**Intersectionality and caregiving:**

**The experience and coping strategies of immigrant women caring for a family member with severe mental illness**

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**Abstract**

**Background:** Intersectionality has become a central analytical framework in the study of multiple exclusion and empowerment experiences among women from marginalized communities and cultural backgrounds. However, the relevance of intersectionality to informal caregiving in mental healthcare has hardly been explored to date.

**Aim:** The purpose of the current study is to examine the experiences and coping strategies of immigrant women caring for a family member with a severe mental illness (SMI) through the lens of intersectionality theory.

**Method**: Semi-structured in-depth interviews were conducted with 26 informal female immigrant caregivers from the former Soviet Union residing in Israel. The interviews were subsequently analyzed using a qualitative categorical approach.

**Results:** The findings revealed that the participants experienced stigma and exclusion in several intersecting categories of identity: socioeconomic status - as middle-aged immigrants; ethnicity - as Russian speaking women in Israel; gender – as victims of domestic violence; and mental health stigma - as relatives of individuals with SMI. The participants’ coping resources included spirituality and religious faith, optimism and resilience, support groups, and social activism.

**Discussion:** The study provides insights into the burdens and rewards experienced by female immigrant caregivers of family members with SMI through the lens of intersectionality theory. In addition, theoretical and practical implications are discussed and recommendations for future research are proposed.

**Keywords**: Intersectionality, immigrant women, female caregivers, exclusion, stigma, mental illness, empowerment/coping

**Introduction**

Intersectionality refers to the interdependent and mutually constitutive relationship between social identities and structural inequities (Bowleg, 2008). Although there are some differences in interpretation, intersectionality theory considers the ways hierarchies of power exist along multiple socially defined categories such as gender, class, and ethnicity (Yuval-Davis, 2006). Feminist critical theory of intersectionality was originally introduced by Crenshaw in 1989, in reference to the impact of co-occurring sources of disadvantage and exclusion experienced among marginalized communities. Crenshaw later expanded this concept in 1991, emphasizing that researchers should not focus solely on dominance but also on social empowerment associated with excluded identities. This perspective views the intersection of identities as synergistic, producing different and distinct experiences of exclusion and empowerment; oppression and opportunity (Logie at al., 2011; Shields, 2008).

While initial studies on intersectionality theory primarily focused on the overlapping experiences of exclusion and empowerment among black-American women, examining the intersection of race and gender (Crenshaw, 1989; Collins, 1998), contemporary research has applied this concept to various social and health-related contexts (e.g., Azhar & Gunn, 2021; Logie et al., 2011). In recent years, there has been a growing emphasis on using intersectionality within the domain of informal healthcare research, particularly among family caregivers of individuals with dementia (Hangelaar et al., 2023; Liu et al., 2022). This requires an analysis of how multiple dimensions of diversity, such as age, gender, socioeconomic status, and ethnicity, interact with each other and influence caregivers’ experiences and coping strategies.

Despite the association of mental healthcare with various forms of stigma and discrimination directed at individuals with severe mental illness (SMI) and their families (Martin et al., 2017; Pescosolido et al., 2021), intersectionality as a critical analytical concept is rarely used in this field (Hangelaar et al., 2023; Morrow et al., 2020). The use of intersectionality is particularly crucial in the context of immigrant caregivers who need to cope with additional social-cultural stressors in addition to their caregiving responsibilities. Based on the experiences of immigrant women from the former Soviet Union (FSU) living in Israel, this article explores how caregiving in the context of mental health is shaped by the intersection of gender, immigrant status, and ethnicity, and the implications of this intersectionality on the family’s burden and rewards.

**Women caregiving for a family member with SMI**

SMIs encompass conditions such as schizophrenia and mood disorders and are characterized by symptoms that significantly impair an individual’s social and personal functioning (Gonzales et al., 2022). The onset of these illnesses often constitutes a distressing and traumatic experience, impacting those directly affected by the illness as well as their family members, who play a crucial role in supporting their loved ones during the rehabilitation process.

The terms “family burden” or “caregiver burden” describe and evaluate the distress experienced by family members as a result of caring for their relatives who have an SMI (Nenobais, Jatimi and Muh, 2019; Gelkopf, & Roe, 2014). It is possible to distinguish between two types of burdens: objective burden, which refers to the economic, functional and social disruptions in the lives of family caregivers, and subjective burden, which stems from the way the latter perceive the illness and emotionally respond to it (e.g., feelings of loss, guilt, and anxiety) (Hegde, Chakrabarti and Grover, 2019; Liu, Heffernan and Tan, 2020).

Public stigma and fear of social rejection are a significant component of the subjective burden felt by family caregivers. It has been well-established that negative public attitudes extend beyond individuals with SMI and affect their family members, who also have to cope with vicarious stigma (Corrigan & Miller, 2004). This form of stigma includes negative social attitudes that place blame on families, particularly parents, for supposedly causing their child’s mental illness through “poor” and “cold” treatment or attachment styles during their childhood (Charles et al., 2021; Shiraishi and Reilly, 2019; Yu et al, 2020).

While the literature presents inconsistent findings regarding gender differences in the perception of caregiver burden ((Xiong et al., 2020), family burden is highly prevalent among female caregivers. The fact that a substantial majority of primary caregivers for individuals with SMI are women (82%), with 90% of them being mothers (Awad & Voruganti, 2008; Sharma et al., 2016; Alyafei, 2021) renders females more susceptible to the negative implications of caregiving. In addition, family stigma, particularly stigma perpetuated by mental health professionals, tends to be directed more toward female caregivers, often based on the misguided and outdated notion of the “schizophrenic mother” (Seeman, 2019). Moreover, studies have also demonstrated that mothers are more frequently subjected to violence and abuse by individuals with SMI, leading them to suffer more from post-traumatic symptoms while caregiving (Solomon et al., 2005; Wildman et al., 2023).

While most studies emphasize the negative impact of caregiving, it is increasingly apparent that caregiving can also have positive effects on individuals and families. The terms “rewards” and “gains” in the context of caregiving refer to these positive aspects (Gelkopf & Roe, 2014; Kulhara et al, 2012; Stanley and Balakrishnan, 2021), and similarly to the distinction regarding burden, they can be categorized as objective and subjective. Objective rewards include the assistance a person with SMI provides to the family member caring for them, such as financial support, help with household chores, and spending quality time together (Kulhara et al., 2012). Subjective rewards on the other hand, pertain to the emotional benefits a family member can derive from providing care for their loved one, such as enhanced self-confidence, recognition of their own inner strengths, experiencing personal growth, and developing resilience (Kulhara et al., 2012; Shiraishi and Reilly, 2019; Yu et al, 2020). Some studies have found that female caregivers and parents tend to experience greater caregiving gains than men (Campos et al., 2019; Polenick et al., 2019; Stanley et al., 2021). In light of this, the primary objective of individual and group psychoeducational interventions for female caregivers is to decrease their sense of burden and stigma while simultaneously enhancing their coping resources and fostering a more positive caregiving experience.

**Immigration, gender, and caregiving**

The current study focused on immigrant women who are caregivers for family members with SMI. The significance of their experience pertains to understanding the intersectionality of multiple stigmas immigrant women encounter as both immigrants and caregivers of family members with SMI. Indeed, immigrants have to contend with the loss of support networks, a decline in employment status or unemployment, changes in social and economic status, language difficulties, discrimination, and social exclusion (Prashizky & Remennick, 2021; Salo & Birman, 2015; Ward & Geeraert, 2016). In addition to personal distress, immigration also contributes to family stress due to loss of support systems, cultural gaps between family members, and changes in gender and marital roles (Kanat-Maymon et al., 2016; Oznobishin & Kurman, 2018).

Multiple stressful events immigrant women experience can make it difficult for them to assist a family member coping with a disability. For example, studies that examined immigrants who care for the elderly found that they suffer from more psychological and health distress compared to non-immigrant primary caregivers (Soskolne et al., 2007; Suwal, 2010). Among all female immigrant caregivers, middle-aged and single mothers constitute a particularly vulnerable group. This vulnerability arises from the fact that they bear the majority of the caregiving burden, often simultaneously caring for aging parents and young children while coping with the loss of support systems and the demands of juggling various roles (Soskolne, 2001). These findings are particularly relevant to immigrants caring for a family member with SMI, as numerous studies have demonstrated a higher level of stress and burden among immigrant caregivers compared to their non-immigrant counterparts (Bradley et al., 2006; Ryder et al., 2000). Immigrant status can not only deplete existing resources but also hinder the acquisition of new ones that are vital for the family to effectively cope with the illness. Difficulties in acquiring a new language, understanding cultural norms, limited social connections, and a lack of familiarity with bureaucratic and systemic processes can all delay access to the necessary knowledge, care, and treatment (Guzder et al., 2013; Kung, 2016).

**FSU immigrant women in Israel**

The current study is based on the experiences of FSU immigrant women in Israel. Most of these women immigrated to Israel during the major immigration waves of the 1990s and 2000s following the collapse of the U.S.S.R. Despite the relatively high level of education and professional experience among FSU immigrants and the tendency of women to better adapt to Israeli society compared to men (Remennick, 2005), they still encountered various challenges and barriers stemming from the intersectionality of their gender, age, and immigrant status. For example, middle-aged immigrant women faced disadvantages in the Israeli labor market and many of them experienced long-term financial and employment difficulties compared to their pre-immigration status or younger immigrant women (Remennick, 2013).

Immigrant women from the FSU also stand out in several family and cultural characteristics that increase their risk for stigma and exclusion in Israeli society. For example, many of these families had few children, typically one or two, and about a quarter of the immigrant families were headed by single mothers, almost three times higher than the prevalence of single-mother families in the general Israeli population (Mirsky, 2009). Previous studies have documented the unique economic and emotional challenges faced by single mothers due to their low income and feelings of loneliness (Mirsky, 2009; Soskolne, 2001). In addition to their immigrant status, these women have had to contend with racist, sexist, and offensive expressions such as “Russian whore” or “husband snatcher,” which exist in Israeli society and are directed toward divorced women in general and FSU women in particular (Slonim-Nevo et al., 1999). While the Israeli mainstream has mostly associated these sexual stereotypes with first-generation Russian-speaking immigrants in the 1990s (Lemish, 2002), some of these labels continue to be directed toward their daughters, who immigrated to Israel as children (constituting 1.5-generation immigrants) (Remennick & Prashizky, 2018). Another factor contributing to the stereotyping of FSU immigrant women was their questioned Jewish status (Remennick, 2012). Indeed, out of a million FSU immigrants who arrived in Israel, approximately 330,000 were considered non-Jewish according to Jewish law (Susser & Cohen, 2009). This approach, led by the establishment and the Chief Rabbinate, caused FSU immigrants to be seen as a defective and suspect ethnic group compared to immigrants from other countries. In this context, women with partial Jewish or Slavic ancestry often experienced ethno-religious othering and discrimination to a greater extent.

Most of the studies dealing with informal caregivers from the FSU emphasize their tendency to care for elderly relatives or those with some kind of disability within the family sphere (Kaplan, 2010). This trend is particularly noticeable in the field of mental health, as Soviet and post-Soviet societies traditionally bear a strong stigma against people with SMI and have less trust in mental health services (Knaifel & Mirsky, 2015; Polyakova & Pacquiao, 2006). This can have a formative effect on coping with mental illness, as a limited family structure and high commitment to care within the family sphere can contribute to the blurring of boundaries and increase dependency within family relationships (Knaifel, 2023). In addition, the strong cultural stigma among the Russian-speaking community (Dolberg et al., 2019), coupled with relatively low mental health literacy (Nakash et al., 2020; Knaifel et al., 2023) can delay the decision to seek professional help, thereby decreasing social support and increasing the family burden of caregiving. Despite these cultural and contextual characteristics, the intersectional stigma experienced by FSU immigrant women caring for a family member with SMI has not been studied to date.

**The aim of current study**

In recent years, intersectionality has emerged as a central theoretical framework for understanding the multiple exclusion and empowerment experiences of female informal caregivers from disadvantaged cultural backgrounds. However, most of the studies that have utilized intersectionality in informal healthcare research predominantly focused on family caregivers of individuals with dementia (Liu et al., 2022), while almost none have addressed it within the context of mental health. The current study attempts to fill this gap by examining the experiences and coping strategies of immigrant women caring for a family member with SMI. Accordingly, the research questions are: 1) What are the various intersecting social categories in the lives of female immigrant caregivers?; 2) How do immigrant women caring for a family member with SMI experience intersectional stigma and exclusion?; and 3) How do immigrant women caring for a family member with SMI cope with their social and health-related adversities?

**Method**

The current study utilizes a qualitative research design to investigate the experiences of FSU immigrant women in Israel caring for a family member with SMI. Qualitative research aligns well with intersectionality, as it allows for the exploration of the complex interplay of multiple identities and disadvantages through in-depth, descriptive narratives of individuals’ lived experiences. (Abrams et al., 2020; Christensen & Jensen, 2005).

**Sample and recruitment**

The data used in the current analysis was part of a larger qualitative study conducted between August 2015 and December 2016 (Knaifel, 2022). The larger study examines the experiences of immigrant family caregivers from the FSU in Israel, with the current study specifically focusing on female caregivers. The inclusion criteria were: (1) serving as a caregiver for a family member with SMI who is recognized by the National Insurance Institute of Israel as psychiatrically disabled (at least 40% disability); (2) being an FSU immigrant who immigrated to Israel after 1990; and (3) being at least 18 years of age.

A total of 26 women participated in the study, who were recruited using purposive and snowball sampling methods. Most of the women (n=20) were recruited through two community-based family counseling centers that assist family members of individuals with mental illnesses. In addition, snowball sampling was utilized to recruit women who were not affiliated with family counseling centers (n=6) by requesting names of potential interviewees from other consumers, family caregivers, and mental health providers.

**Data collection**

The research instrument employed consisted of in-depth semi-structured interviews (Patton, 2002). The first part of the interview focused on the participants’ spontaneous narrative (“Tell me your family’s story”). In the second part of the interview, more specific questions were asked to explore the participants’ experiences and coping strategies. These questions included the following: “Please tell me about your experiences as a family caregiver.”; “What difficulties have you experienced as an immigrant caregiver?”; “Can you tell me about times you felt you and your mentally ill family member were rejected?”; “What characterizes your relationship with your mentally ill relative?”; “What are your sources of instrumental and emotional support?”; and “Which strengths and services have helped you cope?”

The interviews were individual and conducted in the participants’ setting of choice (e.g., home, family counseling center, coffee shop). Each interview lasted between 60 and 150 minutes. All the interviews were conducted by the first author in the participants’ native language. The interviews were audio-recorded, transcribed, and subsequently translated into English.

**Ethics**

An institutional ethics committee 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 participants’ names as well as any other identifying information have been deleted or changed.

**Data analysis**

The data analysis utilized a qualitative categorical approach (Hsieh & Shannon, 2005), which involves both inductive and deductive processes. Inductive analyses were used to identify codes and categories that emerged from the data, while deductive approaches were applied to explore categories guided by the intersectional theoretical framework informing this analysis (e.g., immigrant status, mental health stigma, sexism, discrimination). The first stage of analysis involved open coding for each interview, entailing a line-by-line coding process and the identification of primary categories based on recurring themes. In the subsequent axial coding phase, categories were further refined, with specific entry criteria established for each category. Factors such as saliency and frequency of mention were used to determine the significance of the categories and their relevance to intersectionality theory. At this stage, some categories were renamed and reorganized. The transition from individual-level analysis to a cross-sectional one was guided by the principles of the constant comparative method. This involved repeatedly moving between individual narratives, common categories, and theoretical concepts. Data saturation was achieved when no new codes or themes emerged.

**Trustworthiness**

Consensus coding was used to ensure the trustworthiness of the analysis. Both authors have expertise in qualitative research and coded the data together for the first five interviews. Next, each author independently reviewed the other interview transcripts, focusing on intersectionality. The authors then met to compare codes and categories and discuss any discrepancies that emerged, until reaching a consensus. A balanced interpretation was facilitated by the authors’ distinct positionalities in relation to the participants. The first author interviewed the participants while the second author contributed to the analysis from an intersectional perspective. The results are presented in the form of a “thick description,” which includes detailed information about the research process, context, appropriate citations, and an open conceptual discussion. The initial data analysis findings were presented at meetings and forums with a select group of participants (member checking) and mental health professionals (external audits), who found the findings to be a close representation of their personal or professional experiences.

**Reflexivity**

It is important to acknowledge and address the researchers’ own perspectives in order to mitigate potential biases that could influence data collection and analysis (Daly, 2007).In this study, the first author is a male who immigrated during childhood from the FSU, rendering him a member of the 1.5 immigrant generation. He possesses expertise as a mental health social worker specializing in working with immigrants with mental illnesses and their family caregivers, including FSU families. Alongside the cultural similarity, there are notable differences between the researcher and the participants in terms of age and gender. This gap created a level of distance that on one hand allowed him to approach the study with a “beginner’s mind,” but on the other hand did not allow him to fully understand the participants’ experience.

The second author is a woman who immigrated from the FSU as young adult, rendering her a first-generation immigrant. She possesses expertise as a social worker and family therapist specializing in working with immigrant families. Based on her personal and professional affinity with the subject matter, she is well acquainted with the experience of intersectionality. Her personal experience of immigration, caregiving, and the processes these involve for women afforded her a better understanding of the participants’ experiences. This “insider” position was helpful in interpreting the findings and recognizing contextual nuances present in the data.

**Findings**

**Participant characteristics**

A total of 26 women participated in the study, consisting of 22 mothers, two spouses, one sister, and one grandmother of individuals with SMI. Participants’ ages ranged from 40 to 75 (*M*=61.12). In 60% of the families, the participants were single mothers (divorced or widowed). Most of the participants immigrated to Israel in the 1990s (66.7%) and some after the year 2000 (33.3%). The average number of years since arrival in Israel was 17.96 (range 3-25).

The psychiatric diagnoses among the individuals with SMI were schizophrenia (15), schizoaffective disorder (3), bipolar disorder (3), major depression (3), and borderline personality disorder (2). The average number of years since receiving the psychiatric diagnosis was 14.59 (range 3-34). In most cases, the onset of illness occurred after immigration (73.3%). Most of the individuals struggling with SMI shared a household with their family (70%).

**The intersection of excluded identities**

The participants’ experience of stigma and exclusion is reflected in several intersecting categories: 1) socio-economic status – as middle-aged immigrants; 2) ethnicity - as Russian-speaking women in Israel; 3) gender – as victims of domestic violence; and 4) mental health stigma - as relatives of individuals with SMI suffering from family stigma.

**Social class: Middle-aged immigrant women**

Most of the participants recounted encountering economic and employment difficulties as a result of immigrating to Israel, with some still grappling with these issues today. For many, these difficulties have led to a decline in their economic status compared to their pre-immigration life in the FSU, forcing them to work long hours and, at times, even face periods of poverty. Single mothers who immigrated to Israel without the support of a spouse or extended family appeared to be particularly affected by these economic hardships.

Kira, who immigrated to Israel as a single mother, was forced to live in a hostel for homeless people for several months. She still finds it difficult to come to terms with this traumatic experience:

*I was penniless, and a social worker told me about a place for homeless people where I could live for a while. I said I would try it, because I had no other choice. I don’t think any “new immigrant” ever lived in that place, definitely not with a child who has problems. It was a place for actual homeless people. I lived there for two months, and I don’t know how I survived it [crying], without a fridge, without food... (Kira)*

While most of the participants did not fall into poverty, they have had to work long hours and sometimes even hold multiple jobs to prevent that from happening. Nina shared her experience:

*I came here on my own, with my children. I wasn’t divorced, but I had no support. My husband only arrived two years after I did. It was very difficult for me to adjust. The kids were alone, because I worked two or three shifts [at a time]. They were good friends. I’d come home at midnight. I worked at the Russian newspaper until around 4. Then I would go to another city where there was a nursing home for people with mental illness, elderly, but with mental problems, and I’d work there until around 11. The journey back home took me until about 12... My kids would be sitting outside waiting for their mother to come home. (Nina)*

The economic hardships faced by some of the participants are not only typical of the first years after immigration, but continue to persist to this day. Sima, another single mother, had to volunteer at a dining hall to ensure at least some access to free food:

*And I have nothing to pay with, because 2,000 shekels is 2,000 shekels, not 20,000. Yes, guaranteed minimal income, but it’s like before going on pension. That’s why it’s 2,000 shekels. I used to get 1,700, and when I turned 55, they added another 200 shekels, so I’m sitting on something like 2,000 shekels a month. That’s why I worked in the dining hall, even though it was voluntary... at least you can always take some bread. You can always take food home, they bring vegetables there, you can always take some. That’s a lot for me. (Sima)*

Economic hardships are also salient among immigrants who came to Israel as middle-aged women and now live without basic economic and nutritional security in their retirement years:

*Many of the immigrants my age, who are in their early 70s, live in poverty. Because at our age, we can’t work anymore, we don’t own an apartment, and many of us also don’t have pensions. I can still work a little, but most people our age are sick, they have many problems, they don’t know Hebrew, and they’re the most in need. Sometimes they even need food. I have a friend, also my age, who can’t even buy fruit for her sick son because they don’t have enough money. (Sophia)*

**Ethnicity: Russian-speaking women in Israel**

Some of the participants noted that after immigrating to Israel they were discriminated against by native Israelis or more veteran immigrants due to their gender and ethnicity, i.e. being “Russian” women. Alina spoke about the negative attitudes that exist in Israeli society toward women from the FSU:

*The Israelis can’t stand us. Some are okay, but some of them can’t stand us. There’s a stereotype of women - that they’re beautiful and that they “snatch” Israeli men… But why does that happen? I don’t quite understand it. (Alina)*

Some of the participants remember specific incidents of rejection and social discrimination they or their struggling loved ones experienced due to their ethnic otherness. For example, Kira recalls working as a cleaner in her first years as a new immigrant and the rejection she experienced when a woman refused to employ her at the last minute because she looked like an educated Russian woman:

*I had so many humiliating experiences when I worked as a cleaner, I can’t tell you, it’s enough to fill an entire novel. But it wasn’t just hard physically, the difficulty was mainly emotional… I’d walk everywhere, because I didn’t have money for transportation. I walked all over Tel-Aviv. And one time, this woman opened the door, a native Israeli, and said to me. “You’re too intelligent to clean my house. I need someone more simple, bye!” and shut the door in my face. (Kira)*

Some participants were not able to clearly distinguish whether they had been rejected due to their ethnicity or because of language barriers. However, it seems their ethnic identity as Russian speakers, the Slavic appearance of some of them, and the doubts surrounding their Jewishness added to this sense of ambiguity:

*I haven’t experienced discrimination. The only time it happened, I preferred to assume that it was because maybe I don’t really look Jewish. I was hospitalized - this was after having joint replacement surgery. I was in the hospital. Two religious women came into the room. What sparked their interest? I don’t know. They asked me where I lived. I told them [that I lived] in Tel-Aviv. So they asked how I even got here. Either they meant because it was far away from where I lived, or because I didn’t look Jewish? Or maybe why I was even in Israel? They weren’t clear, but I didn’t know what to think, and I felt quite uneasy. Such a strange question, ambiguous. (Vera)*

The discrimination, racism, and sexism directed toward Russian women by native Israelis were also reflected in the experiences of the participants’ daughters struggling with SMI. Some participants’ described sexual harassment their daughters had experienced in Israel due to being labeled as “Russian whores” and “easy to get.” These incidents made it difficult for them to find respectable employment and fit into Israeli society. Bronislava spoke about the sexual harassment her daughter had to deal with:

*It was non-stop. One guy grabbed her ass, another guy tried to kiss her, a third guy did something else. If she had collected testimonies and filed a lawsuit against her managers, she could have been rich. For instance, one time she came to me and said, “Mom, I went to look for a job again. I walked into a store selling dresses, and the owner said, ‘You’re enchanting. You could present the merchandise. That would be great. You’re hired, because you’re beautiful, and you can start working tomorrow… I only have one request: this is a family business and you need to be part of the family, and you need to sleep with my son. He’s a bachelor and he’s obviously going to like you.’” She came and told me that, and my daughter has never lied to me. So many people have harassed her because of her beauty. It got to the point where she was willing to give up her beauty… she only wore second-hand clothes, but she still looked like a true queen. When she looked good, people would immediately give her these jealous looks, saying she was a Russian whore. (Bronislava)*

Marina shared that her struggling daughter had been sexually harassed in the rehabilitative framework where she was employed, by a male co-worker who also had SMI. Following the incident, the daughter had to leave her place of work:

*I think the fact that she was a Russian woman made it worse. You see the attitude. Healthy Russian women are often treated like whores, and what kind of treatment is a young, beautiful woman who can’t defend herself going to get… Of course he [the harasser] would never have allowed himself to harass the manager or any other woman. But with her, he went up to her several times and tried to hug and kiss her by force. In the end, she [the daughter] had to leave that place because of him. (Marina)*

**Gender: Women as victims of domestic violence**

Most of the women (18 of the 26) described incidents of violence perpetrated by the men in their lives, specifically their ex-husbands and sons struggling with SMI. Several single mothers spoke about the violence they were subjected to by their ex-husbands during their first years of marriage and how it affected their personal and family life. Nelly described her ex-husband’s violent behavior, which stemmed from his addiction to alcohol. Like many men from the FSU, he had probably suffered from undiagnosed mental health challenges, which he attempted to medicate by drinking alcohol:

*He was such a good looking guy, an athlete. So what if he drank, who doesn’t drink? My parents didn’t drink, maybe only on holidays. I mean, I didn’t know what it was like to live with drunks. I thought that once we were married he’d stop drinking, that I would fix him. He was able to not drink for a year, or a year and half, and then it all collapsed and he turned into a crazy person. Yelling, hitting me, breaking things. I went through everything. I say all drunks are crazy. He won’t calm down until he gets it out of his system… until I had enough and I divorced him. (Nelly)*

Even after divorcing their husbands, some women shared that their husbands continued to hound them and tried to get back into the family by any means possible. Bina talked about a traumatic violent event her husband had put her through after they had separated:

*Finally, he [the ex-husband] moves away to a different city, to Tel-Aviv. Life supposedly goes back to normal. A year and a half later, he comes back. I opened the door for him by mistake, there was no eye-hole. I open the door, he barges into the apartment, and the nightmare returns. He wants to come back to the family. I’m in a state of shock, I’m screaming. There was a little rooftop outside my window. I lived on the first floor, but there was a rooftop below. I tried to jump out the window and he hit me on the head, and the neighbors see all of it. They hear noise, they come out, the see what’s going on and they call the police… they took me by ambulance. Thank God nothing happened to my head. (Bina)*

Aside from the violence some of the participants experienced at the hands of their ex-husbands, about half of the participants described incidents of severe physical, verbal, or emotional abuse inflicted upon them by their mentally ill sons. The participants attributed these traumatic events to their son’s illness and the madness that suddenly took hold of them, which made them dangerous and unpredictable. Most of the participants linked this violence to a regression in their son’s mental state stemming from a refusal to persist with the psychiatric treatment regimen:

*My son would hit me very hard and I would walk around with black eyes. He’d also get into fights in public, but he was also very violent toward me. He has this thing where he refuses to follow rules and only does what he thinks is right. I couldn’t get him into the hospital. I even had a girlfriend who worked at an HMO and she wrote me a letter, saying that I was walking around all black and blue… He’s a really good boy, but with me he’s different – a real tyrant. And my girlfriends would say, “Why do you put up with it? Why are you sacrificing yourself like this? Why don’t you take pity on yourself?” And he would curse me a lot, and threaten me, and hurt me, and abuse me, and he became so vicious. He wasn’t like that… I got to the hospital with him only after many years. (Alina)*

*To tell you the truth, I was living in constant fear… constant fear. From 1999 to 2009 – that’s ten years. I didn’t know how the day would end. If he’d be in a good mood, or if he was going to go crazy… he had outbursts. He could break things. At home he broke many things and… he also hit me. Then he’d cry and regret it, but what was done – was done… There were times when he’d throw a fit and yell. Every time he’d threaten to break something… every time he stops and says he’s not going to hurt me. “Don’t worry, I’m not going to hurt you.” But who knows? Who can know?? Can he control himself right now? I’m not only scared to go near him, I’m also scared to look him in the eyes. Because he’s insane! You get it? And he says, “Come, give me a hug.” I’m paralyzed with fear to the point that I even can’t move, let alone walk. I’m terrified. (Vera)*

The participants’ accounts indicate that the probability of violent incidents increases when dealing with sons with SMI living with single mothers, as was the case with Alina and Vera. However, Stella’s story demonstrates that husbands with SMI can also be violent toward the women who live with and take care of them:

*Sometimes he can flip in a matter of seconds and turn into a very violent and aggressive person, and then he says very harsh things to me. He starts yelling and then you either need to be quiet or run away. And I’m worried about the neighbors and the whole street hearing everything, and it really upsets me, and the worst thing is he doesn’t see that he’s causing the conflict and he thinks I’ve started it. He projects everything onto me. If he screams and I ask him to lower his voice, he says I’m screaming or I’m beating him. He can make a scene in front of guests and relatives. (Stella)*

**Mental health stigma: Family stigma toward mothers of adults with mental illness**

The participants elaborated on their role as family caregivers for people struggling with mental illnesses. Many emphasized family obligation as a core value that guided them in their caregiving work and imbued it with meaning, despite the difficulties and personal price they have had to pay for it. Alexandra highlights the gender aspect of caring for a family member with a mental illness:

*Men often either avoid or run away from the problem. Not always, but mostly. That’s psychology, I’m not making it up. You see that it’s mainly mothers who take care of the children, even though most of them are married and the fathers exist, but they distance themselves from the issue. (Alexandra).*

As part of their role as family caregivers, beyond coping with the challenging symptoms of their loved ones’ illness, these women have also had to deal with family stigma. This stigma is directed towards the parents of individuals who are struggling with SMI, especially mothers, who are often perceived as directly or indirectly responsible for their child’s mental illness:

*I almost had a fight with her [the social worker] recently because she says to me, “You raised her this way, that’s why your daughter has this a problem.” How can she say such a thing? I can’t stand her. [To say] that I brought my daughter up this way and that’s why she has a problem? When she said this to me, I wanted to fight her. It’s so offensive. Instead of helping me, she blames me. The audacity! And I know my daughter has had this affliction since she was a child, and I went to so many doctors, neurologists, and psychiatrists in Russia... and I did everything for her and went through everything with her, and she tells me that this is how I raised my daughter! (Yana)*

The participants noted that stigma directed at families dealing with mental health issues is especially prominent in relation to single mothers, particularly among professionals and institutions. As a result, these women lose trust in the caregiving systems, feel abandoned and rejected, and are unable to receive the help they need:

*Doctors and social workers... if they know you have a healthy child, they protect you. And if they see that you have a sick child, they start to discriminate against you in a big way... The system insults you... talking about poor upbringing, and they don’t really want to help you. I really feel it... They know you’re alone, without a husband, with a sick child, and there’s no one protecting you. And it’s very odd, this relationship with at-risk families, because they give you less help, even though I need more help, because I’m alone. (Alina)*

Stigma towards families dealing with mental health issues is not only prevalent among professionals from the mainstream culture, but also among individuals who share the same cultural background as the women. Some participants recounted instances where professionals from the Russian-speaking community held strong mental health stigmas and displayed judgmental and accusatory attitudes toward the parents of those struggling with mental illness.

Bronislava described the hostile attitude directed toward her and her daughter by a Russian-speaking police officer whom she tried to turn to for help:

*The system’s attitude toward us is very problematic. One time, I needed to call the police because [my daughter] Lena, was in a psychotic state. And the officer, full of contempt, says to me, “What do you want?” And he says it in Russian, the officer was Russian, and he said to me, “What do you want from me, you mother of a slut?” And he said it with such hostility, before he even came into the house to see what was going on. (Bronislava)*

Alexandra recalls that the most significant opposition to her appointment as guardian for her granddaughter (n place of her struggling daughter) came from Russian-speaking social workers who questioned her capacity to serve as an appropriate parental figure in light of her daughter’s mental illness:

*Throughout the whole process, those people from the welfare department spoke about me and said such horrible things... The tried to destroy me, of course the Russians did. It’s obvious... the Russians from the welfare department, Russian-speaking social workers. They spoke with so much anger, saying “The entire south of Israel knows the daughter...” and “Look at this grandmother... she screams… she doesn’t have a husband, she doesn’t have an apartment, and she doesn’t have a steady job, so how can she raise the granddaughter, how can she educate her?” (Alexandra)*

**Coping resources**

The findings revealed that the resources that helped the participants cope with the intersectionality of adversities in their daily lives were: 1) spirituality and religious faith; 2) optimism and resilience; 3) support groups; and 4) social activism.

**Spirituality and religious faith**

Some of the participants emphasized mental processes such as faith, prayer, and a relationship with God as part of the spiritual coping strategies that help them in times of distress and crisis. Sima shared that she prays for herself and for her struggling son:

*What helps? God helps me. If it weren’t for God, I don’t know what would have been left of me by now. He’s keeping me together, for now. Faith, it’s a real thing. It’s not just empty faith. When I can’t do anything about the situation, I pray to God... I also pray for him [the struggling son]. If I hadn’t prayed, I shudder to think what would have become of him. At least he manages to get up and go to work... (Sima)*

Daria linked her choice to believe in God with the need to find meaning. She described the power of faith as a source of stability and security that made it easier for her to cope:

*I’m an optimistic person. I believe that God really helps, I feel it in my life... I chose to believe because it makes things easier for me... I’m sure it’s played a significant role in how I cope. I needed to find what would help me the most, and I chose God, and that’s also what I say to my children and husband. I think that faith is the most important thing, because it’s constant. It doesn’t depend on the person’s health at that particular moment, it depends on your faith. (Daria)*

Marina also described how religious faith had taken on a central role in her life following the crises she had undergone and the profound transformation in her worldview - from believing that human beings were the sole masters of their destiny to a more fatalistic perspective of a higher power being the exclusive determining force:

*You understand [crying]... what I’ve been through, it’s already... it’s so difficult. Only God gives me strength. If it weren’t for God, I couldn’t have endured all of this... But God sustains me [crying], he helps... I don’t rely on myself anymore... Once, I used to say that we’re young and strong, and we can do everything on our own, and now, I say that everything is in God’s hands. (Marina)*

**Optimism and resilience**

Some participants reported that personality traits such as optimism and joy of life have helped them survive the most challenging periods in their lives and cope with the sadness and burnout that accompany their roles as family caregivers:

*I also have these personality traits that make me not sad. I’m kind of optimistic... because I had no strength left for crying... and it was important for me to stay optimistic and positive. Because otherwise, if you’re the one whose crying, nothing gets better. To be optimistic, to look for the upside, not the downside, that’s my motto in life. To find moments of joy and comfort. Because the world I live in is harsh and bleak, and in this world, it’s important to also find joy. It’s hard to find it... but I found it. (Luba)*

An optimistic outlook makes it easier to see the positive, even in the most challenging events. As Stella described it:

*I have this ability, I can turn shit into candy, squeeze a plus out of minuses. I always tell myself that if I have an enemy, I need to find something I love about them and make them my friend. And there were many events in Moscow where this helped me. Turning minuses into a plus. That’s the trait [...] and I’m also a very active woman, not passive. That also helps a lot. I don’t give up easily in all kinds of situations. (Stella)*

Victoria linked optimism, a trait she inherited from her father, with the ability to develop resilience and strength. In her view, a positive and creative approach to life makes it possible to grow and even flourish, despite challenges:

*My father instilled in us a love for life, optimism, and a willingness to work hard. Not an addiction to work, but a love of action and a desire to learn and know things. So these attributes: joy of life, humor, resilience. Resilience, meaning not succumbing to circumstances, even though there are all kinds of periods in life. I call it life resilience... There’s something good in every bad situation. My father liked to say that everything’s for the best. It’s cruel to say that everything’s for the best because is it really for the best when a young and talented child is thrown down like that? It’s cruel to say that everything’s for the best, but to say that you can find the good in every bad situation is better from a philosophical perspective, and it’s also more humane*.

Alexandra described the strengths she discovered within herself, especially as a single woman without a partner or family support system:

*It’s not unique, but it’s the truth. If you stop, people will walk all over you. You can’t stop. My whole life I never had anyone to rely on. A Soviet woman without a husband – that takes tremendous strength, and I can’t be stopped. Here, people can’t even do the smallest things with their hands, even some of the men, and I had to do everything on my own. (Alexandra)*

**Support groups in family centers**

Most of the participants who had previously turned to mental health family counseling centers (n=20) elaborated on these centers’ unique contribution to enhancing their coping methods and resilience. The psychoeducational interventions at the family counseling centers provided participants with essential tools and knowledge about mental illness, their rights, and the services available to them in the mental healthcare system, which transformed their perceptions and coping strategies.

*At first, I was on the verge of depression. But I realized that if I wasn’t going to be strong, no one would help me. The group helped me realize that I needed to be strong because that’s the only way I could help my son and myself. Being strong means knowing what to do, who to turn to, and how to be. I came here, to the family counseling center, so I already know who to approach and what to ask for. (Tamara)*

Of all the interventions, many participants highlighted their participation in support groups for Russian speakers as a significant and empowering experience that helped them make changes on the emotional, cognitive, and sociocultural levels. The participants reported that the Russian-speaking support group was a unique framework that alleviated their loneliness and allowed them to connect with families facing similar issues, share their problems for the first time with others, and lighten their emotional load:

*When I came to this group, first of all, I saw that I wasn’t alone. Because when you feel alone, you’re just isolated, like on a desert island, and it’s a terrible feeling. And when you see that you’re not alone, then... it’s not like, “Oh, I’m alone, I feel so bad,” no, it’s the opposite! You know, when I heard what people there had gone through, I said, “Wow, my case is nothing!” It’s unbelievable what goes on there! I sat and cried when I heard the stories. (Victoria)*

Most of the women who participated in support groups or family clubs (another framework for group meetings at family centers) noted that it was a unique opportunity for them to take a break from their daily routine and expand their social and cultural support network:

*The group helps mainly in communicating with other parents, because we’re isolated here. Minimal communication, mostly at work, if there’s even anyone to talk to. A couple of words, “How are you?” “Fine.” “Bye.” In general, the club for Russian speakers can get together twice a month, not once a month, because for most people it’s is the only chance they get to go out. Women put an effort into it, put on earrings and nice clothes, because otherwise, where else can you go to just talk…shops and the market... (Alexandra)*

The close bonds formed among the group members gradually expand into a community and enrich their social network and leisure activities outside the family centers:

*In the group, we meet new people, and already there are people who connect, send greetings to each other on holidays, and give each other a box of chocolates. For me, this is also very important, and for Tanya [her struggling daughter], it’s very important. She keeps saying, “Mom, look at the gifts people at work get, and we get nothing.” There’s one woman I particularly connected with, and she helps me a lot. She knows Hebrew well and she helps me when I need to translate something. We exchanged phone numbers in the group and there are two friends I talk a lot to on the phone. We greet each other on holidays and ask each other “How are you? How are you feeling? How’s everything?” And that’s given me a lot. One couple from the group has a car, and they offered, “If you want to go somewhere, we can take you.” And that’s very important because I actually have become very tired... (Marina)*

**Social activism on behalf of other families**

Some participants shared that one way they cope with social hardships is through social activism aimed at helping other families facing similar issues. According to the participants, their social activism stems from a sense of mission as immigrant caregivers, which gives them a unique and empowering sense of purpose:

*The project is called “Families for Families.” They invited me because they saw that my husband or I were there every day for three months when he [the son] was hospitalized, and they said they also need Russian-speaking family members. They need it for people whose relatives are being hospitalized for the first time. While the patient is in treatment, their family members are in a state of panic. For ten months, we received guidance from doctors, psychologists, and various people who spoke to us about medications and social rights so that we could come every day from 2 PM to 6 PM and talk to the new patients’ family members. People called me, and I came to help and talk to them. I’d listen to other people’s problems and tell them how I deal with them. (Svetlana)*

Some participants’ social activism involved organizing and facilitating group meetings with other families (self-help groups) for the purpose of sharing information and mutual support:

*We organized it based on what we were taught in the group. Five families with similar issues... We all gather together, and for an hour and a half we talk, about a quarter of an hour each... My role is to coordinate it and distribute the time among people evenly. You know, people who have experienced a traumatic event start talking and you can’t stop them. I saw how the facilitator does it in the group, she would stop them very skillfully... and I would try to understand how she does it. Very graciously, she would say: “Alright, true... and how is it for you?” And that’s how she shifts the focus of the conversation to another family. And it’s very similar with us, we go by the clock, about a quarter of an hour for each person. What happened for each of us in the past three weeks, what we discovered, what’s new at the family center, what’s new in terms of the rehabilitation basket, etc. (Bronislava)*

Bronislava’s story demonstrates that activism on behalf of other families creates a sense of closeness and solidarity among the participants and addresses both personal and social needs.

Some of the participants had not yet provided concrete assistance to other families but expressed a desire to do so in the future:

*My dream is to continue learning and developing things for other families and our children. Support and communication among families are very important. I see it in the group, it gives people a lot of strength, and it’s important to continue this and open clubs in family centers where people can get together and talk. So I would like to develop these kinds of meetings for parents and children, so people can meet each other and stay in touch outside the family centers too. (Victoria)*

Victoria’s description illustrates the process of change and the transition she and other participants are undergoing, from being the ones who receive assistance to being those who provide it.

Other participants’ social activism is aimed at changing public policy and involves participating in protests and demonstrations with the goal of improving the living conditions of vulnerable populations.

*I have a friend who organizes meetings in the Knesset or on television on the issue of the housing crisis among immigrants, and sometimes I go with her to join the struggle. Just last week, I was called to participate in a meeting about the situation of people with disabilities in Israel, and I went and shared my story. Maybe it’ll help in some way, because there were important people there. It’s important to me that they [policy makers] recognize the difficulties families with psychiatric illnesses have to deal with, especially new immigrant families, and that things change in terms of stipends and housing, because otherwise it amounts to discrimination among disabilities. (Sophia)*

**Discussion**

The current study sought to examine the experiences and coping strategies of immigrant women caring for a family member with SMI through the lens of intersectionality theory. To date, intersectionality and informal mental health caregiving has hardly been explored. Based on the experiences of immigrant women from the FSU in Israel, the article described how mental health caregiving burdens and rewards are shaped by the intersectionality of gender, immigrant status, and ethnicity.

The findings reveal that the participants experience intersecting stigmatized and marginalized identities based on their status as middle-aged immigrants, their ethnicity as Russian-speakers in Israel, their gender as women who have experienced domestic violence, and their role as family caregivers for a loved one with SMI. The intersection of these identities has negative implications for their self-perception, their sense of social belonging, and their access to essential resources for personal and family recovery, which they often do not receive from the system. Alongside this, the findings have also uncovered processes of empowerment these women have undergone, precisely because they were in the position of being threatened, alienated, and socially marginalized. These processes are expressed in the women’s ability to respond and cope with the multiple challenges in their lives, implementing strategies that might not have been available to them had they not been in their marginalized position. These strategies enable them to regain a sense of control and confidence, create new social capital, and even engage in proactive initiatives for change, reflecting a sense of resilience and empowerment.

The social marginalization of these women is primarily influenced and shaped by their immigrant status and economic instability, and at times, even poverty. Despite the benefits new immigrants receive from the state due to its open immigration policy for Jews (Tartakovsky, 2023), most of the women, especially those in midlife, have experienced a sharp decline in their socio-economic status since immigrating to Israel. The economic and emotional burden is even higher and more painful for single-parent families. In line with previous studies, our findings indicate numerous instrumental and unique challenges faced by single mothers, which constitute the majority of their objective burden. These include difficulties in finding employment, long working hours for minimal income, or partial income that does not cover their basic needs (Soskolne, 2001). In terms of subjective burden, they have had to cope with feelings of loneliness and the stigma existing within Israeli society toward divorced women from the FSU, which they did not have to contend with in their country of origin (Slonim-Nevo et al., 1999). The stigma against divorced women in Israel is not unique to Russian-speaking women. However, since the large wave of immigration in the 1990s, it has become primarily associated with Russian ethnicity due to the high prevalence of single mothers from the FSU and the relationships some of them have had with native Israelis, which created a threat for local women.

The experience of exclusion associated with the ethnic stigma against Russian-speaking women in Israel manifests in several, often intertwining, dimensions. The establishment, especially the Chief Rabbinate, perceives the Jewish ethnicity of Russian immigrants as flawed due to the relatively high proportion of those who are not Jewish according to Jewish law (Susser & Cohen, 2006). In light of this, women from the FSU, particularly those with a Slavic appearance, tend to be subjected to more suspicious and negative attitudes in their interactions with conservative groups in Israeli society. In addition, some women have experienced rejection and discrimination in the labor market due to cultural-linguistic gaps, which have made their occupational and social integration more difficult. This is compounded by exposure to racist, sexist, and offensive expressions toward first-generation or 1.5-generation Russian-speaking women, such as being labeled a “Russian whore” or “easy to get” (Lemish, 2002; Remennick & Prashizky, 2018). In our study, participants described encountering such attitudes toward their struggling daughters, which made it difficult for them to maintain employment in the open market as well as within rehabilitation frameworks, thereby adding to the mothers’ burden.

In addition to the external social challenges the women are forced to cope with, they also grapple with multiple challenges within the family sphere. Their marginalized social status seems to have implications for their self-perception and relationships with their struggling children. Many of the women, especially single mothers, reported often being involved in violent conflicts with their struggling loved ones. In most cases, the violence was more common and recurring when the children struggling were men living with single mothers and the relationships were characterized by blurred boundaries and mutual dependency. In many cases, these women had previously suffered abuse from their spouses. However, while they felt free to separate from their spouses, they struggled to set boundaries for their children and expected rescue from an external source, e.g. the mental healthcare system. This situation reflects both the cultural loyalty of women from the FSU to their families and their external locus of control, expecting solutions to family problems to come from outside sources (Leipzig, 2006; Remennick, 2007).

Stigma in mental health is a central component of the subjective burden family members, particularly parents and mothers have to contend with (Corrigan & Miller, 2004). The current findings suggest that the level of stigma against women, especially single mothers, is particularly strong. As a result, many of them experience self-stigma, feelings of guilt, and a sense of “parental/maternal failure,” which become central burdens in coping with the illness. The findings indicate that the source of stigma is mostly among healthcare and welfare professionals, as well as representatives of other institutions (street-level bureaucrats) to whom women turn for help in times of crisis and distress. Even professionals who share a similar cultural background with the women often view them as failed mothers, holding them responsible for the outbreak of their children’s mental illness (Corrigan & Miller, 2004; Kim & Salyers, 2008). Thus, stigma toward immigrant women coping with mental health burdens is reminiscent of the attitude toward women from multi-problematic families who are in ongoing contact with welfare departments and experience frustration and alienation because the professionals who are supposed to help them blame them for their family’s situation (Krumer-Nevo, 2022). This reflects a structural stigma, indicating that systems that are supposed to assist these women often exclude them due to their compounded marginality as immigrant, Russian-speaking women, with a history of domestic violence, who are (in some cases the sole) caregivers of a family member with SMI.

From the perspective of intersectionality theory, the marginalized positions discussed here exhibit a mutual influence of interrelated and interdependent identity categories that include ethnicity, gender, and socioeconomic status (Yuval-Davis, 2006). The findings indicate that it is not always possible to separate the marginalization and oppression experienced by single mothers based on a specific dimension of their identity (such as gender, ethnic origin, immigrant status, etc.). Rather, there is an intersection of marginalized identities that weakens the women and distances them from potential centers of power and essential resources. The added category of family caregiver in the field of mental health places the women at high risk for various social and health-related difficulties due to the heavy burden it entails (Gupta et al., 2015). The intersection of their roles as caregiving mothers with their marginalized socioeconomic, ethnic, and gender identities further weakens these women, pushing them to the fringes of society and making their problems even more severe than those faced by the loved ones they care for.

Alongside marginalization and the loss of vital symbolic and material resources, the findings reveal how immigrant women cope with this reality. Some of the women and mothers who experience social marginalization also undergo processes of personal and social growth and empowerment. In fact, they use the new opportunities that have become available to them as a result of immigrating and caring for a loved one with SMI to start a new chapter in their lives and cultivate a sense of belonging and new social capital. They are not just helpless, passive victims of their objective circumstances but actively challenge these conditions, build their status, and gather new sources of support while developing faith in their inner strengths.

For example, the findings indicate that many of the participants draw upon spiritual beliefs and religious faith to cope with their loved one’s SMI. This finding is surprising given the marginal role spirituality and religiosity traditionally play in Russian-Soviet culture, which is largely secular and atheist (Remennick, 2012). This can be explained by the perceptual shift experienced by family caregivers who have immigrated to Israel and need to cope with a chronic illness in the family. Firstly, religious faith plays a central role in constructing a Jewish-Israeli identity, and many immigrants from the FSU expand this dimension as part of their acculturation to Israeli society (Remennick & Prashizky, 2012). Secondly, numerous studies have found that family caregivers rely on spiritual resources to alleviate the subjective burden of coping with the illness (Azman et al., 2017; Hernandez & Barrio, 2015). In times of crisis and distress, even individuals from secular backgrounds, particularly women and single mothers, turn to spirituality and religion to find peace, solace, strength, meaning, and a sense of control over events that are in fact entirely beyond their control (Abu-Raiya, 2015). This phenomenon appears to be characteristic of FSU immigrant caregivers as well; by adopting a fatalistic worldview, they are able to shape a “normalizing” meaning for traumatic events while gaining an emotional resource that is not dependent on external circumstances.

In addition, some participants referred to optimism and resilience as another internal resource that helps them cope. They emphasized their ability to recover from crises by attributing a positive interpretation to negative events in their lives, seeing them as opportunities for change, learning, and growth. This is consistent with research on family caregivers, which has found optimism to positively correlate with feelings of wellbeing and resilience and negatively correlate with mental distresses such as depression and anxiety (Mackay & Pakenham, 2012).

The majority of professional and social support FSU immigrant women receive for coping with mental illness in their families comes from their participation in psychoeducational support groups conducted in Russian in mental healthcare centers. These support groups have emerged as a significant resource contributing to positive changes on an emotional, cognitive, and sociocultural level. These findings align with extensive literature from Israel and around the globe describing the connection between participation in culturally tailored support groups and a reduction in feelings of burden and stigma on the one hand, and improvement in levels of hope, mental wellbeing, and coping strategies of families on the other (Hackethal et al., 2013; Kung, 2016). However, the participation of women from the FSU in support groups is somewhat surprising, given reports from professionals about the difficulty of recruiting them for consistent participation in therapeutic support groups (Berezkin, 1999; Knaifel & Kanevsky, 2017). It is possible that the fact that these are psychoeducational support groups and the participating mothers come from a background of social marginalization makes them more meaningful and valuable to them. The strong stigma within the Russian-speaking community toward mental health problems and the women’s cultural-linguistic otherness within the general Israeli population has turned these groups into exclusive social-cultural spaces where the women can feel safe and protected from social rejection. These mental healthcare groups provide an opportunity to expand their social circle and create a sense of collective belonging based on cultural affinity and a shared connection to the field of mental health—a unique and empowering resource not found in other social spaces (Knaifel, 2023).

Another coping resource some of the women have adopted is social activism. This is directed toward helping other immigrant caregiving families facing similar situations as well as advocating for the rights of individuals with disabilities and their families. Although in many mental health studies, this approach has been documented as a central tool in the recovery and empowerment process of families, social activism among FSU immigrant women in Israel is much more rare.

Previous research has identified various factors contributing to the lack of participation of FSU immigrants in volunteer activities in their adopted countries. These include poverty, long working hours, language barriers, and social isolation from more established segments of the volunteer community in the host society (Aleksynska 2011; Voicu and Serban 2012), as well as a sense of apathy or skepticism rooted in their pre-migration experiences of “mandatory volunteerism” (Uhlin 2006). However, a study conducted by Khvorostianov and Remennick (2016) focusing on the voluntary activities of FSU immigrant women in Israel revealed that many of them were personally empowered by helping others. Most were motivated by a desire to build co-ethnic support networks and overcome social marginalization in Israeli society and adopted voluntary activities as a strategy for social integration.

The current findings support these conclusions and further suggest that specifically in the context of mental health, many women find a meaningful way to be active, volunteer, and assist other families. In doing so, they also enhance their social status, which has been affected by their status as immigrant women dealing with mental illness in the family.

In conclusion, intersectionality and the reduction in existing social resources have prompted the women to acquire new coping resources that diminish their sense of loneliness and enable them to develop a sense of belonging to new communities. This is not typically characteristic of older FSU immigrants, who tend to isolate and experience social and cultural segregation (Dolberg et al., 2019; Remennick & Prashizky, 2023). Thus for example, faith and religiosity not only serve as a specific coping resource but also provide the women with a sense of belonging to the Jewish-Israeli society, which is characterized by a strong connection to faith and religion. In addition, the integration of these women as facilitators in family counseling centers in general and support groups in particular provides a sense of belonging for other women coping with mental health issues who share a similar cultural background. Finally, participation in social activism provides support for other women from the FSU and promotes the status of families coping with mental health issues. These experiences attest to the resilience and empowerment these women have developed in light of, and perhaps because of, the intersectionality of their marginal positions.

**Implications for policy and practice**

The current study has several significant implications at both the theoretical and practical levels. Within the framework of intersectionality, it is essential to examine not only the challenges and discrimination these women experience but also their strengths, resources, and empowerment processes. Most studies conducted from an intersectional theory perspective tend to focus on the negative aspects of marginalized identities, with less attention given to the transformations and opportunities this situation creates for women (Li et al., 2022). In contrast, qualitative research conducted from an intersectional perspective that holistically explores women’s narratives can make a significant contribution to identifying the various dimensions of vulnerability and resilience that shape their therapeutic experience.

At the theoretical level, this research sheds light on the need to examine the field of mental healthcare through an intersectional lens, with a specific focus on the relationships that shape the sense burden and transformations family caregivers experience. In fact, the central conclusion of the current article is that traditional concepts in mental healthcare, such as burden and transformations, can be examined from the perspective of marginalized identities, or at the very least alongside it. This is especially crucial for research focusing on minority groups, such as the LGBTQ+ community, immigrants, refugees, and ethnic minorities, who suffer from multiple stressors and social marginalization that go beyond the scope of standard situations of caregiving for a family member with SMI. In some cases, the concepts of burden and transformations are insufficient to express the variety of interwoven experiences, contexts, and threats minority/marginalized groups encounter in their daily lives. An intersectional approach can provide a more holistic, comprehensive, and in-depth understanding of the experiences of minority populations and the implications of social distress at both the individual and family levels.

At the organizational level, the research highlights the importance of adapting psychoeducational interventions, which have been found effective in reducing the sense of burden among family caregivers (Dixon et al., 2001), to the emotional, social, and cultural-linguistic needs of immigrant caregivers. The added value of culturally tailored support groups for immigrant family caregivers lies in providing a comfortable and safe social environment for them, not only for coping with mental illness but also for dealing with the bureaucratic and social challenges immigrants often encounter. In light of the social isolation and limited family structure of FSU immigrants, it seems the support provided by the group can serve as a partial substitute for family and social support lacking in the community. Therefore, we recommend that upon completing the support groups, efforts be made to encourage the establishment of self-help groups or family clubs that can continue to provide ongoing emotional and social support to former FSU immigrant women. Additionally, it is important to establish specific groups for family caregivers in general and single women in particular that can address their unique needs and focus on collaboration with relevant systems, such as welfare services. In these interventions, alongside professional knowledge it is crucial to include the experiential knowledge of the women themselves, such as personal and family empowerment and recovery stories. Furthermore, beyond acquiring knowledge and expanding support resources, these groups offer an opportunity to identify unmet needs that the state is not addressing adequately, such as increasing disability stipends and providing public housing solutions for those struggling with mental illnesses and their families. Therefore, developing social activity at the grassroots level to influence policy changes in areas where families experience social injustice can also become a goal of these women’s self-help groups, and it is important to provide room and support for these processes.

In group and individual interventions with immigrant women, it is vital to emphasize crisis management and the importance of setting boundaries for the struggling loved ones, especially in cases of violence and aggression. Different therapeutic approaches, such as the one proposed by Haim Omer (Omer et al., 2011; 2015), can be used to expand the strategies for countering domestic violence (e.g., avoiding escalation, mobilizing support during crises, etc.). These approaches can strengthen female immigrant caregivers’ sense of control and empowerment, which has been undermined due to multiple challenges and transitions. In some cases, we recommend highlighting the connection between keeping the mental illness a secret, a common practice among FSU immigrants (Knaifel, 2023), and the perpetuation of the cycle of violence, as this prevents families from seeking external support and creating change in the family dynamics. Part of the external support can be mobilized with the help of other women from the group who have experienced similar challenges.

On a systemic level, the current study has shown that specific groups of immigrant caregivers, such as those without a family support system (e.g., single mothers with one child) and immigrants experiencing ongoing economic and employment adaptation difficulties in Israel, are particularly vulnerable and in need of extensive assistance from the system. In addition to identifying their internal coping resources, these families need active advocacy and mediation from social workers and other professionals to protect them from domestic violence and to access relevant healthcare and welfare services for both themselves and their struggling family members.

The findings indicate that caregiving families coping with mental illness are still marginalized. Despite policies promoting deinstitutionalization, the shortening of hospitalization periods, and the development of community rehabilitation systems that have made families the primary source of support for those struggling with mental health issues, these families are often still perceived by the system and professionals as a burden and the source of the disorder (Martin et al., 2017). The marginalized status of families in the mental healthcare system is exacerbated in the case of immigrant families, due to their sensitivity to rejection caused by previous experiences with systems, the lack of appropriate resources (such as language and knowledge), and their different cultural background, which creates a gap in expectations between them and the professionals involved in their care. The findings suggest that among some professionals, especially in the social welfare sector, stigmatizing perceptions still exist toward parents in general and single mothers in particular, labeling them as the “main culprits” responsible for the child’s illness. Hence, there is a need to continue educating caregiving teams to change these judgmental perceptions. Staff education is particularly crucial in the case of FSU professionals, who are more likely than others to harbor deep-seated stigmas toward mothers in the mental health field, which they carried over from their country of origin and struggle to shed even many years after immigrating to Israel. Another issue in this context is that professionals from a similar culture who could serve as cultural mediators sometimes become sources of institutional oppression, further increasing the sense of isolation and alienation experienced by immigrant women.

Therefore, in terms of policy design informed by intersectionality, it is essential that cultural competence policy does not only focus on reducing specific cultural and linguistic differences but also takes into account the broader sociopolitical context in which immigrant caregivers and professionals find themselves. This encompasses their ethnic, gender, and family identity, their socioeconomic status, and the geographical region in which they reside. In contemporary social work, the prevailing assumption is that marginalized socioeconomic status, ethnicity, and gender identities are not separate but interconnected (Nadan, 2017). Therefore, without a critical examination of the systems and mechanisms that create and perpetuate social inequality and injustice at the institutional level, it will not be possible to effectively sustain a practice of cultural competence.

**Limitations and recommendations for future research**

The current study has several limitations. First, it was conducted in the very specific cultural context of Israel and focused on a group of immigrants with unique cultural characteristics, i.e. FSU immigrants. Second, there is significant variation among the participants in terms of the timing of the onset of the illness and their immigration to Israel. Third, the majority of participants had previously engaged in activities at family counseling centers, and many were recruited through these centers, which may potentially bias the findings related to this systemic resource. Lastly, in presenting the findings pertaining to marginalized identities, an attempt was made to separate the categories and present them as distinct in order to highlight the central focus within each category. However, in practice, and in the spirit of intersectionality, it is not always possible to separate the various social categories, which are often interwoven (socioeconomic status, ethnicity, gender, and mental health). The category of stigma in mental health is particularly representative of this interconnectedness.

Future research should further utilize the theoretical framework of intersectionality to trace social connections that shape the sense of burden and coping strategies of family caregivers. It is crucial to expand the research population, with a particular emphasis on recruiting women who have not turned to family counseling centers, as well as wives and sisters, who were less represented in the current study. In addition, future studies could compare the experiences and coping resources of immigrant families from different ethnic-cultural backgrounds in both the Israeli and global contexts. Such a comparison could contribute to a deeper understanding of the universal, cultural, and relational influences on the marginalization of immigrant women and help identify the challenges and resources that aid in their coping processes.