90 minutes, were conducted in the participants' preferred language (i.e., English or Korean) between May and December 2012. The interview questions sought in-depth understandings about participants' help-seeking and self-management of suicidal behaviours. Interviews were digitally recorded, transcribed verbatim (excluding identifying information), translated into English where necessary, and checked for accuracy by the first author (a bilingual, Korean and English researcher who also conducted the interviews). Participants received a nominal honorarium of CAD$30 to acknowledge the time spent and their contribution to the study.

Data analysis was concurrent with data collection, and continued until data saturation was reached (Green & Thorogood, 2009). With the overarching goal of providing a detailed, context-rich account, particular attention was paid to the ways in which culture influenced the participants' suicidal behaviours in the context of help-seeking and self-management. Using constant comparative methods (Strauss & Corbin, 1998), interview transcripts were read multiple times by the two authors. The first few interviews were open-coded to identify all potential codes (Green & Thorogood, 2009; Punch, 2005). These data were then reassembled into selective codes and condensed and ranked by gathering together those that were most strongly connected and represented (Strauss & Corbin, 1998). The cyclic process of collecting, analyzing, and coding data led to the development of preliminary findings, which in turn guided adjustments to the questions used in subsequent participant interviews. Coded data were reread to explore relationships between them and inductively derived themes which were further advanced by asking culture-specific questions of the emergent findings including: "How is culture represented here?" and "What and how are cultural norms used to explain help-seeking for and self-management of suicidal behaviours?" The findings were organized into two themes: 1) resisting professional help; and, 2) developing effective self-management strategies. Illustrative quotes are linked to participant demographics to contextualize the findings.

RESULTS

Resisting Professional Help

The majority of participants agreed that they did not and/or could not seek professional help for their suicidal behaviours, in large part for fear of the stigma attached to traversing cultural norms through harbouring a mental illness and seeking help for that ailment. Participants explained how seeking help was taboo, especially within Korean cultures. As a 26-year-old male participant confirmed, "Koreans believe counselling and seeking help from a psychologist or psychiatrist is only for psychos." Many participants also denied needing professional help, reasoning that their condition was not serious enough to solicit such assistance. A 20-year-old female participant's response illustrated such self-triage in refuting the need for professional help:

> R: If you had suicidal thoughts now, are you willing to seek professional help?
>
> P: Actually I thought about it but then my case is not that severe and I think I can just let it pass so … no.

Evident were participants' alignment to cultural ideals outlawing professional help for mental illness, along with tendencies to downplay and deny the severity of their suicidal behaviours. Participants also highlighted challenges in accessing professional help, while some suggested the available services were ineffectual in treating their suicidal behaviours. A 20-year-old female university student explained that when she had received counselling for recurrent suicidal thoughts, the services did little to identify or alleviate the underpinning issues:

> When I got to the first appointment, all I had was 10 minutes because they wanted me to do a survey and that's our initial meeting and you need to wait three more weeks. Okay, fine I'll wait three more weeks while I'm in agony. And three weeks passed and the counselling psychology students do it. And I was very irritated because they only focused on suicide, nothing else. They don't focus on family issues, they don't focus on poverty, they don't focus on my mom who I was caring for …. They were like "how many times do you think of suicide," like are they close together …. They only cared about the suicide part but if … I didn't mention suicide then they would just put me in a waiting list like two months later … so I just stopped going.

In this narrative, the participant expressed her frustration in regard to the wait times for counselling services, as well as the ineffectual triage and treatment modalities for people at risk of suicide. In particular, the participant criticized generic quantitative survey questionnaire approaches when evaluating suicide risk and the lack of focus on context, which is critical to understanding the underpinning issues fuelling the suicidality. She highlighted how predetermined approaches, not sensitive to individual context, failed to recognize her real suicide trigger points (e.g., the family and financial issues) and potential protective factors (e.g., caring for her mother) which could be used as a way to buffer her from suicidal thoughts.

In addition, the lack of knowledge about available resources, as well as language and cultural barriers, featured as reasons why participants had not sought professional help. A 62-year-old female participant thanked the interviewer for the opportunity to freely talk about suicide, suggesting:

> I think many Korean immigrants are suffering from depression and suicidal thoughts but they just don't know where to go to get help. I'm sure that there are many great psychiatrists and counsellors in Canada but because many of the first generation Korean immigrants speak limited English, they can't really express their state in English so it's almost impossible to seek help from Canadian healthcare professionals.

While appreciative of the services available within Canadian public health care system, this participant's narrative illustrates how language barriers can inhibit immigrants from accessing those resources. A 48-year-old female participant who had sought marriage counselling suggested ethnic matching might help to increase the uptake of professional series for Korean-Canadian immigrants:

> Of course many Koreans are okay with divorce … but the counsellors recommending divorce bluntly like that? Yeah it was a culture shock (…) it would be really great if there were Korean counsellors here who can help immigrants. There is a tremendous stigma around seeking professional help for their mental health among Koreans that I couldn't even tell anyone that I've sought counselling before. But, I think even though they don't say it out loud, many Koreans would actually consider seeking counselling if we have Korean counsellors available here.

A 20-year-old female participant confirmed that though counsellors had helped her overcome suicidal urges, she still wasn't able to disclose to them about her family conflict—the core issue underpinning her suicidal behaviours:

> P: But, I never told them [counsellors] that I was getting hit [by her father] all the time. Like it was really, really bad.
>
> R: Why not?
>
> P: Because I had to protect my family. I didn't, you know, my siblings were very young, and I understood that my parents were stressed out and poor, and they would take out their anger on me, but I felt like I deserved it too. For like the longest time I didn't tell anyone. I never talked about it until maybe one or two years ago. So, that was, yeah, although I got help from my counsellors, they could never get to the root of the problem.

Apparent in this and many other participant examples was the degree to which cultural values prohibited self-disclosure about particular factors contributing to their suicidal behaviours. So while physical abuse and conflict within the family could fuel suicidal behaviours, preserving the family's honour trumped any temptation to fully confide in health care providers.

Only four of 15 participants had sought professional help for their suicidal behaviours. Noteworthy is that, of the two participants who had attempted suicide in the past, only one had sought professional help.

Nonetheless, three of four participants who had sought professional help for their suicidal behaviours acknowledged significant benefits from receiving treatment[s]. Emphasized was the importance of seeking professional help before suicidal behaviours intensified. As a 48-year-old woman described, "When you are at that stage, you don't have a coping skill. You can't think through anything." She continued on to describe how she felt relieved after talking to her counsellor about her problems:

> So I met him [the counsellor] once a week and it was so helpful because at that time I couldn't talk to anyone about it. So during the one-and-a-half-hour counselling session, I spent more than a half of the session crying. I cried so much but after I cried, I felt better. Also because he was an immigrant himself too, he understood what I was going through.

Evident in this participant's narrative was how beneficial talk therapy can be by providing the space and explicit permission to talk freely, without risking judgment or ostracism, about their suicidal thoughts and the underpinning issues. Noteworthy also was the importance of building rapport as indicated by the participant's suggestion that a shared immigrant status fuelled her confidence that the counsellor understood her challenges.

Developing Effective Self-management Strategies

The fear of being known to have mental illness and/or seeking professional mental health care also led to participants investing time in developing self-management strategies. Many participants expressed their concerns for "disappointing and disgracing their families and friends," "causing others trouble," "not being taken seriously or ridiculed," and/or "not finding others' support beneficial" in explaining their reluctance to disclose details about their suicidal behaviours to others. In addition, given the predominance of small, close-knit Korean-Canadian immigrant communities in Vancouver, ensuring one's own and family's privacy—to avoid any potential gossip—was a strong motivator for focusing on and opting for self-management strategies. For example, a 31-year-old female participant who contemplated suicide as a result of a series of deaths in her family explained how her grief and suicidal thoughts intensified because she was not receiving any concession or comfort from her family:

> [After the death of the participant's dad and daughter] mom always says not to tell anyone about it [her pain] because it is embarrassing. She thinks talking about her pain and her family issues to someone is a disgrace to the family. But the funny thing is that they [the participant's mother and sister] don't want to talk about it with no one, not just with other people but like they wouldn't speak to me about it either. Actually, they get mad at me when I bring up the topic. They just want to bury it but I can't.

Emerging from such scenarios, most participants were deeply invested in self-management wherein suicidal behaviours were claimed as an individual's private ordeal to be dealt with and managed alone. A 62-year-old female advised:

> Well, it's easier said than done but if you can, you have to take care of yourself. You are the only one who can do something about it. Don't expect other people or things that are making you feel depressed and consider committing suicide to change. So, try to think positively and manage yourself. Don't be impulsive.

This participant suggested that deconstructing triggers and orienting oneself away from suicidal thoughts was the ultimate solution. Appealing to characteristics of self-reliance and strength, participants' recommendations also challenged others to seek help as the conduit to developing effective self-management and converting their negativity towards self-administered remedies.

While the fear of disgracing their family inhibited participants from seeking professional help, those same collective cultural ties summoned participant's self-management efforts. Indeed, the most consistent self-management motivation was participants' concern for their family and friends. For example, a 20-year-old female student explained:

> I thought if I killed myself my mom would not manage. Like I was the only good thing going on in her life. Yeah. I think during those times, just back then, if it wasn't for my mom, I would have probably done something.

This participant valued the relationship she had with her mother; and the respect and responsibilities she felt toward her were barriers to acting on the suicidal thoughts she experienced. While the participant conceded that she did not get the emotional support directly from her mother, such reflective thoughts served to protect her against acting on her suicidal thoughts. Similar scenarios were evident across most participants' interviews, and consistently suggested was the power of the relationships in one's life for quelling suicidal thoughts. Included here also were ideals about how one should self-manage for the benefits of others—as well as oneself.

In addition, religion and spirituality were catalysts for some participants' self-management. The Christian doctrine of heaven and hell, for example, fuelled negative views of suicide. A 31-year-old female participant who self-identified as Catholic explained how she managed her suicidal thoughts after the death of her father and daughter:

> Yeah, it's a perilous sea but there must be somewhere we can disembark somewhere out there. It's like we need to cross this sea to get there, for perpetual peace and happiness? [R: Would that be death?] Yes, I think we can get there through death. So it might be my religious side talking but I think if I commit suicide … if I jump off of this boat, then I will never get there and see my dad and my baby (crying) so I have no other choice but to keep on riding on this boat so I can meet them one day.

Many participants also reminded themselves that life had good moments as well as bad, as a 38-year-old woman explained:

> Life is like waves. There are ups and there are downs. Some get hit in the face and complain but some surf them as they come and go.

In line with this philosophical viewpoint, a 30-year-old female participant described how suicidal behaviours can be prompted by a bad moment or transient phase that will ultimately pass. Based on a suicide attempt in which she tried to drown herself in the bathtub when she was drunk, the participant warned against alcohol and drug use because they can amplify negative situations and suicidal thoughts, and potentiate actions toward self-harm:

> Everyone has that thought of suicide in their mind—everybody does, I think, but actually initiate in action, you need help from drugs or alcohol so some people, not all but, it could have been a mistake. Like you wake up in the morning and realize that you were so silly last night right?

In the context of developing effective self-management strategies, the self-talk and advice provided by this and many participants was to deconstruct and switch one's thinking patterns without the impairments invoked by alcohol and drugs. In combination, these strategies could advance one's mental health by fully examining

and mobilizing effective self-management strategies. In line with this, a 37-year-old male manufacturing technician articulated how suicide cannot be the easy way out:

> There is no easy way out. It [suicide] looks like an easy way out but I think killing yourself is one of the hardest things you can do. Yeah, you need a lot of courage and if you had that much of courage, you can go through whatever problem that you might have in your life.

In suggesting the channelling of strength toward effective self-management to overcome the problems driving suicidal behaviours, this participant illustrated how such philosophical underpinnings and strategic self-talk can be used to reduce the risk for self-harm.

DISCUSSION

The current study findings suggest that in managing suicidal behaviours, most participants preferred and opted for self-management approaches—rather than seeking professional or social supports. Some participants even tried to convince themselves that their psychological pain and distress, and their suicidal behaviours were not serious enough to warrant professional help. This finding can be explained by Korean-Canadian immigrants' cultural tendency toward the underutilization of mental health services amid fears of dishonour associated with harbouring a mental illness (Noh & Avison, 1996), as well as seeking professional help (Yoo & Skovholt, 2001). Also, the current study revealed participants' concerns about the practicability and value of seeking professional help. The potential benefits of ethnic matching in mental health care services were evident in the current study, and these findings augment the assertion of Donnelly, Hwang, Este, Ewashen, Adair, and Clinton (2011) that limited English skills and a lack of professional health care interpreter services form additional barriers to mental health counselling services for many immigrants. Patient-provider ethnic matching may be especially important for Korean-Canadians who have limited social support, given that suicidal behaviours can recursively flow toward and from poor family dynamics (Han, Oliffe, and Ogrodniczuk, 2013b). Inversely, loyalty to and support from family and friends can bolster resilience and offer significant support (Dixon Rayle & Chung, 2007). In that sense, as Noh, Kaspar, and Wu (1992) suggested, social supports received from Korean-Canadian individuals (as distinct from networks and wider cultural milieus) can be effective in bolstering mental health. These findings also support Thoits's (1986, 2011) hypothesis that sociocultural similarity is key to empathetic understandings of patients' stressful situations. In other words, as Thoits (1986, 2011) posited, sociocultural similarity in general increases the affinity between the patient and provider, which is essential to effective health care and social supports. As such, social and cultural understandings are indeed critical for an individual (as a therapist, family member, or friend) to empathize and understand those in need of help (Cabral & Smith, 2011; Choi-Wu, Kviz, & Miller, 2009; U.S. Department of Health and Human Services, 2001).

As Donnelly and colleagues (2011) argued, the Canadian public health care system's underdeveloped responsiveness to the unique cultural needs of subpopulations can further isolate immigrant groups, including Korean-Canadians. The current study findings illuminated the need for Canadian health care providers to meaningfully engage Korean-Canadian populations who experience suicidal behaviours to identify and address the root cause of their psychological distress. In particular, first-generation Korean-Canadians can be caught between traditional Korean collectivist philosophies and Western ways of life, creating inner as

well as family (e.g., parent-child generational) conflicts (Han et al., 2013a). Hence, recognizing how these potentially disparate, changing values and ways of life can fuel conflict and influence suicidal behaviours can help health care providers better locate and understand at-risk individuals of Korean descent and their families. In this way, health care providers will also be better equipped to treat mental illness by recognizing the most culturally acceptable treatment modalities. In addition, the explicit permission to talk about cultural beliefs and life circumstances in the context of mental health challenges is key to enhancing providers' effectiveness with Korean-Canadian immigrant clients.

While there is ongoing debate about the benefits and efficiencies of ethnic matching in health care services (Flicker, Waldron, Turner, Brody, & Hops, 2008; Farsimadan, Draghi-Lorenz, & Ellis, 2007), the foremost concern is to garner genuine effort on the part of health care providers to understand immigrant patients in order to produce the best outcomes (Chang & Berk, 2009). Also, ahead of discussing the pros and cons of ethnic matching, two issues should be thoughtfully considered. First, it is crucial to understand what underscores Korean-Canadians' reluctance to seek professional help for mental health issues and suicidal behaviours (Noh & Avison, 1996; Jang, Kim, Hansen, & Chiriboga, 2007; Shin, 2002). Second, the current study revealed Korean-Canadian participants' lack of awareness of mental health programs and illness services. The tendency toward underutilisation of mental health care services also intersects with language and other culture-specific barriers, including the fear of dishonouring self and family by having and/or being treated for mental illness. Therefore, a need exists to raise awareness about mental illness among Korean-Canadians, perhaps by attempting to shift cultural norms that currently heighten fears and reluctance to talk about suicidal behaviours and/or to seek professional help.

Overcoming Korean-Canadians' tendency to conceal distress because it contravenes cultural norms (e.g., keeping family honour) and specific Korean-Canadian immigrant contexts (e.g., close-knit community) might be best achieved through raising awareness and increasing targeted education. In particular, making available and evaluating the uptake of resources in Korean (e.g., on-line as well as in clinics) and providing specialist counselling services to Korean-Canadian immigrants who are at risk of suicide may be fruitful. In addition, policy-makers who legislate for immigrant populations could design care pathways and/or counselling strategies and programs to raise awareness about how cultures can intersect with suicidality among immigrant subgroups, including Korean-Canadian immigrants. This could promote mental health among Korean-Canadian immigrants, as well as reduce the shame commonly linked to mental illness.

The current study has two limitations. First, by focussing on first-generation Korean-Canadian immigrants, the results are limited in what they can detail about other Canadian immigrant populations. That said, the current study findings for the most part confirm the work of others examining immigrant groups elsewhere (Choi-Wu et al., 2009; Noh et al., 2002; Shin, 2002; Noh, S., Speechley, M., Kaspar, V., & Wu, Z., 1992), and therefore support lobbying for action toward culturally sensitive mental health services. Second, the current study sample's gender split (11 females and four males) likely says more about the help-seeking and self-management of Korean-Canadian immigrant women. Evidence suggests that men are especially unlikely to seek help for mental illness, and future studies might advance the field by focussing on men—especially given the high rates of male suicide in Canada (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012; Statistics Canada, 2014).

Withstanding the aforementioned limitations, the current study contributes to the literature by augmenting what we know about Korean-Canadian immigrants' suicidality, help-seeking, and self-management behaviours. This not only adds empirical weight to the literature connecting culture and suicidality, but it also it demonstrates the clear need for culture-specific research as a means to developing culturally sensitive counselling and mental health services. In addition, confirmed by the current study are the therapeutic benefits afforded by qualitative interviews (Murray, 2003; DeCou, Skewes, Lopez, & Skanis, 2013). In particular, the value of talking in-depth about an ordinarily taboo subject, such as suicide, was especially evident in the current study. In this regard, the current study both empirically and methodologically augments the existing knowledge to further guide the development of suicide prevention programs targeting Korean-Canadian immigrants.

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