**A Culturally Adapted Family Psychoeducation Program:**

**The Experiences of Russian-Speaking Immigrant Mothers who Care for Adult Children with Severe Mental Illness**

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**Abstract**

The successful integration of cultural competence with evidence-based practices in mental health services is still limited for particular cultural populations. The current study explored culturally adapted family psychoeducation for immigrants from the former Soviet Union who care for a family member with severe mental illness. Semi-structured in-depth interviews were conducted with 18 Russian-speaking immigrant mothers who participated in culturally adapted psychoeducation groups in Israel. Qualitative content analysis revealed five salient processes and changes that participants attributed to their engagement in the intervention: 1) from a language barrier to utilization of and satisfaction with services; 2) from a lack of information to acquiring new mental health knowledge; 3) from harboring a family secret to exposure and sharing; 4) from social isolation to cultural belonging and support; 5) from families blurring boundaries to physical and emotional separations. The results showed that these changes - linguistic, cognitive, emotional, socio-cultural and relational - improved family coping and recovery. Implications for cultural adaptation of family psychoeducation for Russian-speaking immigrant caregivers are discussed.

Keywords: Russian-speaking immigrants, severe mental illness, family psychoeducation, cultural adaptation, cultural competence, evidenced-based practice, qualitative research

**Introduction**

Following the collapse of the Soviet regime in the early 1990s, more than 1.6 million Russian-speaking citizens emigrated to Israel, the US, Canada, Germany and other Western countries (Remmenick, 2012). Just in Israel, over one million immigrants arrived from the former Soviet Union (FSU) between 1990 and 2006; this was the largest wave of immigration in the history of the country and it increased the Jewish population of Israel by about 17% (Al-Haj, 2019).

Whereas some immigrant groups from the FSU have adjusted well to the Western countries, others have shown elevated levels of psychological distress, somatization and psychiatric disorders (Jurcik, Chentsova-Dutton, Solopieieva-Jurcikova, & Ryder, 2013; Mirsky, 2009). For example, in epidemiological studies conducted in Israel, FSU immigrants were found to be at about 1.5 times greater risk for developing psychotic, affective and anxiety disorders than native-born Israelis (Mirsky, Kohn, Levav, Grinshpoon, & Ponizovsky, 2008; Weiser et al., 2008). At the same time, FSU immigrants display relatively negative attitudes toward mental health services and utilize them at low levels (Shor, 2006; Ristner, Ponizovsky, Kurs, & Modai, 2000). Additionally, FSU immigrants who have received mental health services and treatments report low levels of satisfaction (Author, 2015b; Dolberg et al., 2019).

Researchers have explained these mental health disparities by noting that FSU immigrants experience more stress and social adversities due to adjustment difficulties in the host country, as well as have limited access to essential resources and support in comparison with the local-born population (e.g., Mirsky, 2009). The language and cultural barriers make it difficult for them to seek help and receive the desired services; these barriers include communication difficulties, high levels of social stigma surrounding mental illness, and the suspicion and distrust of the system (Author, 2015a; Polyakova & Pacquiao, 2006). Such negative attitudes towards mental health services have also been shown to be related to the political abuse of psychiatry in the Soviet Union (van Voren, 2010), as well as a limited knowledge of Western mental health care and treatments (Dolberg et al., 2019).

Implementing culturally competent care has become a central strategy over the last two decades to reduce ethnic disparities (Kirmayer, 2012). This type of care aims to make health care services more accessible and effective for people from diverse ethnocultural communities. Cultural competence has been defined as: ‘‘the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs’’ (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. v). Cultural competence is especially important, albeit challenging to implement, in the context of evidence-based interventions in mental health care. While evidence-based interventions aim to produce accurate and generalizable knowledge, it may sometimes disregard the subjective experiences, values and life contexts of patients and their families (Kirmayer, 2012).

One of the most vital evidence-based interventions in mental health care is family psychoeducation. This intervention, developed by Falloon and colleagues in the early 1980s (Falloon, Boyd, & McGill, 1984), has become one of the leading practices utilized in working with families who care for relatives with severe mental illnesses (SMI), such as schizophrenia, bipolar disorder and major depression (Dixon et al., 2001; McFarlane, Dixon, Lukens, & Lucksted, 2003). The multi-family group intervention includes a series of weekly meetings with family members (usually 12-15 sessions) and are led by a mental health professional. The five core components of the psychoeducational model are: joining, education, problem-solving, establishing a strengths-based treatment environment, and multi-family contact. The goals of the group intervention include: imparting essential knowledge about mental illnesses and possible treatments, encouraging families to engage problem-solving coping, and decreasing family members’ expressed emotions. In a series of studies, this intervention has been shown to help families reduce the stress, burden and stigma that come with caring for a relative with SMI (Dixon et al., 2001; McFarlane et al., 2003). In addition, the family group intervention has been shown to help decrease symptoms and psychiatric hospitalizations among persons with SMI, as well as to improve their functioning and quality of their life (Dixon et al., 2001; Giron et al., 2015).

In recent years, as part of the goal of increasing cultural competency in mental health services, attempts have been made to adopt the family psychoeducation to different cultural contexts, such as Chinese and Hispanic minorities in the US (Hackethal et al., 2013; Kung, 2016a). These studies have demonstrated the effectiveness of psychoeducation interventions in addressing the needs of families from different cultural backgrounds (see also Lefley, 2012). However, empirical studies examining cultural adaptations of family psychoeducation for immigrants from the FSU are still lacking.

The aim of the present study was to fill this gap and explore the experiences of Russian-speaking immigrant mothers of persons with SMI in Israel. The main study questions were: (1) What are the salient processes and changes experienced by Russian-Israeli mothers following participation in a culturally adapted psychoeducational group (CAPG)? (2) Which components of the family psychoeducation program are most essential for meeting the unique cultural characteristics and needs of Russian-speaking immigrant caregivers?

**Method**

This paper is part of a larger qualitative study investigating experiences among Russian speaking immigrants in Israel who care for a family member with SMI. The current study presents specific findings on the experiences of Russian-speaking mothers who had previously participated in CAPGs. Utilizing a qualitative approach in this study enabled us to conduct an inductive examination of culturally adapted evidence-based interventions as reflected in the eyes of participants and their subjective perspectives and experiences (Kirmayer, 2012).

**Participants**

The criteria for inclusion in the study was as follows: (a) cares for a family member with SMI who is recognized by the Israel's National Insurance Institute as psychiatrically disabled (at least 40% disability); (b) an FSU immigrant who emigrated to Israel after 1990; (c) at least 18 years old; (d) living with, or having at least weekly contact with a family member with SMI; (e) participated in a Russian-speaking psychoeducation group in the community family counseling centers.

Eighteen mothers of an adult son or daughter with SMI participated in the study. Participants ranged from the age of 49 to 71 (*M*=60.5). In 67% of the families, the participants were single mothers (divorced or widowed). Most of the participants immigrated to Israel in the 1990s (61%), and the remainder immigrated after the year 2000 (39%). The average number of years since arrival in Israel was 18.1 (range: 5-25 years). Most of the participants had an academic degree (89%).

According to the demographic characteristics provided by the mothers, most of the adult children with SMI were male (72.2%). The psychiatric diagnoses included: schizophrenia (n=13), bipolar disorder (n=3), and major depression (n=2). The average number of years since receiving a psychiatric diagnosis was 14.5 (range: 3-34 years). In most cases, the sons or daughters with SMI lived in a joint residence with their family (72.2%), while the others lived in community rehabilitation housing such as hostels or assisted living facilities.

**Study Procedure**

Participants were recruited from family counseling centers (FCCs) in the community, which assist families of individuals with mental health problems and are funded by the psychiatric rehabilitation unit of the Ministry of Health. The participant recruitment process was carried out by the mental health professionals who worked in FCCs. They identified potential participants who met the inclusion criteria and subsequently informed them of the study. If an FSU caregiver was interested in participating, the professionals provided her with my contact information to obtain a more detailed explanation about the study.

This study was carried out in two FCCs that, alongside providing typical family psychoeducation, offered culturally adapted interventions for FSU immigrant caregivers. Interventions were carried out by Russian-speaking clinical social workers and family therapists who were employed by each center and had experience working with families of persons with SMI.

The research instrument used was a semi-structured in-depth interview (Patton, 2002). The first part of the interview focused on the spontaneous narrative of the participants (“Tell me the story of your family.”). In the second part of the interviews, participants were presented with more specific questions about their experiences in the Russian-speaking psychoeducation group. The questions were taken from the Narrative Evaluation of Intervention Interview (NEII) (Hasson-Ohayon, Roe, & Kravetz, 2006 .( This tool can be utilized to evaluate the subjective experiences of interviewees retrospectively, including family psychoeducation group intervention (see Levy‐Frank, Hasson‐Ohayon, Kravetz, & Roe, 2012). The open-ended questions asked participants to describe both the outcomes of the intervention, as well as the process of participating in it; for example, questions included: “Please describe what the intervention contributed to you”; “What changes, if any, took place during participation in the intervention?”; “How does this intervention differ from other interventions that you have attended in the past?”; “What did the group leader who delivered the intervention do that helped you?”; “What components of the intervention were helpful?”. These questions were formulated in a way that encouraged participants to spontaneously report on their experiences with the intervention (Hasson-Ohayon et al., 2006).

Data were collected by me at the end of the 15 psychoeducation group sessions.

Each interview was conducted individually, lasted between one and two hours, and took place either in the participant’s home or at the FCC (whichever the participant preferred). The interviews were conducted in Russian – my own mother tongue and that of the participants. The interviews were audio-recorded, transcribed, and then translated into Hebrew/English.

The university’s institutional ethics committee approved the research. Informed written consent was obtained from all participants prior to beginning the interview. To preserve confidentiality, the names of the participants, as well as any other personal information that might identify them or their family members, were either changed or deleted from transcriptions and analyses. Participants were informed that they could withdraw from participation at any time and for any reason, without incurring negative consequences.

**Data analysis**

Data were analyzed using qualitative content analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998). The first stage of analysis involved a process of open coding for each interview. Line by-line coding was performed, and common themes were identified. During the second stage, I identified significant themes relating to the intervention process and its consequences. In this phase, themes were mapped more precisely, and “entry criteria” for each category were established. Factors such as saliency and frequency of mention were used to determine the significance of the themes. At this point, some of the themes were renamed and reorganized. In the third stage, the analysis transitioned from being based on an individual-level analysis to a cross-sectional one. This phase was guided by the principles of the constant comparative method, which involves simultaneous inductive and deductive processes (Glazer & Strauss, 1967).

To ensure the trustworthiness of the analysis, several steps were taken. First, I consulted with another experienced qualitative researcher, who served as an external expert, commenting on and analyzing the data and emerging themes (Creswell, 2007). Second, the research design, data collection procedures, data analysis, interpretation of data, and organization of findings were described in detail. Third, the analysis process and subsequent results were presented before the mental health professionals who led the CAPGs for Russian-speaking caregivers in other FCCs. They remarked that the findings resulting from the data analysis accurately represented their experiences as leaders of these groups.

**Reflexivity**

The influence of my own bicultural and professional identity as an FSU immigrant and social worker in mental health field is reflected in my choice of subject and research population. As such, I have a close personal and professional connection to the research topic. The cultural closeness has placed me in the “insider” position with respect to the participants and enabled me to recruit them and build rapport relatively quickly during the interviews. In addition, my personal and clinical experience with FSU immigrants facilitated the analysis process, and made it possible to recognize cultural nuances present in the data. Unlike the participants, I have not experienced caregiving for a family member with SMI, and I am a younger male (whereas all of participants were middle-aged women). This “outsider” status helped some participants feel at ease, as they felt an advantage in having accumulated knowledge and experiences that I had not, which subsequently led them to want to share their insights and experiences with me.

**Findings**

The qualitative content analysis revealed five salient processes and changes that participants attributed to their engagement in the CAPGs: 1) from a language barrier to utilization of and satisfaction with services; 2) from a lack of information to acquiring a new mental health knowledge; 3) from harboring a family secret to exposure and sharing; 4) from social isolation to cultural belonging and support; 5) from family blurring boundaries to physical and emotional separations. The quotations and excerpts are integrated into the results section to provide an illustration of the processes and changes that Russian-speaking mothers experienced.

**From language barrier to utilization of and satisfaction with services**

The fact that the family psychoeducation groups were offered in participants’ native Russian language helped them to overcome the typical linguistic barrier as it enabled non-Hebrew-speaking caregivers to both participate in and benefit from the group sessions. Most participants stated that they were not fluent Hebrew speakers and needed linguistic and cultural mediation even many years after their immigration.

*I have been in the country for 20 years, but the language is still difficult for me. I kept working with Russians and I didn’t have a high level of Hebrew, which is why I’m having a hard time. I tried to approach a social worker, but they mostly speak Hebrew and I don’t understand anything so I was very happy to have an organized Russian-speaking group here. (Eva)*

Some participants said that they tried to apply to an FCC in the past and participate in groups but, due to language barriers, they were unable to receive satisfactory service.

*In the beginning, I came there [FCC] and no one understood me. I explained to them that I want to discuss issues…and preferably in Russian, because even if I can communicate my problems in Hebrew, I won’t understand what they will tell me… and at that time I was unable to receive this help because there weren’t any Russian-speaking social workers. Only after a year and a half, they contacted me when a Russian-speaking worker arrived, and she invited me to join the group. (Marina)*

Participants indicated that the need to receive help in the Russian language stems not only from objective linguistic difficulties, but also from an emotional need. Some of the participants who were fluent Hebrew speakers also described their preference to communicate in Russian in stressful and crisis situations: "When we began to participate in the group, we preferred Russian. I didn’t care that much, but my husband said that he wants to discuss this extremely sensitive matter only in Russian, even though he knows Hebrew". (Daria)

The additional advantage of having a group that was linguistically accessible was the bond that was formed with the group leader, and her ability to serve as a mediator between caregivers and the mental health providers of their adult children:

*I can’t converse with any of her staff members because they are all Hebrew speakers and for me this is a real problem and barrier. I even asked Olga (the group leader) to contact the people working in protected housing so that I could understand what’s going on there. So, Olga helps me out a lot in these situations because I can rely on her. (Karina)*

**From a lack of information to acquiring new mental health knowledge**

Participation in the group contributed to a change in the mothers' cognitive understanding, as it became a space in which they learned and acquired vital knowledge that reshaped their attitudes toward the mental health field. Most of the mothers stated that, until they began to participate in the group, they severely lacked information regarding existing services and rights in the mental health field. They felt that this situation hindered the recovery processes of their dear ones and intensified the burden imposed on them as family caregivers:

*I want to say that we lack information…there is almost no information available in Russian. Not in the hospital, not about the rehabilitation services, not about our rights… And I feel that we have a real hunger for information. It’s absolutely a real hunger, because I can’t find anything, I don’t know who to turn to, and I don’t know about the existing options for us. (Marina)*

The educational nature of support groups at the FCC enabled the participants to acquire knowledge, tools and vital information regarding mental illness, rights and relevant services. This new knowledge decreased the vagueness concerning the field of mental illness and gave participants a sense of control in their role as primary caregivers:

*Once they invited a psychiatrist to the group who described very clearly the situation surrounding the children, the illnesses and the parent caregivers, and gave clear definitions. Because there is very little literature available in Russian I really lacked information. I would like for the families to have clear information because it helps us to understand the illness and deal with it more correctly. (Nina)*

Some of the essential information that the group participants were initially exposed to was regarding progressive community rehabilitation services that did not exist in the FSU. These services help people with SMI to integrate in their communities: “After I began participating in this support group, I heard that there is a rehabilitation allowance and that a coach can be arranged… this is something that I only discovered here.” (Lydia)

The knowledge that accumulated over the course of the group meetings empowered the participants and generally improved their sense of control, security and assertiveness as caregivers when dealing with the system in order to utilize rights and new services:

*When I came to his social worker at the clinic, I immediately showed him what the counselor from the FCC printed about this or that new service, and he [the social worker] was surprised. He pretends that he doesn’t know, or perhaps the information reaches the group before it gets to him, I don’t know. But what matters is that we know what, when and from whom we need to request services. The knowledge gives us a lot of power. (Bronislava)*

**From harboring a family secret to openness and sharing**

Group participation gave mothers a space to vent and changed how they coped. They changed from regarding mental illness, and its accompanying stigma, as something that had to be concealed, to sharing and being open about their experiences. Before participating in the group, mothers’ knowledge and attitudes regarding mental illness stemmed mainly from stereotypes and stigmatic opinions that they developed in FSU:

*Over there, by us [in the FSU], it [the illness] was a terrible shame and people would keep away. Like venereal disease -- God forbid that someone should know… here, because of our Soviet mentality, I didn’t tell anyone, and since I didn’t tell anyone, I couldn’t expect help from anyone for many years. (Bina)*

The fear of rejection and discrimination, due to mental illness, in their country of origin caused them to internalize the public stigma and react with withdrawal and caution even after they immigrated to Israel. In Svetlana’s opinion, an especially pronounced stigma was prominent among intelligence and well-educated Jewish-Russian families that she met in the group:

*I remember that, in the beginning, people in the group were very closed off [when it came to talking about mental illness] because of the stigma. People think it’s something that you should be ashamed of, and this is all due to the mentality and attitudes that we internalized over there. People think that things like this don’t happen in intelligent and refined families. This mentality can be seen when parents come for treatment and ask how it could be that this happened to us, we raised our son in the best way possible.*

Most participants reported that, for them, the group was a unique space where, for the first time, they could share their family problems with others, problems that previously had been kept secret. The trust felt in fellow group members, one’s personal openness to share, and the act of listening to each other’s stories were significant factors in the emotional change that the participants experienced:

*Thanks to the group I was able to speak about and share issues that I had never told anyone, and it was an emotional relief for me. It’s important for me to have a place where I can unburden my heart, open up and talk, because I feel much better afterwards. (Marina)*

Some of the participants reported that, because of the definite cultural stigma in the Russian-speaking community and fear of rejection, they cannot share their problems with their friends, and that the group became the exclusively safe area for being open and sharing:

*I don’t talk too much with the neighbors. Although half of my neighbors are Russian… You can’t tell anyone about this problem because no one will understand. But here they will understand. That’s why people come to the group. Each one relates his problems and receives emotional support, and we also try to help each other at least by telling each other what I am telling you now. And what I am telling you, I don’t tell anyone. Because nobody cares. My other friends only want me if I’m happy. No one wants to hear painful stories. (Luba)*

**From social isolation to cultural belonging and support**

Participation in the group helped to broaden the socio-cultural resources of the mothers who, due to their status as immigrants in a new country and parents (mostly single parents) of children coping with SMI, suffer from a sense of alienation and social isolation in their daily lives. For most of them, participating in a Russian-speaking group was a unique opportunity to get to know additional families and broaden their support network:

*I feel that it undoubtedly widens my social circle, the fact that I go to the support group. Where else do I go? I don’t go anywhere else. And the fact that, due to my son’s illness, I am forced to go out and communicate…and it helps me cope. (Natalia)*

Beyond the social support received, the group meetings enabled the participants to experience, once again, a sense of cultural belonging. They felt belonging to a group of intelligent and educated people, which characterized their status in the FSU but had decreased after their immigration to Israel:

*Beyond that, people that participate in the group belong to an older generation. There [in the FSU] they graduated from university, they had very respectable positions, but as life went on, they found themselves in Israel. But here, they found themselves with nothing at all, and they feel very uncomfortable about it. At the family center they can at least speak to each other and feel at home. (Alexandra)*

The sense of loneliness and cultural alienation was reflected in the responses of participants who had once participated in Hebrew-speaking groups. Nina described the differences between the two groups, and emphasized the advantages of belonging to a group of people who share a common cultural background:

*Once I participated in a group of Hebrew speakers and I left because it made me feel worse. Often, they would begin to argue and shout, and then I couldn’t manage to understand very much although I get along well in Hebrew. I’m a talkative woman, but there among the Hebrew speakers, I wasn’t able to say a word… Now in the Russian-speaking group it’s more interesting and also the people are more intelligent. Here we feel closer to each other… (Nina)*

The close ties that often formed among the group members continued outside the FCC, as the group members organized their own group gatherings. It appears that the common cultural orientation enabled participants to maintain these bonds, which subsequently enriched the mothers’ social life:

*I am very grateful to the group because, thanks to them, I met people like me, and we became such good friends that today we are a clique... We now meet outside of the family center, we meet in our homes, we drink tea, we celebrate Russian holidays, we discuss various problems. (Luba)*

**From blurry boundaries to physical and emotional family separation**

Participation in the group led to changes in the relationships that mothers had with their adult children with SMI. It is evident that the process they underwent in the group contributed to the creation of a renewed balance regarding boundaries, communication and family dynamics that had been blurred following the outbreak of mental illness in the family and the immigration to Israel. The tension in the relationships, which escalated at times, is especially evident in the relationships between single mothers and adult male children. Vera described the transformation as one which used to be characterized by a state of fear and helplessness in her interaction with her son to one in which she was able to set clear and empathetic boundaries:

*Before I began to participate in the group, I felt like I was in a vacuum. I didn’t know how to speak to him, when to give in to him, when to retreat and when to confront him. I was like a hen… Let’s say he calls me and begins to shout, I used to be silent and listen to him and afterwards I was exhausted and worn out for half a day. Now, at least on the phone, I can say: “Anton, don’t shout. If you go on like this, I’ll hang up.” I began to be brave, at least on the phone, and even at home, when he arrives and starts to become upset, I say: “Anton, let’s sit down and discuss things.” (Vera)*

The change that the group participants underwent was reflected in the warmer emotions they expressed towards adult children with SMI and the improvement in their communication with them:

*The life that I had made me harsh and critical. And I was always making remarks and getting into arguments with him [my son]. Maybe I shouldn’t have acted that way with him. In the group, I realized that I should have related to him differently… with more, so to speak, warmth and love. Now I act differently towards him… and it greatly improved our relationship… (Klara)*

Other participants emphasized their tendency to be over-involved in the lives of their adult children. This tendency was especially evident in their dealings with the health system and encumbered the process of achieving appropriate boundaries within the family. The changes that resulted from the mothers’ participation in the group helped them realize the negative and hindering implications of being over-involved in the rehabilitation and autonomy processes of their children:

*Roslan [son with SMI] made two attempts to enter the hostel. The first attempt was completely my fault. I used to intervene in what went on there, in the hostel, and I didn’t trust the staff. Can staff members manage to function with a mother like this who intervenes in every matter? Then I realized that I mustn’t intervene, and only then was the move to the hostel successful… And that’s mainly due to the support that I received in the group. Before that, I was a completely different person. (Luba)*

Another change that the group participants underwent related to their ability to set boundaries and create, at least occasionally, periods of time and rest for themselves. This change is reflected in their new ability to balance between the commitment and care for their children with SMI on the one hand, and the commitment and care for their own personal needs on the other hand:

*Thanks to the support group, my husband and I began to go out, because we hadn’t gone out at all before that… We forgot that we are a couple, we were only parents of an ill child and that was all. For many years we didn’t travel together anywhere and then we decided that we should give it a try. At first, we went for two days and we saw that he got along well by himself. Now we can even travel for five days and that’s also thanks to the process we went through in the group. (Svetlana)*

**Discussion**

The present study explored the efficacy of culturally adapted psychoeducation groups for Russian-speaking mothers who care for adult children with SMI in Israel. This study, which is the first of its kind, examined the success of adapting an evidence-based family psychoeducation intervention to the cultural and contextual needs of FSU immigrants. Russian-Israeli mothers described their participation in the CAPGs as a major resource that facilitated their ability to cope with mental illness in the family, and greatly contributed to the many changes they experienced on emotional, cognitive, socio-cultural and relational levels. These findings are congruent with the extensive research literature that has demonstrated the associations between participation in psychoeducation support groups and a decreased sense of burden and stigma, along with an improvement in hope, coping strategies and interpersonal communication (Dixon et al., 2001; Levy-Frank et al., 2012; McFarlane et al., 2003).

Beyond the overall benefits of family psychoeducation, the findings also showed that Russian-Israeli mothers who participated in CAPGs benefited in some unique ways from these interventions: elimination of the language barrier, resulting in greater service use; acquisition of knowledge about Western mental health care; increased openness and sharing of experiences with others; decreased social isolation through feelings of cultural belonging and support exchanges. The findings are congruent with other studies that have identified the need to adapt evidence-based psychoeducational interventions to the cultural background of the families, and thus to make them more accessible and effective for diverse families (Hackethal et al., 2013; Kung, 2016a; Lefley, 2012).

On the organizational level, recruiting a Russian-speaking mental health professional to work at an FCC is a critical step in making culturally adapted interventions accessible. The group leader was perceived by the mothers as being not only a professional authority, but also as a cultural and linguistic mediator with Israeli society in general, as well as to deal with the mental health system in particular. These findings are in line with studies indicating that many first-generation FSU immigrants have difficulty speaking the new language even after many years in Israel (Remennick, 2012); however, even among those who acquired the new language, they preferred to express themselves in their mother tongue in cases of crisis and distress (Author, 2015b; Polyakova & Pacquiao, 2006).

Moreover, the mothers’ status as immigrants often led them to encounter linguistic and cultural barriers, as well as feelings of social alienation, which impeded their ability to receive resources that would be essential for the family’s coping with mental illness. The findings support previous studies indicating that immigrant caregivers are in need of accessible services, and professionals to actively provide cultural mediation and advocacy in order to fully utilize the rights and services to which they are entitled (Kung, 2016b). This is especially relevant in the case of FSU immigrants whose knowledge regarding the Western mental health field is extremely lacking (Dolberg et al., 2019). In the Russian-speaking groups, mothers were introduced to recovery-oriented mental health care and community rehabilitation services, both of which they had not been acquainted with in their country of origin. This learning process contributed to mothers’ perceptional change towards mental illness and mental health care and increased their sense of empowerment, hope and their family coherence as primary caregivers.

The findings showed that FSU immigrant caregivers invested considerable effort in concealing the illness, which subsequently led to strong feelings of guilt, shame and fear of rejection, which in turn led to their withdrawal from their immediate environment (Larson & Corrigan, 2008). These findings are congruent with many studies that have noted a pronounced public stigma of mental illness in general, as well as stringent and negative stances among FSU immigrants towards the field of mental health that persist after they immigrate to Western countries (Author, 2015a; Dolberg et al., 2019; Polyakova & Pacquiao, 2006). The present findings indicated that the experience of mental health stigma may be even more pronounced in high-educated families who consider themselves to be part of the Russian-Jewish intelligentsia. The process that the mothers underwent in the group helped to lessen their subjective sense of burden and normalized their feelings of guilt, shame and anxiety.

A more comprehensive analysis of the findings indicated the grave implications of double stigma and exclusion on FSU caregivers' emotional and social experiences. Because of the stigma of mental illness and mothers’ fear of rejection, mothers distanced themselves, either physically or emotionally, from their fellow Russian-speaking community members. At the same time, due to lingual barriers, cultural alienation and previous rejection experiences most of them reported not feeling a sense of belonging and openness towards the local-born population. Thus, they lose out in both ways and have difficulty finding a secure social and emotional space. In these circumstances, CAPG for Russian speakers had essentially become the only space where the mothers felt protected from social rejection and a place in which they developed a sense of belonging, which was based on cultural similarity to the other group members, as well as their common connection to the mental health field. In line with Bourdieu’s (1977) theory, participation in CAPGs allotted FSU immigrants a type of social arena to preserve and foster their cultural capital. Within the group, they not only received social and emotional support, but they also were able to connect with their native culture by way of language, symbols, prestige and common experiences.

These findings contradict previous findings that demonstrated FSU immigrants’ tendency to cope with crises and distress within the family space, and to be less likely to seek formal support in general and support groups in particular (Leipzig, 2006; Shor, 2006; Slonim-Nevo, Sharaga, & Mirsky, 1999). These differences can be explained by certain contextual factors. Firstly, most previous testimonies were gathered within clinical practices and recruited families that were mainly in the initial stages of coping. Secondly, the present study focused on mothers who are caregivers, a group that is generally more involved with mental health services as compared with other family members (Pattyn, Verhaeghe, & Bracke, 2015). Thirdly, the mothers in this study were not only coping with SMI in the family but also with multiple social adversities related to being immigrants. In light of their minimal family structure (i.e., multiple single-mothers, families with an only child) and having relatives who remained in their countries of origin (Remennick, 2012), mothers’ need for, and dependence on, external assistance is greater. Finally, the mental health stigma and fear of rejection prevented some mothers from receiving help from their nuclear or extended families, even when the relatives were in the country. The mothers’ participation in the group considerably broadened their support network and, to a large degree, substituted for the family support that they were lacking.

Our findings may suggest that authoritarianism and parental control, two attributes that have been previously noted as being defining characteristics of the Russian-Soviet family (Slonim-Nevo et al., 1999; Yakhnich, 2016), may be undermined in stressful circumstances such as immigration and mental illness in the family, which may subsequently lead to the blurring of family boundaries. On the one hand, in inter-family relations, mothers experienced a strong parental obligation to care for the adult child with SMI, but on the other hand, they experienced difficulty in caring, and often became critical and over-involved in the lives of their children – as such, they experienced blurred boundaries within the family. It has been suggested that the collectivist cultural background of FSU immigrants, which emphasizes the centrality of the family on account of the individual’s autonomy (Jurcik et al., 2013), may explain mothers’ difficulties in creating separateness within the family unit, even when it came at the cost of sacrificing and neglecting their personal health needs. Similar findings were reported in other studies that examined families from culturally collectivistic backgrounds, such as the Chinese populations in the US (Kung, 2016a). As part of the psychoeducational group process, the mothers reexamined these patterns and acquired tools to improve communication, set boundaries empathetically and recognize the importance of family separateness for easing the recovery process for themselves and their dear ones with SMI.

**Limitations and future studies**

The present study has a few limitations. First, one-time self-reported findings must be treated with caution because they do not provide information about changes over time and may depict participants’ most pressing issues at the time of the interviews. Second, there was considerable variance across participants in regard to the amount of time that passed since the start of the illness, time since immigration, and specific cultural background within the larger society of the FSU. Third, the study represented mothers’ experiences only, but did not include other Russian-speaking caregivers such as fathers, spouses and siblings.

In future studies, it will be important to offer a more balanced representation of immigrant caregivers of varying family proximity. Moreover, quantitative studies could compare between the experiences of burden and stigma among Russian speakers who participate in typical (non-culturally-adapted) psychoeducation groups and among those who take part in culturally adapted groups. In future qualitative studies, in addition to examining family members’ experiences, interviews should be conducted with persons with SMI and with mental health providers to get a multifaceted perspective on culturally adapted interventions.

**Implications for clinical practice and policy**

Theoretically, the present study supports the possibility of integrating evidence-based practices with cultural competence in mental health services. In the past, integration of these seemingly contradictory approaches involved epistemic and political tensions (Kirmayer, 2012). The present findings demonstrated that this integration is possible, effective and essential for addressing the needs of ethnically and culturally diverse family caregivers.

As for clinical implications, mental health professionals and family therapists in Western countries, and those working at FCCs in particular, can use these findings to adapt the suggested interventions to the needs of FSU immigrant caregivers. Due to the socialization practices of Russian-Soviet culture that discourage openness and expression of feelings (Jurcik et al., 2013; Leipzig, 2006), a psychoeducational approach that integrates directive, educative and cognitive techniques may be more advantageous for FSU immigrants as compared to other approaches, such as dynamic techniques.

As for the educational aspect, it would be important to distribute information in the Russian language, to broaden participants’ knowledge of the recovery-oriented approach of Western mental health care and to conduct training sessions focused on the utilization of rights and services in the mental health field. The very essence of the emotional work conducted with FSU immigrants is aimed to decrease their feelings of guilt and shame that result from the stigma of mental illness in the family. Therefore, it is important to both normalize and decrease these emotions during group sessions, as well as refute the mistaken stigmatic attitudes existing toward families of persons with SMI (Larson & Corrigan, 2008).

An additional aspect that deserves a central focus in interventions with FSU immigrants is the dynamics of dependence-separateness relations within the family. Emotional and physical separation from adult children with SMI can be cautiously encouraged; however, it is also important to be aware of the culturally-rooted ambivalence that family members may feel regarding the separateness and autonomy of their dear ones. The paradigm of expressed emotions (Leff & Vaughn, 1985) can be used in order to describe the negative influence of criticism and over-involvement in the family on the recovery processes of persons with SMI.

From an organizational standpoint, it is essential to acknowledge the benefits that group meetings have on immigrant caregivers not only from emotional and educational perspectives, but also from the social and cultural angle. An additional value of CAPGs for Russian speakers is that they provide them with a comfortable and secure social venue, not only for coping with mental illness but also for helping them with bureaucratic and social difficulties they encounter as immigrants in new country. Self-help groups should be encouraged after the intervention ends, so that participants can keep in touch with each other and continue supporting one another over the long-term.

On the policy level, it is important to incorporate cultural competence training for mental health service providers on system-wide, organizational and clinical levels. The findings of the present study provided evidence regarding the implementation and efficacy of CAPGs in two Israeli family centers; however, it is essential to continue investigating the implementation of these interventions in diverse organizational and cultural contexts. These systematic inquiries are necessary in order to evaluate and establish cultural competence as a leading practice in the mental health care field, particularly for providing support to family caregivers, as well as reducing the gap in the receipt and utilization of support.

For example, objective economic hardship may have a negative impact on the subjective health of immigrant caregivers which, in turn, may exacerbate their economic problems.

The following is a conceptual model of the burdens experienced by immigrants who care for a family member with SMI.

Additional demographic information is provided in Table 1.

**Table 1**

*Demographic Characteristics of Immigrant Caregivers (n = 32) and Family Members with SMI* *(n = 30)*

|  |  |  |
| --- | --- | --- |
| **Characteristics** | ***n*** | **%** |
| Gender (*n* =32)  Male  Female | 4  28 | 12.5  87.5 |
| Marital status (*n* = 32)  Married  Divorced  Widower | 13  15  4 | 40.6  46.9  12.5 |
| Relation to family member (*n* = 32)  Mother  Father  Spouse  Other (e.g., sibling, grandmother**)** | 24  4  2  2 | 75.0  12.5  6.3  6.3 |
| Education (*n* = 32)  Academic degree  Non-academic degree | 27  5 | 84.3  15.7 |
| Family member diagnosis *(n* *=* 30)  Schizophrenia  Schizoaffective disorder  Bipolar disorder  Major depression  Personality disorder | 17  3  4  4  2 | 56.7  10.0  13.3  13.3  6.7 |
| Onset of mental illness (*n* *=* 30)  Before immigration  After immigration | 8  22 | 26.7  73.3 |
| Residence (*n* *=* 30)  With family  Hostel or supported housing  Independent housing | 21  6  3 | 70.0  20.0  10.0 |

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