Immigrant Caregivers: The Double Burden Experience of Immigrants Caring for a Family Member with Severe Mental Illness

**Abstract**

The aim of this study is to examine the factors that shape the burden experience among immigrants caring for a family member with severe mental illness. In-depth semi-structured interviews were conducted with 32 immigrant caregivers from the former Soviet Union in Israel. The interviews were analyzed using qualitative content analysis. The participants described their burden as an accumulation of economic, linguistic, social, emotional, and health-related adversities that negatively affect their coping and adaptation on the personal and familial level. The results showed that the objective and subjective burdens they experience include dimensions pertaining to their role as family caregivers, dimensions pertaining to their immigrant status, and the circular interaction between these two, which intensifies the overall experience of burden. The study proposes a new term – the “double adaptation burden” – that can help promote the design of research, interventions, and policies suited to the multiple challenges of immigrant caregivers.

**Keywords:** family caregivers, immigrant caregivers, former Soviet Union immigrants, severe mental illness, caregiver burden, qualitative research

**Introduction**

Over the last several decades, the field of mental health has undergone a process of deinstitutionalization in Western countries, with the locus of care for individuals with severe mental illness (SMI) slowly transferring from psychiatric care settings to the community. These changes have increased the responsibilities and subsequent stress of family caregivers and have made them a central, and sometimes the exclusive, instrumental and emotional support system for individuals with SMI. But what happens when, parallel to caring for a relative with SMI, family caregivers undergo other stressful changes in their lives, as occurs in the immigration process? How is the care for a family member perceived during the cross-cultural transition? These questions and issues are at the focus of the present study.

**The caregiver burden and family adaptation for SMI**

Severe mental illnesses (SMI) are defined as diseases such as schizophrenia, bipolar affective disorder, major depression and personality disorder, the symptoms of which negatively affect an individual’s cognitive, emotional, and social functioning, making it difficult to achieve meaningful goals in life (Corrigan et al., 2008). The onset of mental illness and the psychiatric hospitalization that sometimes accompanies it is often experienced as a stressful and catastrophic event that harms the normative life cycle of the family system, deeply affecting all of its members and forcing them to adapt to a new routine in the shadow of illness (Shiraishi & Reilly, 2019; Spaniol & Nelson, 2015).

“Family burden” is the commonly used term in the literature to describe the distress experienced by family members as a result of providing intensive care for their loved ones (Awad & Voruganti, 2008; Gelkopf & Roe, 2014). Two types of burdens can be distinguished: an objective and a subjective burden. Objective burden is related to the complexity of the family member’s daily life and the financial, occupational, social, and family disruptions brought on by caregiving. The subjective burden, on the other hand, has to do with the perceptions and emotional reactions of family members; it often involves feelings like loss, guilt, and shame, and coping with the stigma associated with having mental illness in the family. Furthermore, the subjective burden of family caregivers often involves much concern about the future, and they suffer from a high level of mental and physical distress compared to the general population and caregivers of individuals with other health conditions (Gallagher & Mechanic, 1996; Gupta et al., 2015).

When both objective burden and subjective burden are high, it negatively affects the recovery from family crisis and the ability of family caregivers to develop resilience and support their loved ones with SMI (Shiraishi & Reilly, 2019). Adaptive processes for SMI in the family largely depend on the ability of family members to organize and rally around crises, acquire new knowledge, overcome stigma, and utilize the care services (Spaniol & Nelson, 2015). For this reason, in Israel and in other Western countries with progressive and recovery-oriented mental health services, family caregivers can receive valuable psychoeducation interventions in family counseling centers (Levy‐Frank et al., 2012). Psychoeducation for families is an evidenced-based practice that has been found to be effective in reducing the levels of stress and burden of family caregivers and improving recovery processes of their relatives with SMI (Dixon et al., 2001; McFarlane et al., 2003).

**Family caregivers in cross-cultural transition**

The burden that family members experience may be especially heavy in the case of immigrant caregivers (ICs), who alongside their caregiver role, must cope with cross-cultural transition in a new country. Thus, ICs may experience a double burden as result of their concern for the family member with SMI while they, at the same time, are coping with acculturation stress related to economic, cultural, and social changes due to their migration (Sam & Berry, 2010; Viruell-Fuentes et al., 2012). For example, many immigrants experience a decrease in their economic status following the move to another country, and those caring for a family member with SMI may find themselves in “double trouble” as they struggle to survive economically while simultaneously fulfilling their caregiver role (Kung, 2016). The accumulation of these stressful situations can negatively affect caregivers’ emotional and physical well-being; for example, studies on immigrants who care for elderly family members have shown that they experience more psychological and health problems than non-ICs (Soskolne et al., 2007; Suwal, 2010).

An additional characteristic of ICs is that they generally bring with them a unique cultural background that differs from that of the host country’s population. Incompatibility between the values espoused by assistance networks in the host country and those engrained in the IC’s culture may lead to conflict and tensions (Kirmayer, 2012). Moreover, ICs have linguistic-cultural barriers when they seek help for themselves or for their family member with SMI (Guzder et al., 2013).

Cultural gaps and social adversities experienced by immigrants are reflected in the intensity of the burdens they experience. Kung (2003) conducted research on Chinese-American ICs of family members with schizophrenia and described the enormous burden they cope with. Kung argues that, beyond the symptoms of illness and the accompanying stigma, the burden on Chinese families is related to the collectivist characteristics of their culture as well as to their immigrant status. These findings are echoed in other studies that found a higher level of subjective and objective burdens among ICs and ethnic minorities (Bradley et al., 2006; Guarnaccia & Parra, 1996; Ryder et al., 2000).

**Immigrant caregivers from the former Soviet Union in Israel**

The present study focuses on immigrants from the former Soviet Union (FSU) in Israel. From 1989 to the 2015, more than a million FSU citizens have immigrated to Israel, enlarging the general population by about 16% (Al-Haj, 2019). This immigration process began following the fall of the Soviet regime, which enabled Russian Jews citizens to immigrate to Israel, the U.S., Germany and other Western countries (Remennick, 2012).

Despite the relatively high level of education and professional experience of FSU immigrants, they face various challenges in the process of adapting to Israeli society, primarily due to underemployment, language barriers, limited social networks, and discrimination from the local-born population on the basis of their questioned status as Jews (Al-Haj, 2019; Remennick, 2012). Nevertheless, over time, most FSU immigrants and their children have managed to integrate into Israeli society while preserving the cultural characteristics of their country of origin (Remennick & Prashizky, 2019).

Certain demographic characteristics can be discerned upon examination of the family structure in the FSU immigrant population; families tend to have few children (usually one or two), and there is a high incidence of single-parent families (Remennick, 2012). Furthermore, ex-Soviet Jews tend to be suspicious of the establishment and its representatives due to their negative experiences in a totalitarian society and therefore, family and close friends are their main source of support in times of distress and crisis (Shor, 2006). This trend is especially prominent in the mental health field, where FSU immigrants are often on the receiving end of pronounced cultural stigma and negative attitudes, causing many to refrain from seeking external assistance for mental health issues (Author, 2015; Dolberg et al., 2019). This situation can lead to an especially heavy burden for ICs, and for women and mothers in particular, who often take on the bulk of caregiver responsibility (Remmenick, 2001). The ICs must care for their family member in parallel to their process of adjustment to a new society, without the family and social support networks they had in their country of origin.

**The current study**

Although the advantage of qualitative studies in a deeper and more nuanced understanding of such complex construction as the caregiver burden (Shiraishi & Reilly, 2019), only a few have investigated the experiences of burden among immigrant and ethnic minority families caring for individuals with SMI (e.g., Guarnaccia & Parra, 1996; Hernandez & Barrio, 2015; Kung, 2016). No such study has specifically addressed FSU immigrants. Moreover, most previous studies dealing with the burden experienced by immigrants caring for individuals with SMI have focused on their cultural background and little is known about the influence of immigration adjustment in this context. The current study attempts to fill this gap, examining the burden experience of ICs from the FSU, on the backdrop of their immigration to Israel. The main research question is: What are the factors that shape the burden experience among ICs of individuals with SMI, and how do these factors influence their personal and family lives?

**Method**

The present study applies a qualitative research method in the constructivist tradition (Patton, 2002). The advantage of the qualitative approach is that it enables an inductive examination of reality as reflected in the eyes of individuals, their life outlooks, and subjective experiences.

**Participants**

This article is part of a larger study investigating the experiences of FSU immigrants in Israel, who are caring for a family member with SMI. The inclusion criteria were that participants must be: (1) caregivers for a family member with SMI who is recognized by the National Insurance Institute of Israel as psychiatrically disabled (at least 40% disability); (2) an immigrant who arrived to Israel after 1990 and emigrated from the FSU; (3) at least 18 years old; and (4) living or maintaining contact on a weekly basis with a family member with SMI.

Thirty-two respondents from 30 families participated in the study: 28 single family representatives and 2 parent-couples. Participants ranged in age from 40 to 75 (*M*=61.12). The average number of years since arrival in Israel was 17.96 (range 3-25). The average number of years since receiving a psychiatric diagnosis of family member was 14.59 (range 3-34). Additional demographic information is provided in Table 1:

Here Table 1

**Study Procedure**

The participants were recruited via two main channels: 1) purposive sampling through two community-based family counseling centers that assist family caregivers of individuals with mental health problems, including FSU immigrants and 2) snowball sampling, in which names of potential participants were requested from consumers, family caregivers, and mental health professionals. The integration of these sampling strategies enabled the recruitment of participants with varied demographic characteristics in regard to gender, age, marital status, area of residence, socioeconomic status, and help-seeking behaviors. The data were collected in Israel in 2015-2016 and sampling was continued until data saturation was achieved.

The research instrument was an in-depth semi-structured 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 interview, more specific questions were asked, addressing various aspects of the participants’ experiences of illness and immigration as family caregivers, for example: “How did your life change after the onset of mental illness in the family?”; “How does the role of family caregiver affect your personal, social, and professional life?”; “Tell me about the changes that took place in the family after immigration.”; "How has coping with mental illness in the family affected your immigration experience?”.

The interviews were individual, with the exception of two interviews conducted with a parent-couple. Each interview lasted between one and two-and-a-half hours, and was conducted in the participant’s setting of choice (e.g. home, family counseling center, coffee shop). The interviews were conducted in Russian, the participants’ mother tongue. The interviews were audio-recorded, transcribed, and then translated from Russian into Hebrew/English by the researcher, who is bilingual.

A human subject committee at Ben-Gurion University of the Negev approved the research. The participants’ written informed consent was obtained before each interview, and they were provided with a written assurance of confidentiality. To preserve confidentiality, the names of the participants, as well as any other personal information that might identify them or their family members, have been deleted or changed.

**Data analysis**

Data analysis based on a qualitative content analysis approach (Schreier, 2012). This analysis consisted of a number of steps, including "breaking" the text down into small units, identifying categories, and reconstructing the data. The first stage of analysis involved open coding of each interview. Line-by-line coding was performed and common themes were identified, which were subsequently specified as preliminary categories. During the second stage, preliminary codes and categories relating to the participants’ burden experiences and their consequences were identified. In the third stage of analysis, categories were mapped more precisely, and “entry criteria” for each category and sub-category were established. Factors such as saliency and frequency of mention were used to determine the significance of the categories. At this point, some of the categories were revised, removed, and/or reorganized. The comparison of categories across cases was achieved through spirality and repeatedly moving between the individual stories, common categories in all interviews and prior theory. Finally, six sub-categories were developed and were then organized into two main categories. This step allowed for the creation of an integrative and orderly category system, which served as the basis for a new theoretical conceptualization of the findings in accordance with the research question.

The data was analyzed by the researcher, whose clinical and research experience with FSU immigrants in the mental health field and his bicultural background facilitated the analysis process. To ensure the trustworthiness of the analysis, several steps were taken: first, the researcher consulted another experienced qualitative researcher, who served as an external expert, commenting on and analyzing the data and the emerging categories. Second, the results are reported as a “thick description,” which includes detailed information about the research process, context, appropriate citations, and open conceptual discussion. This type of reporting ensures adherence to the interview text and allows the reader to appreciate the researcher’s interpretation. Third, after completing the study, the researcher returned to several of the participants (member checks) and shared the research findings with them (Lincoln & Guba, 1985). Their feedback was that the findings properly reflected their family story, and the voice they sought to express in the study. In addition, the analysis process and its results were presented in several academic and professional forums to researchers and mental health providers who encounter immigrant caregivers in their daily work. They found the study to be a close representation of the reality they encounter in the field.

**Results**

The present study addressed the burden experiences of ICs. Following the interview analysis, two main categories were identified: the objective dimensions of burden – the instrumental “price,” and the subjective dimensions of burden – the emotional “price.” Each of these categories is composed of several sub-categories that provide a more multifaceted and detailed breakdown.

**Dimensions of objective burden**

From among the various difficulties that characterize their lives, the participants mainly emphasized three objective factors that create most of their burden as ICs: 1) economic and occupational difficulties; 2) housing problems; 3) language difficulties. These categories highlight social adversities and barriers that ICs suffer from, and the negative implications of these for the caregivers and their family members with SMI.

***Economic and occupational difficulties***

Participants indicated that their economic difficulties stemmed from two primary, interconnected reasons: difficulty in immigration adaptation and caring for a family member with SMI. Because most people with psychiatric disability have a hard time finding steady employment, they often subsist on a disability allowance from the National Insurance Institute but still require the economic assistance of their relatives. Participants spoke of the economic burden this entails; this was the main theme in many of their narratives. For instance, Mikhail (age 70) began his story with this:

*Well, what can I say? The burden is mainly economic. I am already an older man, retired, and I must work in order to support my sick daughter… the money is not enough for her…she doesn’t work, and because of her illness, she isn’t able to find anything suitable…I’m already tired of working and want to rest, but I have no other choice.*

Most participants (n=24; 75%) described economic and occupational difficulties they had in the past, or (for some) were still experiencing, following immigration. These difficulties forced most of them to lower the standard of living they enjoyed in the FSU; In Israel, they often worked long hours and sometimes experienced periods of poverty*.* Some of the participants used the word “survival” to describe their adaptation hardships as ICs. The economic difficulty is especially prominent among single mothers who immigrated to Israel alone and don’t have any family support:

*I had so many economic problems and I had to constantly survive and survive. I was constantly fighting for Adik (son with SMI), trying to find him a proper setup, and deal with economic problems. Now it scares me to look back and understand how I survived all that (Kira, 65).*

In most cases, ICs are not able to cope with the double economic burden for long and have to choose what to concede and to which goal they will devote most of their resources – to the care of the family member or to their work and career development. Some of the participants said that because of economic adversity and the need to work long hours, they couldn’t fully fulfill their role as caregivers. Other participants preferred to sacrifice their professional careers and their wishes for personal development in favor of dedicating themselves to caring for the family member:

*I was offered many jobs that I wanted. I could have also studied at nursing school. But I lost out. I was very involved with my son rehabilitation. We are rehabilitating him, and it has affected us…I didn’t have time to learn and* *get my degrees recognized … I haven’t worked here in my profession [nursing] for even a single day. (Eva, 62)*

***Housing problems***

The subject of housing problems came up in almost all of the interviews, which confirmed that this matter was a central, sensitive, and painful issue in the participants’ lives. The families living in rented apartments (n=18; 56%) expressed the greatest distress, and since they cannot afford to buy an apartment, they await solutions from the state. It is evident that moving from one rented apartment to another does not allow them to settle down and creates increased stress, both economically and in terms of the time and discomfort involved:

*In my twenty-two years here, I moved nine times, and every move like that is very difficult and involves many related expenses for movers and moving. Landlords made problems, either they would evacuate us or they needed the apartment and once again we had to look for a new apartment. (Bronislava, 72)*

The participants noted an association between their housing situation and the mental health condition of their family member. Oksana (40), whose brother had lived in several housing arrangements, sees a connection between solving the housing problem and her brother’s recovery:

*I wish a housing solution could be found. I would like for him to be able to move out of the hostel and have an apartment where he could live with assistance. Therefore, public housing is a solution… Because he wouldn’t have to move from one place to the other and would be able to be mentally stable as well…. It could definitely help him feel like a human being.*

One of the frequent barriers to recovery is the inability of family caregivers and individuals with SMI to live in separate apartments. Living in crowded quarters under one roof creates tension and pressures, and negatively impacts the efforts of individuals with SMI and their family caregivers to create healthy physical and emotional boundaries:

*The economic aspect affects us a lot. Sure, if I had the money to pay for the apartment all by myself, maybe I would have left a long time ago, and we would have split up. Because it’s hard for us to live together… And we are forced to live together, even though we don’t get along so well. (Natalia, 61)*

***Language difficulties***

Language acquisition is one of the central challenges in the adaptation process of immigrants to a new society. Most of the participants (n=18; 56%) reported that they have no command or only partial command of Hebrew, though some of them have been living in Israel for over 20 years. Even participants that have acquired the language have trouble understanding and speaking freely in their encounters with various bureaucratic systems, and they prefer to speak their mother tongue.

Some participants related that caring for their family member made it difficult to dedicate themselves to learning Hebrew in their first years in Israel:

*I went to an Ulpan [program for learning Hebrew]. But at the Ulpan…I wanted learn the language very much, but I had thoughts and worries on my mind. Half of my mind was listening to the lesson and the other half was worrying, what is he doing now and how does is he feeling? (Nina, 70)*

Most of the participants stated that the language barrier is their biggest obstacle in acquiring new mental health knowledge and getting the external assistance they need: “There is a definite lack of information in Russian, and perhaps there are good things, but you don’t know about them. And then we are forced to search almost blindly” (Raisa, 69 and Yaakov, 71).

One of the roles of family caregivers for individuals with SMI is to help them take full advantage of their rights and to locate the proper rehabilitation services for them. The language difficulties of ICs and the shortage of available translators in the mental health system impede their ability to fulfill this role:

*We can’t bang on the table in Hebrew. They give us a piece of paper and we leave, but what does it say? Because of this matter of the language barrier, you can’t demand what you are entitled to.… All in all, this really causes us to despair. (Janna, 70 and Anatoli, 72)*

Participants said that due to the language barrier, they are forced to ask the family member with SMI to be a language and cultural broker; in most cases, he or she acquired the language more rapidly because of being younger than the caregiver. But the role of language-cultural broker that is forced upon them doesn’t benefit individuals with SMI and may create an additional emotional burden for them and for the family caregivers:

*After my husband died, I had to deal with the burial and cemetery and tombstone, and I couldn’t do it all… because I didn’t know Hebrew well, and she [the daughter with SMI] helped me with the translation and all the bureaucracy. She behaved so nicely that I took advantage of it…and in the end, it got her out of her schedule and once again she had an attack and had to be hospitalized…(cries). (Marina, 65)*

**Dimensions of subjective burden**

In addition to the objective burden, participants described at length the subjective burden, that is, their emotional reactions to caring for a family member with SMI on the backdrop of their adaptation to the cross-cultural transition. The emotional reactions relate to three interconnected categories: 1) loss and guilt; 2) fear of stigma and social rejection: 3) stress-related health problems. These categories highlight the unique nature and intense pain associated with the dual adaptation that participants must cope with, as well as their efforts to give meaning to their difficult reality.

***Loss and guilt***

Most participants described feelings of sorrow and loss that overcome them. These are especially prominent in the narratives of parents where the onset of their child’s mental illness occurred following immigration. Non-immigrant family caregivers usually must cope with one loss, namely the expectations and hopes for a “healthy” family member. By contrast, ICs also mourn the loss of resources they had prior to immigration and unfulfilled expectations from their new country. Alyna (61), for example, who immigrated to Israel to ensure a better future for her son, mourns and grieves his illness as well as the loss of the support network she left behind in her country of origin:

*After immigration, I began to realize that my son had severe mental difficulties, and it was very painful for me to see…because I actually came to Israel because of him. There I had connections, there I had everything. I had such good friends there, such connections. Why did I need all this pressure [cries]?*

Some participants, especially those who immigrated *because* of their family member’s illness, said that immigrating to a foreign country aroused feelings of sadness and loss. For example, one participant whose son first immigrated to Israel alone and developed his illness there, explained:

*Immigration is enjoyable for young people, but in my case, immigration is a punishment. My son’s illness is actually the most significant factor that influenced me to move. Otherwise, it would have been better to remain in familiar surroundings, under regular conditions, with familiar people... In other words, not only did I have to immigrate but I also have to cope with his difficulties, and when it all piles up on you together, it’s even harder. (Natalia)*

Guilt is a component of the subjective burden that accompanies family coping with mental illness. Participants described that they feel guilty about the timing of immigration and a lack of sufficient parental presence in their children’s lives in light of their own acculturation difficulties:

*He had many difficulties, and later on became ill… It’s too bad that we didn’t immigrate when he was a bit older, because he had many problems in kindergarten as well as in school. He studied in a class where there were no Russian-speaking teachers and he stayed there each day until four because I felt that I needed to work, that I must learn the language well. And now I think that all this together had a negative impact on him. (Darya, 50)*

Nina felt guilty that she couldn’t look after her son and protect him from the social dangers lurking for an adolescent boy: "When he was still in school, the outbreaks began. You see, I worked very hard, at two jobs. I am to blame. I should have watched over him more. I didn’t notice that he had depression."

***The fear of stigma and social rejection***

Attitudes, reactions, and negative behavior of society towards individuals with SMI and their family members contribute to the subjective burden that the participants experience. Some of the participants also described fear of rejection or actual experiences of rejection due to their different cultural background as FSU immigrants.

Most participants reported that they had encountered a discriminating attitude towards them on the part of native-born Israelis or veteran immigrants, and some of them continued to experience discrimination against FSU citizens in many life spheres through the present:

*It happens all the time that when Russians come to request something, they are refused, and when Israelis come, they agree…and it doesn’t matter how long those people have been here, 10 or 20 years. This exists in all fields… there is discrimination. (Oksana)*

Other participants reported that they experienced stigma and rejection in the context of the mental health field. As is evident from Alexandra’s story (61), this stigma was especially prominent among welfare providers toward single mothers:

*When they [welfare workers] saw me, they immediately labeled me. They said that the grandmother is very dominant, very involved, and that this had a negative influence. So, no one spoke to me very much over there, but when we were at the court session, the judge said: “What do you have against her, there is a very good grandmother sitting here. Give the granddaughter to her grandmother". And the welfare workers said that because my daughter is mentally ill, I’m not able to raise my granddaughter… Here you have another example of stigma.*

Participants felt that in some of the cases, the negative attitudes they experienced at the hands of institutions stems both from their minority status as immigrants and their role as caregivers of a family member with SMI. As a result, they lose trust in the health care services and feel abandoned and rejected:

*At the family center, mental health providers give us lectures saying that we should cooperate with the doctor… but the doctors don’t aspire to this so much. That’s how it was in Russia, I must say, and here it’s the same thing. But here it’s twice as insulting. Because when you belong, when you are in your own country, and a person speaking your language tries to ignore you, it’s insulting, but when you arrive in a host country, it has a doubly destructive influence. That is to say, here you also get the feeling that you’re not wanted at all. (Natalia)*

***Stress-related health problems***

The participants described that they suffer from a variety of health problems as a result of coping with the double stress of immigration and mental illness in the family.

Most participants experience daily anxiety and fears as part of their caregiver role*:* "The experience of a main caregiver is one of constant stress. Because it’s many situations of uncertainty and waiting…and also you mustn’t relax and rest". (Nelly, 49)

The emotional stress experienced by the participants is intensified by the pressures of their first years following immigration:"I was also depressed because of housing problems. I didn’t have money… It causes depression, even without the problem of caring for a disabled family member. A healthy person can also become depressed because of this situation". (Arkadi, 64)

The participants noted that the caregiver burden and acculturative stress negatively affects their mental health, and some of them remarked that they have been diagnosed with depression, anxiety, and/or insomnia.

*The issue of psychiatry [in our family] has played a major role in our adaptation to Israel. We were hit hard and it changed our whole life. No doubt about it… I am a more optimistic person, but my husband had a very hard time. He falls into depression and I need to support him too.* *(Darya)*

Nine participants noted that they take medications for their mental health issues:

*I look healthy and like everything is fine by me, but I also have many problems. I take three Clonazepam… because I can’t sleep. And I also have fibromyalgia with body pains, and then even if I want to sleep, I can’t and I can’t relax. (Yana, 54)*

The stress and heavy burden that family caregivers experience have implications on their physical health as well. The participants said that they or other family members have suffered from numerous physical problems as a result of their tense relationships with the relative with SMI:

*We’re already older people, we are going through hell with the daughter, and it affects our physical condition as well. After she divorced and returned home, my wife developed diabetes and my blood pressure got higher, and I began to take medication regularly. And this is all because of the pressure that we experience at home with her… a lot of confrontations and shouting. (Mikhail)*

**Discussion**

The current study aimed to explore the factors that shape the burden experience of ICs and its influence on their personal and family lives, based on the particular case of FSU immigrants in Israel. The findings show that objective and subjective stress factors associated with immigration such as emotional, social, and economic adversities cause difficulty in coping with mental illness in the family. Simultaneously, objective and subjective stress factors related to coping with SMI in the family contribute to challenges in the immigration adaptation process. This maladaptive situation leads to the experience a “double burden” for ICs. The double burden includes dimensions pertaining to their role as family caregivers, dimensions pertaining to their immigrant status, and the circular interaction between these two that intensifies the overall sense of burden. The cultural background of ICs also influences their subjective burden. These effects, as evidenced by the findings of the present study, are shown in Figure 1:

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**Double objective burden**

The primary factor that shapes the double objective burden experienced by caregivers is related to economic difficulties. The findings of the present study are consistent with previous findings, according to which family caregivers must provide financial assistance to their family member with SMI, and find themselves facing economic hardship (Azman et al., 2019; Iseselo et al., 2016). Caregivers who are also middle-aged immigrants have a very limited or non-existent economic capacity, due to economic and occupational challenges that they themselves face following immigration (Kung, 2016).

This study showed that one of the main sources of economic difficulties for ICs is unstable housing. The high cost of living in Israel and the lack of public housing increased feelings of stress and uncertainty among both caregivers and individuals with SMI. Prior studies on ICs and ethnic minorities reported a high level of emotional distress and family conflicts due to financial and housing difficulties, and indicated the need for the system to provide this population with public housing (Guada et al., 2011; Guarnaccia & Parra, 1996).

Another objective dimension of burden, which is exclusive to ICs, is related to language difficulties. On the one hand, caregiving demands in the first years after immigration can disrupt the acquisition of a new language. On the other hand, language difficulties diminish the ability of ICs to engage external support and utilize essential rehabilitation services for their relatives with SMI. These findings are consistent with other studies that have found that caregivers’ ability to help their loved ones is impeded by language barriers (Guzder et al., 2013; Kung, 2016). As a result, their sense of burden is exacerbated, as well as the burden experienced by family members enlisted to help with language or cultural brokering (Oznobishin & Kurman, 2009).

**Double subjective burden**

The primary factor that shapes the subjective burden of caregivers is their own emotional responses, which often include loss and guilt (Hernandez & Barrio, 2015; Spaniol & Nelson, 2015). Beyond the burden associated with the intensive care for individuals with SMI, the psychological distress of immigrant families, particularly immigrant parents, is intensified by grief over the loss of resources available to them in their country of origin and the hope of providing a better future for their children by moving to the host country. Indeed, in this study, the fact that in some cases children became mentally ill after immigration intensified the parents’ feelings of loss and guilt.

An additional subjective dimension of burden for ICs is the fear of social rejection. ICs are at a double-risk for stigma and exclusion, owing to their minority status as immigrants in a new society and the social stigma associated with families of psychiatric patients, who tend to bear the most responsibility for the onset of mental illness (Larson & Corrigan, 2008). In this context, the cultural characteristics of FSU immigrants, such as the high prevalence of single mothers (Remennick, 2012) and a strong cultural stigma toward mental illness (Dolberg et al., 2019), may intensify feelings of anxiety, suspicion, and loneliness, and reduce caregivers’ ability to engage essential external resources.

The negative impact of the subjective burden of caregivers is reflected in high rates of mental and physical morbidity among them, compared to the general population (Gupta et al., 2015). In the case of ICs, the accumulation of stressful events due to both illness and migration appears to lead to the development of health problems. Indeed, post-migration social adversities are known to increase the risk of mental and physical illness, while improvement in socio-cultural integration is associated with improved health status (Viruell-Fuentes et al., 2012).

**The double burden as an intersection of social and health-related adversities**

From a broader, integrative perspective, the findings indicate that the double burden experienced by ICs leads to a partial blurring of the subjective and objective dimensions of burdens. While differentiation between subjective and objective burdens is very common in the research literature (Awad & Voruganti, 2008) and out of convenience were also differentiated in the current study, some of the findings cast doubt upon the relevance of this distinction regarding ICs’. Instead, the participants experienced their burdens as a pile-up stress, with an intersecting complex of social and health-related adversities with reciprocal and circular relations between them.

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

Within the framework of the intersectionality theory, immigrant caregivers may experience situations of adversity and social marginality not only due to the intensity of stress and burden but also due to the intersection of their excluded identities (Viruell-Fuentes et al., 2012). Thus, for example, the immigrant category generally includes sub-categories of ethnic and social status marginality. The caregiver category includes sub-categories of gender (generally women) and age (generally elderly or middle-aged mothers). Furthermore, ICs may experience a sense of the threat of rejection and social exclusion in light of the intense stigma associated with families of psychiatric patients. A combination of various intertwined categories creates an ongoing threat to the social and health status of ICs, which further exacerbates the problems they face. These findings clarify previous studies that highlighted the heavy burden experienced by ICs as compared to non-ICs, but which had difficulty identifying the specific factors that create it (Bradley et al., 2006; Kung, 2003; Ryder et al., 2000).

**Limitations and future studies**

The present study has some limitations. Firstly, there was significant variety among the participants in terms of the timeline of illness and immigration. Secondly, although this study aimed to investigate all kinds of family caregivers (parents, spouses, siblings), in practice, the vast majority of those who agreed to be interviewed were parents, and especially mothers. This restricted sample of caregivers limited the ability to compare across participants with different burden experiences and therefore may have reduced the theoretical sensitivity of the data analysis. Thirdly, the lens adopted in the present study focused primarily on examining immigration adaptation processes; it gives less attention to the unique cultural background of FSU immigrants and the cultural changes they undergo upon immigration to Israel.

It would be informative for quantitative follow-up studies to compare the burden experienced by ICs with the burden of non-ICs. Moreover, it is important to examine whether the double burden identified in this study among FSU immigrants in Israel is found among ICs from other cultural groups and contexts.

**Implications and conclusion**

The present study offers several important contributions. On the methodological level, the study investigates a hard-to-reach group – ICs. Due to cultural and language barriers, it is empirically difficult to interview this group and to map its characteristics and needs (Bradby et al., 2007).

On the theoretical level, this study illuminates the complex dynamics between two processes that occur simultaneously in the lives of ICs: coping with mental illness and coping with cross-cultural transition. To conceptualize the two processes and the reciprocal relations between then, the study proposes a new term: “the double adaptation burden.” This concept makes it possible to focus on ICs’ experiences in a context that is uniquely their own, distinct from the burden experienced by non-immigrant family caregivers and to the stress experienced by immigrants who are not coping with SMI in the family. In addition, this term could contribute to the recognition of ICs as a “dual-risk population” and to design interventions and social policies that better suit their unique needs and challenges.

In terms of clinical practice, the study makes a practical contribution to mapping the needs and difficulties of ICs. The study emphasizes the need to adapt family psychoeducational interventions, which have been found to be effective in reducing the sense of caregiver burden (McFarlane et al., 2003), to the emotional, social, and cultural-lingual needs of ICs. For example, many immigrant families, especially parents, experience significant emotional and symbolic losses, which strongly shape their subjective burden. Therefore, in clinical practice, it is important to recognize, legitimize, and validate these feelings, which in the immigration context can be especially painful and destructive. Furthermore, the accessibility of family counseling centers and cultural-lingual adaptation of psychoeducational groups may assist ICs in acquiring essential mental health knowledge as well as expand their social support and feelings of cultural belonging.

On the policy level, this study points to the need to recognize ICs as a vulnerable group and to broaden the range of resources offered to them on the systemic level. The study identifies two of the highest-risk types of immigrant families: families in which the onset of mental illness occurred shortly after immigration and families headed by single mothers. These two groups are particularly in need of comprehensive emotional and instrumental support. Providing adequate public housing and incorporating cultural competence practices into mental healthcare systems are of great importance for improving the adaptation and recovery processes of ICs and their family members with SMI.

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