Cultural Adaptation of the Illness Management and Recovery Intervention Among Israeli Arabs

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Awareness of the need for culturally adapted mental health interventions is growing. The authors describe the cultural adaptation of an evidence-based practice (EBP), illness management and recovery (IMR), to the Arab population in Israel. The process included reviewing the literature on cultural adaptations of EBPs and interviewing Arab and IMR professionals, which helped inform modifications that reflected the norms of Arab society in Israel related to family, religion, and beliefs about mental health. The process yielded a culturally adapted IMR intervention, which was translated into Arabic and used to train Arab practitioners on implementation with Arab clients in Israel.

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Culture affects multiple aspects of illness and recovery, including religious beliefs, explanatory models of illness, emotional expression, family and community structure and traditions, and help-seeking attitudes. Accordingly, factors such as familiarity with clients' cultural characteristics and language and inclusion of family members and community figures in treatment are crucial. Thus, cultural adaptations of interventions are essential for their effectiveness (1, 2) and reduce cultural gaps in service provision (3).

For the cultural adaptation process of a certain intervention to succeed, it must adhere to the principle of cultural relevance. According to Castro et al. (2), three conditions are necessary for cultural relevance: the content should be understood by members of the cultural group, should motivate those individuals, and should be applicable to everyday life.

Cultural adaptations involve systematic revisions designed to adjust the intervention to the needs of a specific group, likely improving treatment outcomes (1). The literature emphasizes the importance of adapting content to meet cultural customs or values, such as strong family relations, and of assuring the intervention's applicability and relevance (2). Arab society in Israel is in need of culturally adapted interventions to promote recovery from mental illness (3).

Illness Management and Recovery

Illness management and recovery (IMR) (4) is an evidence-based practice (EBP) aimed at helping people with serious mental illness make progress toward recovery goals and acquire the knowledge and skills to better manage their difficulties. It was developed on the basis of five strategies found to be effective from a review of 40 empirical studies: psychoeducation, behavioral tailoring for more effective use of medication, relapse prevention, social skills training, and coping strategies. IMR has been implemented in several countries, including Israel, where a controlled trial found it effective in improving knowledge, daily functioning, hope, and quality of life; advancing progress toward personal goals; and enhancing ability to cope with stress and symptoms (4). Recently, the Hebrew version of IMR has attracted growing attention among Israeli Arab mental health practitioners, who noted its potential usefulness for Arab people with serious mental illness in Israel. They also recognized that the intervention required cultural adaptation. Whereas the core elements of IMR were relevant to Arab society in Israel, two barriers affected the intervention's implementation: the use of Hebrew and the irrelevance of many of the examples of illness- and coping-related experiences and some of the self-management strategies within Arab society. These barriers emphasized the need to develop a version that would be

HIGHLIGHTS

- Cultural adaptations of evidence-based practices (EBPs) are essential for these practices' accessibility and effectiveness.
- Cultural adaptations to illness management and recovery involved identifying and addressing practitioners' needs to acquire specific skills related to engaging, incorporating, and working collaboratively with key stakeholders.
- Integrating research-based evidence and cultural contexts is crucial to facilitating equality and access to effective treatment.

culturally adapted to Arab culture and take into consideration Arab society's communication codes, local rules and traditions, social structure, religious beliefs, and explanatory models of mental health and illness (5).

Although it is modernizing, Arab society in Israel largely remains patriarchal, with the family playing a central role. When someone develops a mental illness, the family supports and helps him or her and often makes most of the treatment decisions (3). Barriers to service utilization include lack of culturally adapted services, lack of awareness of the right to treatment, as well as stigma and lack of information about mental illness (5). Consequently, Arabs with serious mental illness and their family members sometimes turn to religious authorities for treatment, believing the illness is related to insufficient devotion. Together, these processes hamper the opportunity to gain social support, which is widely recognized as crucial for recovery (3, 5).

The Cultural Adaptation Process of IMR

The adaptation process began by establishing a steering committee to coordinate collaboration among key stakeholders: IMR and Arab rehabilitation experts, the Ministry of Health, the Ono Academic College National School of Rehabilitation, and the Joint Distribution Committee–Israel Division of Disabilities and Rehabilitation. The process was informed by three theories. The first theory was the heuristic framework for cultural adaptation of interventions (6). According to this framework, cultural adaptation should proceed in the following four phases: information gathering, preliminary adaptation design, preliminary adaptation testing, and adaptation refinement. We have not yet completed the fourth phase, but we have conducted a study on the effects of the adapted intervention and barriers and facilitators to its implementation, which will form the basis of future refinements.

The second theory was Bronfenbrenner's ecological theory (7), which proposes that to promote change, therapists must work within the broader cultural context. Accordingly, one of the main cultural adaptations of an intervention is to engage the family—as well as other cultural elements that are essential to participants' acceptance of the treatment—into the treatment process. Third, our process was informed by the ecological validation model, which stresses the need to maximize client-treatment match in terms of language, persons, metaphors, content, concepts, goals, methods, and context (8) (Table 1).

Throughout the adaptation process, we maintained a balance between recommended adjustments and the core components of the original IMR. Fidelity has been maintained by retaining the content and chapters of the curriculum of the original intervention. The revisions involve changing examples and expanding the psychoeducational material, including religious explanations about coping with mental illness. Finally, resources about stressors and coping have been added or revised to ensure relevance to the lifestyle in Arab society in Israel. The adaptation involved four stages.

Stage 1: gathering information. To inform subsequent adjustments, information was gathered through a literature review and a focus group of eight Arab mental health practitioners trained in implementing IMR. Over 1 year, they met eight times as a group, facilitated by two IMR experts. Key issues that emerged included the role of religious discourse about illnesses; Arab cultural values, particularly as related to family involvement; sources of stress and stigma in Arab society in Israel; and language accessibility and literacy. The IMR experts analyzed these group sessions and drew lessons for the next stages.

Stage 2: selecting and implementing the required adaptations. Two authors (S.D.-I., P.G.-E.) distributed the intervention manual to the facilitators and members of the focus group. The authors then reviewed the proposed adaptations and selected and refined them while balancing the recommended changes with the original IMR, as described above (Table 1). These adaptations included an expanded role for the family (developing an IMR "family manual" aimed at helping family members' support their loved ones' recovery process and at providing psychoeducational information about the potentially helpful role of medication and its management, etc.); religious explanations about coping with mental illness relevant to the Arab society in Israel; and the removal of irrelevant content, such as examples about using drugs and alcohol, which are forbidden by Islam.

Stage 3: translation. The culturally adapted IMR was translated into Arabic, a process overseen by the steering committee to ensure comprehensibility. This is particularly critical with Arabic, because it is a diglossic language with a literary and spoken form, which differ dramatically, and has significant local variations. (An accessible form combining the two forms was selected for the translation.) This stage ended after the two (bilingual) IMR experts reached consensus.

Stage 4: training Arab professionals and implementing the adapted intervention. Twenty-two Arab mental health practitioners signed up for the first IMR training, which took place in an Arab community in central Israel that was relatively accessible both in terms of geographical distances and culture, in that the setting facilitated sharing of culturally relevant difficulties and dilemmas. Upon completion of the didactic IMR training (90 academic hours), the practitioners began to conduct 13 IMR groups in two main Arab population centers, in central and northern Israel, which were attended by approximately 102 Arabs with serious mental illness. Because of religious beliefs, two groups comprised only men, and one comprised only women. Family members were invited and encouraged to participate in the meetings. Family members were involved in the meetings because decisions in the Arab society in Israel are often made with or even by the family. (Meetings with families were held separately from those held with clients.) Thus, this parallel

TABLE 1. Summary of cultural adaptation of illness management and recovery (IMR) for Israeli Arabs[a]

Component of original IMR toolkit	Culturally adapted IMR	Dimensions of ecological validation model[b]
Adjusting the manual's content for greater relevance to Arab society in Israel		
Recovery strategies: developing a support system	Added relevant strategies, such as family support, to promote recovery and help the person with serious mental illness make decisions	Content, methods, context
Practical facts about mental illnesses (refers mainly to biological factors, without spiritual or religious aspects)	Added explanation about the religious context of mental health	Content, concepts, context
Stress-vulnerability model and treatment strategies (examples of people who have found ways of coping in other contexts: "When I get stressed out, it helps me to…go to art museums and see paintings and drawings.")	Added examples relevant to Arab society: "When I feel stressed, I take a bath, pray to God and read the Quran. This helps me relax and think more positively."	Content, methods, context
Building social supports (in places other than concerts, parks, and museums, as suggested in the original manual)	These places were replaced by others more relevant to Arab society, such as weddings and extended family get-togethers	Content, context
Using medication effectively ("The best way of making decisions involves a partnership between you and your doctor, relying on the knowledge of both of you.")	We start the topic by adding a statement by Muhammad that Allah created illness and medication. In addition, the statement in the original toolkit was expanded to include, "You can also rely on a family member when making decisions regarding medication. Does any member of your family accompany you in your visits to the doctor? If yes, how can he help you ask those questions?"; under the subsection Exercise: Strategies for Getting the Best Results From Medication, we added, "Asking a family member for help"; in examples for Personal Beliefs Regarding Medicines, we added common negative beliefs in Arab society, such as, "In my society, whoever takes psychiatric medicines has little chance of getting married."	Content, concepts, methods, context
Reducing relapses	Added examples for triggers and warning signs of a relapse in symptoms in Arab society, such as becoming extremely religiously devoted and quarreling with close relatives	Content, context
Coping with stress	Added typical daily stressors, such as lack of public transportation and neighborhood intrusion and/or overinvolvement by neighbors and second-degree relatives who often live next door; in the subsection on effective coping, we added the recommendation to "talk to someone about the stress you're experiencing" and the following example: "I feel stressed when there's a lot of noise around me…. My brothers come with their kids, and the kids play together and make a lot of noise…. It helps me to take a break and go to my room. I like listening to music on the earphones; it muffles the noise and takes me away to a quieter place."	Content, methods context
Drug and alcohol use (the topic recommends reducing or completely stopping drug and alcohol use; it is the client's choice whether to reduce or stop and whether to involve the therapist)	After consulting with members of the focus group, it was decided to remove this topic completely because Islam prohibits drug and alcohol abuse, although the problem exists in Arab society	Content, context

continued

TABLE 1, *continued*

Component of original IMR toolkit	Culturally adapted IMR	Dimensions of ecological validation model[b]
	Involving the family in the treatment	
General recommendation to involve significant others in parts of the process, with no specific guidelines in the manual or reference to the facilitator's skill in leading the meeting with the family	We prepared a special IMR manual in Arabic for families, which included brief information about each topic and the illness and guidelines for improving communication and for helping the family understand the client's experience, with emphasis on participation in promoting personal goals	Methods, context
Encouraging participants to involve families and encouraging families to participate	We encouraged participants to invite their families to participate, and family members were invited to attend group and/or individual meetings	Methods, context
	Adapting the facilitation process	
The facilitation is based on three strategies: psychoeducational, cognitive-behavioral, and motivational	The adapted manual includes eight additions: the family member's role in the recovery process and in setting and achieving rehabilitation goals; family communication skills; the family as a key agent in taking up client rights; psychoeducational explanation about the importance of medication and its management; the family's role in preventing relapse; knowledge about spirituality and religion; basic family therapy skills to help facilitators integrate family members and understand their significant role; and using video clips, paintings, diagrams, cards, and role-playing to overcome the family's difficulty to express emotions, read, and write	Goals, methods, context
	Meeting location	
Making the intervention accessible is important but not critical; it is possible to have participants travel to the meetings	Given conditions in Arab society in Israel, where mobility is restricted because of lack of public transportation and the fact that single women may not travel alone, meetings must be highly accessible	Methods, context
	Developing unique training for facilitators	
General training sessions countrywide without reference to sociocultural groups	Culturally adapted training, with meetings held in a relatively accessible location that is familiar and provides a culturally suitable background	Methods, context

[a] A more detailed version of this table that includes numbered sections of the IMR manual is available in an online supplement.
[b] Dimensions of the ecological validation model are from Bernal et al. (8).

process of working simultaneously with clients and with family members was designed to maximize the potential benefit of IMR.

Feasibility and Feedback

Out of the 102 participants who began attending the 13 groups, 77 participated in the entire intervention (26 weekly sessions), which illustrates its feasibility. The IMR practitioners provided valuable ongoing feedback during the 9-month supervision, offering useful comments, for example, about the positive impact of incorporating art activities and suggestions for future revisions in the manual. Finally, upon completion of the intervention, interviews with 14 IMR practitioners and 19 consumers were carried out, providing additional valuable feedback, which will be used to guide the ongoing dynamic process of cultural adaptations.

Conclusions and Implications for Policy and Practice

Cultural adaptations of mental health EBPs are attracting growing interest, and efforts are underway to make interventions developed mostly in high-income countries

(1)—and found to be effective—accessible and culturally relevant to diverse populations, cultures, and minority groups worldwide. This column focuses on the process of creating a cultural adaptation of IMR for Israeli Arabs. The process was challenging and involved multiple dilemmas, including deciding how to best involve key community stakeholders, such as religious leaders and families, and to incorporate religious beliefs and family values and traditions.

Family members were granted a much more central and structured role in the Arabic version of IMR. Although they did not participate regularly in the actual intervention, family members attended separate meetings with instructors. The adaptation focused on encouraging family involvement and strengthening ties between family members and mental health professionals to help families better support their loved ones. To facilitate this process, we developed an IMR manual in Arabic for the families, which aimed to help improve communication with and understanding of their loved ones' experience with mental illness and to help families develop ways to better support the recovery process. Importantly, this focus did not distract from the core components of the intervention but rather added to and supported them.

The adaptation also involved identifying and addressing practitioners' needs to acquire specific skills related to engaging, incorporating, and working collaboratively with key stakeholders who play important roles in the recovery process. Finally, we added explanations about spiritual strategies for coping with mental illness within the context of religious belief. A growing literature suggests that religion and spirituality contribute to positive coping with mental illness (9). Nevertheless, religion can also have a negative influence, particularly when it replaces or delays effective treatment (10). It was therefore important to stress that while spirituality may be very helpful for many, it should not replace effective, evidence-based treatment.

Practical and Policy Implications

Culturally adapted interventions can contribute significantly to helping people with mental illness from diverse cultures and social groups. Our pioneering effort to create and implement an Arabic version of IMR and to train personnel in its application has helped shift clinical practice from "intuition based" to structured, evidence-based, and culturally sensitive. The process can be seen as a test case of cultural adaptation of an EBP for Israeli Arabs that might inspire and inform future efforts to create culturally sensitive adaptations of EBPs. Integrating research evidence and cultural contexts is crucial to facilitate equality and access to effective treatment. We hope that, in the future, the right to receive culturally adapted mental health services will be recognized in Israeli law and that resources will be allocated for this important purpose.

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