**Cultural competence in family psychoeducation groups:**

**The experiences of Russian-speaking mothers of persons with severe mental illness in Israel**

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**Abstract**

The successful integration/implementation of cultural competence and evidence-based practices in mental health care are still limited and unclear for some diverse cultural populations/contexts. This study explored the cultural adaptation of family psychoeducation to the former Soviet Union immigrants who care for a family member with severe mental illness. Semi-structed in-depth interviews were conducted with 17 Russian-speaking 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 this intervention: 1) from language barrier to service using/consumption, 2) from lack of information to acquiring a new mental health knowledge, 3) from 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 on lingual, cognitive, emotional, socio-cultural and relational levels improve family coping and recovery. Implications for cultural adaptation of family psychoeducation for Russian-speaking immigrant caregivers are discussed.

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

**Introduction**

Following the collapse of Soviet regime in the early 1990s, more than 1.6 million Jews emigrated to Israel, US, Canada, Germany and other Western countries (Remmenick, 202). Only in Israel over one million immigrants came from the former Soviet Union (FSU) between 1990 and 2006. This was the largest wave of migration in the history of the country and increased the Jewish population of Israel by about 17% (ICBS, 2019; Tolts, 2015).

While some immigrant groups from the FSU are adjusting well in Western countries, others show elevated levels of psychological distress, somatization and psychiatric disorders (Jurcik, Chentsova-Dutton, Solopieieva-Jurcikova, & Ryder, 2013; Mirsky, 2009). For example, in epidemiological studies in Israel FSU immigrants were found to be at about 1.5 times greater risk of developing psychotic, affective and anxiety disorders as well as suicide behaviors than native-born Israelis (Mirsky, Kohn, Dolberg, & Levav, 2011; Mirsky, Kohn, Levav, Grinshpoon, & Ponizovsky, 2008; Weiser et al., 2008). At the same time, FSU immigrants display relatively negative attitudes toward, and a low level of utilization of mental health services (Shor, 2006; Ristner, Ponizovsky, Kurs, & Modai, 2000). Also, the FSU immigrants that receive some mental health services and treatments report low satisfaction (or less likely to report satisfaction) (Author, 2015; Dolberg et al., 2019).

The researchers explain these mental health disparities in that FSU immigrants experience more stress and social adversities due to adjustment difficulties in migration and have limited access to essential resources and support in comparison with local-born population (Mirsky, 2009; Nakash et al., 2014). The lingual-cultural barriers make it difficult for them to seek help and receive the desired service such as communication difficulties, high social stigma and the suspicion and distrust of the system (Author, 2015; Polyakova & Pacquiao, 2006). Such negative attitudes towards mental health services are also related to the abuse of psychiatry by the establishment in the Soviet Union (van Voren, 2009) and limited knowledge about Western mental health care and treatments (Dolberg et al., 2019).

Cultural competence it is a central strategy in the last two decades to reduce ethnic disparities and aims to make health care services more accessible

and effective for people from diverse ethnocultural communities (Kirmayer, 2012). 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 et al., 2003, p. v). The cultural competence is especially important and challengeable in the case of evidence-based practices, which aim to produce generalizable and validate knowledge, but sometimes sealing over the subjective experiences, values and life contexts of patients and their families (Kirmayer, 2012).

One of the vital evidence-based practice in mental health care is family psychoeducation. This intervention developed by Falloon and colleagues in the early 1980s (Falloon, Boyd, & McGill, 1984), and over the years has become a leading practice in working with families who care the relatives with severe mental illnesses (SMI), such as schizophrenia, bipolar disorder and major depression (Dixon et al., 2001; Lefley, 2009; McFarlane, Dixon, Lukens, & Lucksted, 2003). The multi-family group intervention includes a series of weekly meetings with family members (usually 12-15 sessions) accompanied 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 goal of the group intervention is to impart essential knowledge about SMI and recovery, to encourage families to engage problem-solving coping and to reduce (decrease) expressed emotions as criticism and over-involvement. In a series of studies, this intervention has been shown to help families to reduce the burden, the stigma and stress, and improve hope, quality of life and communication with their relative (McFarlane et al., 2003; Dixon et al., 2001). In addition, the family group intervention helps to decrease the symptoms relapse and psychiatric hospitalizations of the individuals with SMI and improves their functioning, quality of their life and recovery processes (Dixon et al., 2001; Giron et al., 2015).

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

The aim of the present study is to fill this gap and to explore the experiences of Russian-speaking mothers of persons with SMI in Israel. The current study joins to few qualitative studies that have examined the effectiveness of cultural competence assimilation in evidence-based practices from the subjective views/perspective of the consumers themselves (Renhazo et al., 2013). The main study question is: What are the silence processes and changes experienced by Russian-Israeli mothers following participation in a culturally adapted psychoeducational groups?

**Method**

**Participants**

This article/paper is part of a larger qualitative study that investigates experiences, perceptions and coping strategies among FSU immigrants in Israel, who care for a family member with SMI. The current article presents specific findings on the experiences of Russian-speaking mothers who previously participated in the culturally adapted psychoeducational groups.

The criteria for inclusion of participants were being: (a) cares for a family member with SMI who is recognized by the National Insurance Institute of Israel 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 or maintaining contact on a weekly basis with a family member with SMI; (e) participated in Russian-speaking psychoeducation groups in the community family counselling centers (FCC).

17 mothers of an adult son or daughter with SMI were participated in the study. Participants ranged in age from 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 some after the year 2000 (39%). The average number of years since arrival in Israel was 18.1 (range 5-25). Most of the participants had an academic degree (89%).

According to the demographic characteristics of the individuals with SMI, most of them were sons (72.2%). The psychiatric diagnoses were: schizophrenia (13), bipolar disorder (3), and major depression (2). The average number of years since receiving a psychiatric diagnosis was 14.5 (range 3-34). In most cases, sons or daughters with SMI lived in a joint residence with their family (72.2%) and others in community rehabilitations services such as hostels and assisting housing.

**Study Procedure**

The participants were recruited via approaching FCC in the community that assist families of individuals with mental health problems and funded by the psychiatric rehabilitation unit of the Ministry of Health. This study was carried out in two family centers that alongside with traditional/usually/regular family psychoeducation offering culturally adapted interventions for FSU immigrant caregivers. Russian-speaking social workers and/or rehabilitation counselors employed by each center and had an experience working with families of persons with SMI carried out the interventions.

The recruitment process of the participants were made by the mental providers/counselors who worked with FSU caregivers in FCCs. They identified potential participants who met the inclusion criteria and firstly informed them about the study. If an FSU caregiver was interested in participating, the counselors provided him with my contact information for more detail explanation about the study.

The research instrument was a semi-structured in-depth interview (Patton, 2002). The first part of the interview was focusing on the spontaneous narrative of the participants ("Tell me the story of your family"), and in the second part were presented more specific questions about their experiences in Russian-speaking psychoeducation group, according to a previously prepared interview schedule. The questions were taken from a Narrative Evaluation of Intervention Interview (NEII) (Hasson-Ohayon, Roe, & Kravetz, 2006 .(This tool can be evaluated in a retrospective way the subjective experience of the interviewees regarding the group's intervention including family psychoeducation (Levi et al., 2012). The open-ended questions referred to describe/asses the outcome and process of the intervention: "Please describe what the intervention contributed to you?"; "What change, if any, took place during participation in the intervention?"; "How does this intervention differ from other interventions you attended in the past?"; "What did the practitioner/moderator/group leader delivering the intervention do that helped you?"; "What components of the intervention were helpful?". These questions were formulated to elicit spontaneous reports of the participants’ experiences of the intervention and do not explicitly refer to any expected specific outcome or change (Hasson-Ohayon et al., 2006).

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

The interviews were individual, each interview lasted between one and two hours, and they took place in home or in FCC, according to the participant’s setting of choice. The interviews were conducted in Russian, audio-taped and fully transcribed by me.

An institutional ethics committee at Author University approved the research.

Informed written consent was obtained before interview from all participants. 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 from transcriptions and analyses. Participants were informed that they could withdraw from participation at any time, for any reason, without negative consequences.

**Data analysis**

The findings were based on the categorial content analysis (Corbin & Strauss, 2014). The first stage of analysis involved 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 consequences. In this phase, themes were mapped more precisely, setting “entry criteria” for each category. Such factors as saliency, vividness, and frequency were used to determine the significance of the themes. At this point, some of the themes were renamed and reorganized. In the third stage there were the transition from the individual-level analysis to a cross-sectional one. This phase was guided by the principles of the constant comparative method, involving simultaneous inductive and deductive processes (Glazer & Strauss, 1967). My clinical and research experience with FSU immigrants in mental health field and my bicultural and bilingual background facilitated the analysis process, making it possible to recognize cultural nuances present in the data.

To ensure the trustworthiness of the analysis, several steps were taken: first, I consulted another experienced qualitative researcher, who served as an external expert, commenting on and analyzing the data and the emerging themes (Creswell, 2007). Second, the research design, data collections procedure, data analysis, interpretation of data, and organization of findings were described in detail. Third, after completing the study, I returned to several of the participants (member checks) and shared the research findings with them. Their feedback was that the findings properly reflected their experiences in the Russian-speaking groups (Lincoln & Guba, 1985). In addition, the analysis process and its results were presented before the mental health professionals who leaded/guided the culturally adapted groups for Russian-speaking caregivers. They found the data analysis to be a close representation of their experiences as leaders/counselors of these groups.

**Findings**

Qualitative content analysis revealed five salient processes and changes that participants attributed to their engagement in the culturally adapted psychoeducation groups: 1) from language barrier to service using/consumption, 2) from lack of information to acquiring a new mental health knowledge, 3) from 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 were integrated into the results section for illustration the processes and changes of Russian-speaking mothers.

**From language barrier to service usage/essential/satisfactory service**

The lingual accessibility of family psychoeducation groups helps to overcome the linguistic barrier and it enabled non-Hebrew-speaking caregivers to participate in the group and benefit from it. Most participants stated that they are not fluent Hebrew-speakers and need lingual-cultural mediation even several years after their immigration.

*I am 20 years in the country, but for me still the language is difficult. I kept working with Russians and I didn't have a high level in Hebrew. Which is why I'm having a hard time. Even trying to appeal to a social worker, but they mostly speak Hebrew and I don't understand anything. So I was very happy to have organized a Russian-speaking group here. Because here in the city I live I have met so many women who also have similar problems (Eva)*

Some participants said that in the past they tried to apply to FCC and participate in groups but due to language barriers, were unable to receive satisfactory service. A change took place when the organization recruited a Russian-speaking social worker:

*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 perhaps I can relate my problems in Hebrew, but I won't understand what they will tell me… and at that time I was unable to receive this help because there was no Russian-speaking social worker. Only after a year and a half, they contacted me when a Russian-speaking social worker arrived and she invited me to join the group. (Marina)*

It is indicated that the need to receive help in the Russian language stems not only from family members' objective lingual difficulties but also from an emotional need. Some of the participants who are fluent Hebrew speakers also described their preference to communicate in Russian in stressful and crisis situations:

*In my work (psychologist), I am confronted with situations in which the client speaks Hebrew quite well, but when I ask him which social worker he would prefer, he says he prefers a Russian speaker. That's how it is…they are afraid that perhaps they won't understand something. They want to explain, but the topic of illness is so difficult that even the familiar Hebrew words escape their memory because it's extremely emotional…. We experienced the same thing, 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 lingual accessibility in the group is the bond that is formed with the counselor/group leader and his ability to serve as a lingual mediator between family caregivers and the mental health services where their adult children are treated:

*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 counselor/group leader) to contact the protected housing in order to understand what's going on there. And there's nobody there that can translate to Russian. And even if there is a translator, very often it's just not that…because translation doesn't always get across and reflect the entire situation. So Olga helps me out a lot in these situations because I can rely on her. (Karina)*

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

Participation in the group contributed to a change in the participants' cognitive level in that it became an area of learning and acquiring vital knowledge that reshaped attitudes concerning the mental health field. Most of the mothers stated that until they began to participate in the group, they severely lacked available 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 members:

*And in general, 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. For example, Tanya (the daughter with SMI) went to learn at college, and only later did I realize that National Insurance Institute can cover that for us…and no one mentioned it to us. And I feel that we have a real hunger for information. It's an absolutely 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. The new knowledge lessened the vagueness concerning the field of mental illness and returned a sense of control and manageability to them as primary caregivers:

*Once they invited a psychiatrist to the group who described very clearly the situation of the children, the illnesses and the parent caregivers and gave clear definitions of all of these cases, because there is very little literature in Russian and before, it was really lacking for me. I would like to have clear information for the families because it helps us to understand the illness and dealing with it more correctly. (Nina)*

Some of the essential information that the group participants were initially exposed to related progressive community rehabilitation services that didn't exist in the FSU and can help people with SMI in their community inclusion (or integration): "After I began participating in this support group, I heard that there is a rehabilitation allowance and a tutor חונך)) can be arranged… that I discovered only here" (Lydia)

The knowledge that accumulated in the course of group meetings empowered the participants and generally improved their sense of manageability, security and assertiveness as family caregivers in their dealings with the systems in order to utilize rights and new services:

*When I come to his social worker at the clinic, I immediately show him what the counselor from the FCC printed about this or that new service, and he [the social worker] is surprised and tells us he didn't know about it at all. 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 have to request. The knowledge gives us a lot of power. (Bronislava)*

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

Group participation contributed to the mother's emotional vent and changed their coping pattern regarding mental illness and its accompanying stigma from a state of concealment to sharing and openness. Before participating in the group, the knowledge and attitudes regarding mental illness among mothers from the FSU stemmed mainly from stereotypes and stigmatic opinions that developed in their country of origin. Bina phrased the attitude that was prevalent in the FSU regarding mental illness and the coping pattern that she adopted as a result:

*Over there, by us [in 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.*

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

*I remember that in the beginning, people in the group were very locked up because of the stigma. People think it's something you should be ashamed of, and this is all due to the mentality and the attitude that we internalized over there. People think that things like this don't happen in intelligent and refined families. This approach 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 framework/platform/place where, for the first time, they could share their family problems with others, problems that previously had been kept a secret. The trust in fellow group members, the personal openness and 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 and share with others 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)*

*Since I began to participate [in the group], I feel relieved. Before, I had the feeling that I was the only one who had such problems, but when I hear that others have them as well, and how they cope with them, I realize that I'm not anything special, and life must go on (Viktoria)*

Some of the participants reported that because of a definite cultural stigma in the Russian-speaking community and fear of rejection, they cannot share their problems with their friends, and actually the group becomes the exclusive safe area for openness and sharing:

*I don't talk too much with the neighbors. Although half of my neighbors are Russian, I really don't wish to speak with them… 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 social 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. People shy away from depressed people. (Luba)*

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

Participation in the group has helped 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 in daily life from a sense of alienation and social isolation. For most of them, participation in a Russian-speaking group was a unique opportunity to get to know additional families and broaden their support network:

*I feel that that it undoubtedly widens my social circle, the fact that I go to the supported 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, the group meetings enabled the participants to experience once again the sense of cultural belonging to a class of intelligent and educated people that characterized their status in the FSU and had decreased after their immigration to Israel:

*Beyond that, people that participate in the group belong to an older generation. There they graduated university, there they had very respectable positions, and as life rolled on, they found themselves in Israel. But here they found themselves with nothing at all, and they feel very uncomfortable about it. And 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 by 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 that 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, I like to speak, but there among the Hebrew-speakers, I wasn't able to say a word. I left because I got a bad feeling from all the people and the stories… Now in the Russian-speaking group it's more interesting... I heard interesting things that I kept to myself, and also the people are more intelligent. Here we feel closer to each other… (Nina)*

The close ties that often form among the group members continued as group gatherings outside the FCC. It appears that the common cultural orientation enables maintaining these gatherings and enriching the mothers' recreational activity:

*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 are very cohesive, so cohesive that we are good friends. We meet now outside of the family center, in our homes, we drink tea, we celebrate Russian holidays, we discuss various problems. (Luba)*

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

The group influenced changes in the relationships that mothers had with their dear ones who cope 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 cross-cultural transition to Israel. The tension in the relationships that escalated at times is especially evident in the relationships between single mothers and male family members with SMI. Vera described the transition from a state of fear and helplessness in her interaction/communication with her son to her ability 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. It has its habits, it doesn't listen, it doesn't understand, it immediately begins to shout. Let's say he calls me, begins to shout, I was silent and listened to him and afterwards I was exhausted and worn out for half a day. Now, at least on the phone, I can react: "Jenia, 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: "Jenia, let's sit down and discuss things". (Vera)*

The change that the group participants underwent was reflected in the more warm emotions they express towards family members 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. 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 say, warmth and love. Now I act differently towards him… and it greatly improved our relationship… (Klara)*

Other participants emphasized an additional aspect of blurred boundaries in the family – their tendency to be over-involved in the lives of their dear ones. This tendency was especially evident in their dealings with the health systems and encumbered family separateness processes. The change that the mothers underwent in the group helped them realize the negative and hindering implications of over-involvement regarding the rehabilitation and autonomy 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… and I used to intervene in order to help my son. And 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 relates to their ability to set boundaries and create, at least occasionally, periods of time and rest for themselves. This change is reflected in the ability to balance between the commitment and care for the children with SMI and the commitment and care for their own personal needs:

*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. 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 explores/ed the efficacy of cultural competence in family psychoeducation, based on the experiences of Russian-speaking mothers in culturally adapted groups in Israel. This study, which is the first of its kind, examines the compatibility of evidence-based intervention in the mental health field for the cultural and contextual needs of FSU immigrants. Russian-Israeli mothers described their participation in the groups 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 relative/relational levels. These findings are congruent with extensive research literature that describes the association between participation in psychoeducation groups and a decrease the sense of feelings of burden and stigma, along with an improvement in the levels of hope, emotional welfare, patterns of coping and interpersonal communication (Dixon et al., 2001; McFarlane et al., 2003). Beyond the universal contribution of family psychoeducation, the findings show that Russian-Israeli mothers who participated in culturally adapted groups benefited in some aspects in particular from these interventions.

On the organizational level, recruiting a Russian-speaking mental health professional to the service is a critical and major measure in accessing culturally adapted intervention. The counselor/group leader is perceived by the mothers not only as a professional authority, but also as a cultural-lingual mediator between them and receiving/absorbing society in general and the mental health system in particular. These findings are congruent to studies indicating that many first-generation FSU immigrants have difficulty speaking the new language many years after their immigration (Remennick, 2012; ICBS, 2019) and yet others who acquired the new language prefer in cases of crisis and distress to express themselves in their mother tongue (Author, 2015; Polyakova & Pacquiao, 2006).

Moreover, the mothers' status as immigrants who often suffer from lingual-cultural barriers and social disorientation also blocks acquisition of new resources essential for family coping with mental illness. The findings support previous studies indicating that immigrant caregivers need accessibility and active cultural mediation/advocacy by accompanying professionals in order to fully utilize rights and services they are entitled to on a personal and family level (Kung, 2016). This is especially relevant in the case of FSU immigrants whose knowledge regarding the Western mental health field is very lacking, vague and limited from the onset (Dolberg et al., 2019; Nakash et t al.,2020). In the Russian-speaking groups, mothers actually underwent socialization to recovery-oriented mental health care and were initially exposed to rehabilitation services, which they had not been acquainted with in their country of origin. This learning process contributed to a perceptional change on their part towards the mental illness and mental health care and increased their sense of empowerment, hope and coherence as family caregivers (Antonovsky, 1999).

The findings indicate that FSU immigrant caregivers invest considerable effort in concealing the illness and subsequently experience strong feelings of guilt, shame and fear of rejection that lead to withdrawal from their immediate environment (Larson & Corrigan, 2008). The findings are congruent with many studies that noted a pronounced public stigma as well as stringent and negative stances of FSU immigrants towards the field of mental health that persist after they immigrate to Western countries (Shulman & Adams, 2002; Polyakova & Pacquiao, 2006). The present findings indicate that the feeling of stigma and considerable effort in concealing the illness as well as fear of rejection that lead to withdrawal from their immediate environment can be more pronounced in high-educated families who consider themselves as a part of the Russian-Jews intelligentsia. The process that the mothers underwent in the group helped lessen their subjective sense of burden and normalize the feelings of guilt, shame and anxiety that compose it.

A deeper analysis of the findings indicates the grave implications of stigma and double exclusion regarding the sense of isolation and emotional, practical and symbolic diversity of FSU family caregivers. Because of the fear of stigma and rejection, they physically or emotionally distance themselves from their fellow community members. At the same time, due to language barriers, cultural alienation and previous rejection experiences, most of them don't feel a sense of belonging and openness towards the local-born population. Thus, they lose out both ways and have difficulty finding a protected and secure social and emotional space. In these circumstances, culturally adapted psychoeducation groups for Russian speakers become almost the only space where they feel protected from social rejection and develop a sense of belonging based on cultural similarity as well as their common connection to the mental health field. In the terms of Bourdieu (1977), participation in culturally adapted groups is, for FSU immigrants, a type of social area for the preservation and fostering of cultural capital. Within the group, they not only receive social and emotional support but continue to preserve association with their native culture and give it renewed validity in terms of language, symbols, prestige and common experiences (see also Prashizky & Remennick, 2015). Therefore, not coincidentally, this socio-cultural space is maintained outside of the FCC as well as by means of telephone contact, gatherings in private homes and celebration of Russian holidays.

These findings contradict previous findings that demonstrated FSU immigrants' tendency to cope with crises and distress within the family space and seek less formal support sources in general and support groups in particular (Author, 2017; Leipzig, 2006; Shor, 2006). These gaps can be explained by circumstantial/contextual factors. Firstly, most previous testimonies were observed in the clinical practice and dealt with families that were mainly in the initial stage of coping. In contrast, present findings are based on retrospective reports of people who had in the past participated in groups and could appreciate their unique contribution to their lives, Secondly, the present study focuses on a group of mothers caregivers that traditionally have a greater cooperation with mental health services in comparison with other caregivers such as fathers, spouses and siblings (Ghosh et al., 204) Thirdly, this is a group that not only copes with SMI in the family but also with multiple social advertises associated with immigration-related difficulties such as economic, occupational and housing problems, social exclusion and marginal status in Israeli society as single mothers (Author, in press). It is indicated that in light of their minimal family structure (multiple single-parent families and/or families with an only child) and due to their status as immigrant families whose relatives remained in part in countries of origin, the need for and dependence on external assistance is greater. Finally, the stigma and fear of rejection prevent some of them from being helped by the nuclear or extended family, even when it exists. The participation in a group considerably broadens the mothers' support network and to a large degree substitutes family support that they are lacking, physically and emotionally, in the challenging daily coping.

It may be inferred from the findings that authoritarianism and parental control that were recorded in the past as some of the characteristics of the Russian-Soviet family (Slonim-Nevo et al., 1999; Remennick, 2015; Yachinich, 2015) may, in the context of coping with immigration and mental illness, be undermined and lead to blurring of family boundaries. In inter-family relations, on one hand, mothers experience a strong parental duty/commitment/obligation to care for the adult child with SMI and on the other hand, they have difficulty directing their care to specific areas, and they are drawn to criticism and over-involvement in the lives of their children that blurr boundaries within the family. It is indicated/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 the mothers' difficulties in creating separateness in the family, while at times sacrificing and neglecting their personal health needs. Similar findings were determined in other studies regarding families from a cultural collectivist background such as Latinos and Chinese in the United States (Hackethal et al., 2013; Kung, 2003). As part of the psychoeducational group process, the mothers reexamine these patterns and acquire tools to improve communication, set boundaries empathetically and recognize the importance of family separateness for advancing recovery processes for themselves and their dear ones with SMI.

**Limitations and future studies**

The present study has a few limitations. Firstly, one-time self-reported findings must be treated with caution, because they do not provide information about changes over time and they may depict participants most pressing issues at the time of the interviews. Secondly, there is a considerable variance between the participants as to date of outbreak of illness and date of immigration, and also as to their cultural background within the FSU. Thirdly, the study represents mothers' experiences while voices of other Russian-speaking caregivers such as fathers, spouses and siblings are lacking.

In future studies, it is important to offer a more balanced representation of immigrant caregivers of varying family proximity. Moreover, in quantitative studies, a comparison can be made between the burden and stigma experience among Russian speakers who participated in regular/usual psychoeducation groups and among participants in culturally adapted groups. In future qualitative studies, in addition to families' experiences, interviews can be conducted with persons with SMI and with mental health professionals to get a more multifaceted perspectives on culturally adapted interventions.

**Implications for practice and policy**

Theoretically, the present study supports the possibility of integrating the evidence-based practices and the cultural competence in mental health services. In the past, integration of these seemingly contradicting approaches involved epistemic and political tensions (see Kirmayer, 2012). The present findings demonstrate that this integration is possible, effective and very essential for the needs of family caregivers from an ethno-cultural diversity. The findings are congruent with other studies that identified the need to adapt evidence-based psychoeducational interventions to the cultural background of the families, and thus make them more accessible and effective for them (Hackethal et al., 2013; Kung, 2016).

As to implications for practice, mental health professionals and those at FCCs in particular will be able to use the findings in order to tailor the suggested interventions to the needs of FSU immigrant caregivers. Due of socialization to the Russian-Soviet culture that don’t discourages openness and expression of feelings (Jurcik et al., 2013; Leipzig, 2006), it seems that the psychoeducational approach that integrates directive, educative and cognitive core techniques may be advantageous as compared to other approaches, such as dynamic techniques, in intervention with FSU immigrants. The fact that the service is given for free and with discretion within the community can also be a significant advantage for this population that suffers, in part, from economic hardships and pronounced wariness when seeking mental health care (Dolberg et al., 2019).

As for the educational aspect, it is important to distribute information in the Russian language and to conduct training sessions for the utilization of rights and services in the mental health field while simultaneously allowing therapeutic space for dilemmas and deliberations that arise concerning their implementation. It is also worthwhile to combine lectures and meetings with other Russian-speaking professionals (psychiatrics, psychologies, rehabilitation counselors) and consumers in order to widen the knowledge of recovery-oriented approach in Western mental health care.

The very essence of the emotional work with FSU immigrants is lessening the feelings of guilt and shame that form as a result of the stigma that accompanies mental illness. This stigma is especially prominent among single mothers and composes the large part of the subjective burden thrust upon them as family caregivers. Therefore, it is important to normalize and change these emotions in the groups and also refute the mistaken stigmatic attitudes existing toward families of individuals with SMI (Larson & Corrigan, 2008).

An additional aspect that deserves a central place in interventions with FSU immigrants is the dynamics of dependence-separateness relations within the family. Emotional and physical separateness processes from family members with SMI can be cautiously encouraged as a process that can advance recovery, while being aware of the cultural ambivalence of family members regarding the separateness and autonomy of their dear ones. Benefit can be gained by use the paradigm of expressed emotions in order to assess the negative influence of criticism and over-involvement in the family on the autonomy and recovery processes of individuals with SMI (Leff & Vaughn, 1985). In this context, the mothers should be assisted in examining the advantages and disadvantages of their total commitment to family members with SMI, and work must be done with them towards adopting a healthier way of life for themselves that includes rest and leisure activities.

From the organizational aspect, it is essential to acknowledge the contribution of group meetings for immigrant caregivers not only from the emotional and educational aspect but also from the social and cultural angle. The added value of family psychoeducation groups among Russian speakers is that they provide them a comfortable and secure social venue, not only as to coping with mental illness in the family but also as to bureaucratic and social difficulties they encounter as immigrants in Israel. Continued work can be encouraged in self-help groups, in which family members will be able to keep in touch/met outside the FCC and continue supporting one another in the long term.

On the policy level, it is important to intensify the supervision in all that pertains to implementing cultural competence in mental health services from the systemic, organizational and clinical aspect (Kirmayer, 2012). The findings in the present study prove the application and efficacy of the practice in two Israeli FCCs, but it is essential to continue to investigate its application in diverse organizational and cultural contexts. These operative guidelines are necessary in order to evaluate and establish the cultural competence as a leading practice in minimizing social gaps in the mental health care.