Telecounseling for the Linguistically Isolated: A Pilot Study With Older Korean Immigrants

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Purpose: Responding to the critical needs of the linguistically isolated, this pilot study tested the use of telehealth technology in providing access to culturally and linguistically appropriate mental health services. The goal of the study was to explore the feasibility and preliminary efficacy of a telecounseling program in the client’s native language.

Design and Methods: Using a small sample of older Korean immigrants living in a low-income housing facility in Orlando, Florida, who had concerns about depressive moods (n = 14), the pilot telecounseling program was implemented via videoconferencing. Four weekly sessions were conducted by 4 Korean mental health counselors based in New York. Results: A high level of completion (86%) and overall satisfaction with the program were observed. Participants also exhibited a significant reduction in depressive symptom severity shortly after completion of the program. At the 3-month follow-up, the participants’ depressive symptom scores remained significantly lower than those at the initial assessment.

Implications. The findings support the value of telecounseling for linguistically isolated populations and suggest further efforts to extend such programs.

Key Words: Telehealth, Linguistically isolated populations, Depressive symptoms

Limited English proficiency has been identified as a critical barrier to health care for immigrant populations in the United States. Provision of language assistance services to patients and training of providers in cultural competence have been suggested as one means to reduce such barriers (Derose, Escarce, & Lurie, 2007; Ponce, Hays, & Cunningham, 2006). Indeed, with the increasing availability of interpretation and translation services in health care settings, problems associated with limited English proficiency have been reduced (Ginsberg, Martin, Andrulis, Shaw-Taylor, & McGregor, 1995). However, language barriers remain a critical unsolved obstacle to mental health services where much of diagnosis and treatment relies on verbal and private communication (Sentell, Shumway, & Snowden, 2007).

If there are no mental health providers in the area who understand the culture and language of a particular client, telehealth may be a viable mode of mental health service delivery. Although
attention has been devoted primarily to the value of telehealth for rural communities (Griffiths, Blignault, & Yellowlees, 2006; Hilty et al., 2006; Yellowlees, Marks, Hilty, & Shore, 2008), it also has the potential to meet the critical mental health care needs of the linguistically isolated as well. The President’s New Freedom Commission on Mental Health (2003) has recommended the use of “health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas in underserved populations” (p. 79). Recently, increasing attention has been paid to mental health care via telehealth (Choi et al., 2012; Norman, 2006; Riemer-Reiss, 2000), and randomized control trials (O’Reilly et al., 2007; Ruskin et al., 2004) report that psychiatric consultations delivered via telehealth are not only as effective as face-to-face encounters in a traditional setting, but also have equivalent levels of patient adherence and satisfaction.

Telecounseling is admirably suited to meet the needs of linguistically isolated groups with limited or no access to mental health professionals who can deliver culturally and linguistically appropriate services. According to the 2010 Census, more than 18% of the U.S. population (47 million Americans) do not speak English as their primary language and more than 25 million speak English less than “very well” (Pandya, McHugh, & Batalova, 2011). Although those with limited English proficiency present higher rates of mental health problems, their access to mental health services is limited (Derose et al., 2007; Ponce et al., 2006; Sentell et al., 2007; Sorkin, Pham, & Ngo-Metzger, 2009). Their unmet needs are great: There are more than 320 languages spoken in the United States (U.S. English Foundation, 2012), and the current United States mental health system lacks providers who can address these linguistic diversities (Cook, McGuire, & Miranda, 2007; Miranda & Cooper, 2004). In this context, telecounseling is a viable mode of service delivery that can link the linguistically isolated with culturally and linguistically appropriate services available but at a distance.

Despite a growing interest in telecounseling for racial/ethnic minorities (Shore, Bloom, Manson, & Whitener, 2008), surprisingly few attempts have been made to address the emotional needs of “language” minorities. In one of the few available studies, Yeung and colleagues (2009) provided telecounseling via videoconferencing to Chinese residents in a nursing home in Boston’s Chinatown. The participants received counseling services from a Chinese speaking mental health professional at Massachusetts General Hospital. The study reports a substantial reduction in participants’ psychiatric symptoms, suggesting that telehealth technology may offer ways to meet the critical mental health care needs of the linguistically isolated.

This study explored the feasibility and preliminary efficacy of a telecounseling program in the client’s native language. Research has consistently shown that psychotherapeutic interventions such as behavioral therapy, cognitive behavioral therapy, bibliotherapy, problem-solving therapy, and brief psychodynamic therapy are effective in the treatment of older adults with depression (Moss & Scogin, 2008; Shah, Scogin, & Floyd, 2012). Unfortunately, linguistically isolated elders often lack access to these treatments. In order to examine the potential value of telecounseling, this study targeted a small number of Korean elderly residents in a low-income housing facility in Orlando, Florida.

Four characteristics rendered this group ideal for the pilot intervention. First is the geographic isolation experienced by Korean elders in Florida. Like other ethnic immigrants in the United States, Korean Americans show an uneven geographic distribution. Areas with large Korean populations (e.g., New York with more than 12% of the total population of Koreans in the United States) generally have established Korean communities with enriched ethnic resources. However, in areas with smaller proportion of Koreans (e.g., Florida with only 1.7% of the total population of Koreans in the United States), such resources may be scarce or nonexistent. Second is the relatively high vulnerability to depression observed in this particular group of older Korean Americans. In a previous survey of older Korean immigrants in West Central Florida, Jang and Chiriboga (2010) found that more than 47% of the participants from this housing facility fell in the category of probable depression. Compared with the 15% reported in a statewide older adult sample of non-Hispanic whites in Florida (Jang, Chiriboga, Kim, & Phillips, 2008), this figure is notably high. Third, residents of this housing facility have a relatively low rate of English proficiency; 86% of the housing residents have reported their English-speaking ability as “not at all” or “not very well” (Jang & Chiriboga, 2010). Fourth, there are no Korean speaking mental health professionals in the area, which makes it difficult if not impossible for the residents to obtain mental health services.

In order to provide access to culturally and linguistically appropriate mental health services, the
target elder population in Florida was linked with Korean mental health providers based in New York through videoconferencing technologies. It should be noted that the focus of the project was on providing access to mental health services in a real-world setting rather than testing a specific mode of psychotherapy or developing a treatment protocol specific to telecounseling. This investigation focused on participants’ adherence, satisfaction, and changes in depressive symptoms.

Methods

Participants and Program

The project was conducted with approval from the university Institutional Review Board. The telecounseling program was conducted during spring 2012. The elderly Korean participants were volunteers recruited at the housing facility through such methods as flyers, presentations at residents’ meetings, and referrals through informants. With an anticipated attrition of 10%–20%, a volunteer-based quota sampling method was used. The goal was to recruit a minimum of 14 participants.

Individuals who expressed an interest in participating were contacted by the project manager for an initial eligibility screening via phone. The inclusion criteria included (a) Korean resident living in the low-income housing facility, (b) aged 65 and older, (c) personal concern about depressive moods, and (d) absence of cognitive impairment (<3 errors on the Short Portable Mental Status Questionnaire [Pfeiffer, 1975]). All screening and assessment tools were in Korean. Each eligible participant was assigned a counselor and scheduled for 4 weekly sessions. During the first counseling session, the counselors conducted further screening to exclude those with severe depression (PHQ-9 > 20), thoughts of suicide (positive response in the ninth item in the PHQ-9), history of psychiatric hospitalization, and current use of mental health counseling or antidepressants. Given the pilot nature of the study, these assessments were designed to reduce the possibility of a psychiatric emergency or of interference with ongoing treatment. Among the 14 individuals in the initial pool, no one met any of the exclusion criteria.

If counselors identified a participant with suicidal thoughts and/or severe symptoms of depression, the study protocol called for a licensed psychologist on the research team (V. Molinari) to review the case and to make appropriate referrals (e.g., local Korean primary care physicians, inpatient hospitalization, local crisis center). However, no such case was identified during the study period.

The program offered 4 weekly counseling sessions (30 min in each) delivered by New York-based Korean mental health counselors. In part, the brevity of treatment was because studies suggest that lengthier interventions lead to greater dropout rates (Pinquart, Duberstein, & Lyness, 2007). Moreover, short-term sessions have been reported as an effective strategy for Asian Americans not familiar with counseling (Hong & Ham, 2001) and for telecounseling (Griffiths et al., 2006). Four licensed social workers, bilingual in English and Korean, provided counseling services. All counselors were women with more than 5 years of clinical experience, and their training and practices were based on cognitive behavioral therapy. Counseling sessions covered problem identification, problem-solving skills, pleasant event scheduling, and client feedback. Counselors had weekly peer counselor meetings via multipoint videoconferencing to discuss client progress and receive feedback from each other. Each client counselor pairing was maintained through all four sessions.

Regarding licensure, Florida’s 491 Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling (Online Sunshine, 2012) requires full state licensure to practice telecounseling. However, there is a critical exemption: “counselors licensed in another state may provide treatment to clients in Florida for an equivalent of 15 days in Florida without a state license.” The timeline of the current project was crafted to ensure compliance with the state licensing board’s requirements.

Telecounseling sessions were provided in a setting convenient to the clients (e.g., home, meeting room in the facility) where privacy was assured. For each session, videoconferencing equipment was brought to the specified location by the study’s project manager. During all sessions, the project manager remained in a separate room in case the client needed assistance or in the event the counselor felt that the client required immediate additional care. The project manager was trained to call the licensed psychologist in case of a crisis. In each counseling session, a phone (landline or mobile) was available as a backup in case of technical failure.

Videoconferencing equipment was installed in all computers to be used for counseling. Counselors used their own internet connected desktop or laptop computers at their locations. For clients, a laptop computer with mobile internet connection was used. In each computer, a Health Insurance Portability
Assessment Plan

Within 3 days after the completion of the 4-week counseling program, each client was interviewed regarding depressive symptom severity and satisfaction with the telecounseling program. Open-ended questions were also asked to solicit feedback from the participants. A follow-up assessment for clients’ depressive symptom severity was conducted 3 months after the completion of the program. All assessments were conducted by the project manager via telephone and included the following two well-validated scales.

Satisfaction with counseling services was measured with the Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The CSQ is an 8-item brief instrument, asking individuals about the quality of service that they received, the extent that the program met their needs, willingness to recommend the program to others in need of similar help, and willingness to return to the program if additional services were offered. Each item was coded with a 4-point Likert scale. The instrument is unidimensional and provides a homogeneous estimate of overall satisfaction with services. The scale has been frequently used for evaluations of diverse programs and has shown good psychometric properties (Griffiths et al., 2006; Roberts, Attkisson, & Stegner, 1983). The total scores range from 0 to 24, with higher scores indicating greater levels of satisfaction.

Posttreatment depressive symptom severity was also assessed with the Patient Health Questionnaire 9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001). As a depression module for the PHQ (Spitzer, Kroenke, & Williams, 1999), the PHQ-9 contains nine items based upon diagnosis of Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) depressive disorders. Participants were asked to report how often, for the past 2 weeks, they have been bothered by problems such as “little interest or pleasure in doing things,” “feeling down, depressed, or hopeless,” “trouble falling or staying asleep or sleeping too much,” and “poor appetite or overeating.” Each item was scored on a 4-point scale ranging from “not at all” (0) to “nearly everyday,” (3), and the total scores could range from 0 to 27, with higher scores indicating greater levels of depressive symptoms. The PHQ-9 has been widely used as a diagnostic and severity measure of depression in various settings and with diverse populations. The scale has been translated into the Korean language and its psychometric properties have been validated (Han et al., 2008).

Results

A total of 14 older Korean immigrants were recruited for the telecounseling program, and all met inclusionary criteria. The age of the participants ranged from 68 to 98, with an average of 80.4 (SD = 7.15) years. More than half of the participants were women (57.1%; n = 8) and about 36% (n = 6) were unmarried. About 64% (n = 9) of the participants had less than a high school education. The number of years lived in the United States ranged from 4 to 40, with an average of 25.3 (SD = 9.88) years. More than 85% (n = 12) of the participants reported their English-speaking ability either as “not at all” or “not very well.” None of the participants had prior experience with using mental health services. Three participants had a computer at home, and only one person had used the Internet. Characteristics of the participants are summarized in Table 1.

All but 2 participants completed all four sessions of telecounseling (completion rate of 86%). After the first session, a 77-year-old woman voluntarily dropped out due to lack of interest and a 98-year-old woman due to fatigue. The latter participant had minor hearing impairment and speaking loudly during the session seemed to exhaust her. During the entire project period, there was only one instance of technical failure. The session, however, was carried out with the use of a backup telephone. The scores for the CSQ ranged from 15 to 24 and averaged 17.6 (SD = 3.44) years, indicating a moderately high satisfaction.

The participants’ depressive symptom scores at three assessment points are graphed in Figure 1. The differences in depressive symptom scores between the time points were assessed with sets of paired t tests. The mean score of the PHQ-9 at the immediate postassessment (M = 8.50, SD = 2.27) was lower than that at the preassessment (M = 11.6, SD = 2.14), and the change was statistically significant (t = 13.1, p < .001). The PHQ-9 scores at the 3-month follow-up averaged 9.25 (SD = 2.00), which was significantly higher.
than the mean at the postassessment ($t = -2.46$, $p < .05$) but still lower than that at the preassessment ($t = 10.5$, $p < .001$). The findings indicated that the depressive symptom severity was reduced on immediate completion of the program, but the observed benefit did not sustain at a statistically significant level after 3 months. It is notable, however, that the participants’ depressive symptom scores at the 3-month follow-up remained significantly lower than those at the pretest.

### Discussion

Findings from the pilot project support the feasibility of use and the positive therapeutic outcomes possible with telecounseling. With only two dropouts out of 14, the completion rate (86%) was reasonably high. Despite the literature on stigma related to mental health service use in ethnic minorities (Leong & Lau, 2001; Lin & Cheung, 1999), participants in this study showed generally high levels of acceptance and adherence to the telecounseling program. The high retention of the participants may be due to multiple factors including brevity of the program and convenience of the location. Also, cultural respect for professionals and the experience of learning (Hong & Ham, 2001) often observed in Korean American older adults might have contributed to the favorable

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of sessions completed</th>
<th>Client satisfaction</th>
<th>PHQ-9 at pretest</th>
<th>PHQ-9 at post-test</th>
<th>PHQ-9 at 3-month follow-up</th>
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<tr>
<td>Mrs. L</td>
<td>77</td>
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<td>13</td>
<td>10</td>
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<tr>
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<td>-</td>
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<td>-</td>
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<tr>
<td>Mrs. Y</td>
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<td>10</td>
<td>8</td>
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<tr>
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<td>77</td>
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<td>-</td>
<td>12</td>
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<tr>
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<td>4</td>
<td>19</td>
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<td>7</td>
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<td>16</td>
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<tr>
<td>Mrs. H</td>
<td>87</td>
<td>4</td>
<td>15</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

Figure 1. Changes in depressive symptom severity.
outcomes. It is worthy of note that, in the aforementioned survey with Korean American older adults in West Central Florida (Jang & Chiriboga, 2010), a majority (85%) said that they would be willing to use counseling services if a Korean-speaking counselor were available. This project reflected the needs of the community and led to successful outcomes.

Overall satisfaction with the program, as judged by results from the CSQ, was also high. In the open-ended questions, participants expressed positive feelings about the program. Some examples include “it was great to have someone listen to my problem,” “I have been waiting for the session all week,” “I felt great after throwing my troubled emotions out,” “talking with the counselor really remedies my loneliness,” “I learned how to think positively,” “I would like to have more sessions,” and “I am thankful for the opportunity to talk with an expert.” Yeung and colleagues (2009) suggest that talking about mental health issues with providers who share the same language and culture but who are geographically distant may help people feel comfortable disclosing their emotions. Given that individuals living in a small ethnic community are often concerned about other people knowing about their psychological problems or discovering their use of mental health services (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007), counseling at a distance may actually increase a sense of security and thereby allow participants to become more open and accepting of psychological interventions.

In the evaluation of depressive symptom outcomes, an interesting finding emerged. The participants exhibited a significant reduction in symptom severity at the completion of the program. At the 3-month follow-up, benefits waned, but the participants’ depressive symptom scores remained significantly lower than those at the initial assessment. It is notable that such a brief intervention had an affect on participants’ depressive symptoms despite the fact that the participants’ initial symptom levels were not severe and did not have a large range to fall. The decision to use a brief, four-session counseling program was based on recommendations from the literature (Griffiths et al., 2006; Hong & Ham, 2001; Pinquart et al., 2007), although limited funding and state licensure restriction also played a role. At this point, it can only be conjectured whether a longer treatment protocol or periodic booster sessions would maintain or even enhance therapeutic gains.

Indeed, although research strongly suggests that psychotherapy is effective for late-life depression and that the benefits are often sustained, all of the evidence-based treatments for depression in older adults listed in Scogin and Shah (2012)’s summary of the literature appear to have protocols with lengths of treatment substantially greater than four sessions. A four-session module may not be intensive enough to yield maintenance of clinically significant symptom reduction.

As a pilot intervention, this study is limited in a number of ways. First, the study was based on a single-group prepost design without a control group. The absence of a control group makes it difficult to determine whether the observed benefit is due to the treatment itself or to simple interpersonal contact for these isolated elders. Second, the generalizability of the findings is limited because of the small pilot sample of one ethnic group in one setting. We, therefore, were neither able to evaluate the characteristics of those patients who fared better nor to assess therapist variability in outcomes. Third, the counselors were asked to treat their clients based on their own particular therapeutic style rather than adhere to a specific treatment manual. Therefore, we were not able to assess the content of the sessions to identify the therapeutic processes responsible for the decreases in depressive symptoms. Finally, efforts should be made to develop a counseling protocol specific to the use of telecounseling and alliance to the protocol or fidelity should be part of the assessment.

Despite these limitations, our findings support the value of telecounseling for the linguistically isolated and suggest further efforts to extend such programs. Future research needs to investigate the specific technical systems necessary for cost-effective telecounseling sessions, to classify ideal characteristics of clients and counselors for telecounseling interventions, to categorize matching therapist/client styles, and to evaluate which interventions are most effective when delivered through telemedicine technologies. The optimal length of mental health treatment interventions for the various linguistically isolated populations also deserves attention. Given the diversities of each group, development and delivery of programs that address cultural and linguistic needs requires iterative processes and continued efforts.

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