**Intersectionality and caregiving:**

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

**Abstract**

Intersectionality has become a central analytical framework in the study of exclusion and empowerment experiences among women from marginalized communities. However, the relevance of intersectionality to informal caregiving in mental healthcare has hardly been explored to date. The purpose of the current study is to examine the exclusion experiences and coping resources of immigrant women caring for a family member with a severe mental illness (SMI) through the lens of intersectionality theory. Semi-structured in-depth interviews were conducted with 26 informal female immigrant caregivers from the former Soviet Union residing in Israel. The interviews were analyzed using a qualitative content approach. The findings revealed that the participants experienced stigma and exclusion in several intersecting categories: economic marginalization of immigrant single mothers, ethnic and gender-based stigma of Russian-speaking women, gender-based domestic violence and mental health stigma by professionals. The participants’ coping resources included spirituality and religious faith, support groups, and social activism. 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. Implications for adapting services for the contextual characteristics of female immigrant caregivers and minimizing intersectional stigma and inequities in informal healthcare are discussed.

**Keywords**: severe mental illness, intersectionality, immigrant women, female caregivers, exclusion, stigma, coping

**Introduction**

Intersectionality refers to the interdependent and mutually constitutive relationship between social identities, power relations and structural inequities (Bowleg, 2008). Although there are some differences in interpretation, intersectionality theory considers the ways multiple intersecting identities such as gender, class, and ethnicity interlocking systems of oppression such as sexism, classism, and racism and how this plays out in individual's and collective lives. Feminist critical theory of intersectionality was originally introduced by Crenshaw (1989; 1991) and has become a central analytical framework in the study of oppression and discrimination of women from marginalized communities.

Crenshaw (1991) emphasizing that researchers should not focus solely on harmful contexts of oppression and marginalization but also on social empowerment and resilience associated with excluded identities. Through an intersectional lens, there is an opportunity not only to better expose multiple layers of inequity and disadvantage occurring from intersecting forms of oppression, but also give attention to overlapping strengths-based resilience processes, resistance, and agency that emerge when people with similar identities unite (Clark et al., 2013; Njeze et al., 2020). The intersectionality framework views the intersection of identities as synergistic, producing different and distinct experiences of exclusion and empowerment; oppression and opportunity (Logie et al., 2011; Shields, 2008).

While initial studies on intersectionality theory primarily focused on the overlapping experiences of exclusion and empowerment among Black-American women (Crenshaw, 1991; Collins, 1998), contemporary research has applied this concept to various social and health-related contexts (e.g., Azhar & Gunn, 2021; Logie et al., 2011). Specifically, the application of an intersectionality framework in healthcare research has the potential to create new ways of understanding of illness/disability, intersectional stigma, and health inequities with implications for improvement care for individuals and families from different socio-cultural background (Bauer, 2014; Weber & Fore, 2007). In recent years, there has been a growing emphasis on employing intersectionality within the domain of informal healthcare research, especially among caregivers of elders with dementia (Hengelaar al., 2023; Liu et al., 2022). The present article focuses on mental health context and describes how the intersectionality framework can be applied to address immigrant women caring for a family member with severe mental illness (SMI).

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

SMIs encompass complex health conditions such as schizophrenia and mood disorders which are characterized by symptoms that significantly impair an individual’s social and personal functioning (Gonzales et al., 2022). 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 (Awad & Voruganti, 2008; Shiraishi & Reilly, 2019). 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) (Charles et al., 2021; Hegde et al., 2019). Public stigma and fear of social rejection are significant components of the subjective burden felt by family caregivers (Corrigan & Miller, 2004).

While the literature presents inconsistent findings regarding gender differences in the level of caregiver burden (Sharma et al., 2016; Yu et al., 2018), higher burden is 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 (Sharma et al., 2016) renders females more susceptible to the negative implications of caregiving. Additionally, family stigma, particularly associated and courtesy stigma perpetuated by mental health professionals, tends to be directed more toward female caregivers, often based on the misguided and outdated notion of the “schizophrenogenic mother” (Fromm-Reichmann, 1948). 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 (Labrum et al., 2021; 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” refer to the positive aspects of caregiving, such as the recognition of inner strengths, personal growth, and developing resilience (Kulhara et al, 2012; Shiraishi & Reilly, 2019). Some studies have found that female caregivers and parents tend to experience greater rewards from caregiving than men (Polenick et al., 2019; Stanley & Balakrishnan, 2021). In light of this, the primary objective of psychoeducational interventions for family caregivers is to decrease their sense of burden and stigma, while simultaneously enhancing their coping resources as well as fostering a more positive caregiving experience.

**Immigration, gender, and caregiving**

The use of intersectionality is particularly crucial in the context of informal immigrant caregivers who need to cope with multiple social-cultural stressors in addition to their caregiving responsibilities. 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 (Bekteshi & Kang, 2020; 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).

The accumulation of post-migration stressors can make it difficult for immigrant women to assist a family member in 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 (Kim & Kim, 2020; Soskolne, 2001). 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 (Remennick, 2001). Acculturation difficulties can also hinder the acquisition of new resources and delay access to the necessary knowledge and treatment for immigrant caregivers who are coping with the illness or disability of their family member (Author, 2022a; Kung, 2016).

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

The current study focuses on immigrant women from the former Soviet Union (FSU) in Israel. Most of these women immigrated to Israel during the major immigration waves of the 1990s and 2000s following the collapse of the Soviet Union (Author, 2022b; Tartakovsky, 2023). Despite the relatively high level of education and professional experience among FSU immigrants (Kushnirovich, 2018) 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, ethnicity, 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). Moreover, 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 (Author, 2022b). In addition to their immigrant and marital status, these women have had to contend with sexist expressions that exist in Israeli society and are directed toward divorced women in general and FSU women in particular (Lemish, 2000; Remennick & Prashizky, 2019).

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, where FSU immigrants traditionally show high levels of personal stigma, suspicion, and distrust toward mental health services (Author et al., 2023; Dolberg et al., 2019; Jurcik et al., 2013). These negative attitudes among the Russian-speaking community can delay the decision to seek professional help, thereby decreasing social support and increasing the family burden of caregiving.

**The aim of the current study**

Most of the previous studies that have utilized intersectionality in informal healthcare research predominantly focused on family caregivers of individuals with dementia (Liu et al., 2022). Despite the association of mental healthcare with various forms of stigma and discrimination directed at family caregivers (Martin et al., 2017), intersectionality as a critical analytical concept is rarely used in this field (Hengelaar et al., 2023). The current study attempts to fill this gap by examining the exclusion experiences and coping resources of immigrant women caring for a family member with SMI. Accordingly, the research questions are: 1) How do immigrant women caring for a family member with SMI experience intersectional stigma and exclusion?; and 2) How do immigrant women caring for a family member with SMI cope with their social and health-related challenges?

**Method**

The current study utilizes a qualitative research design through feminist-constructivism approach (….). One of the basic tenets of this approach is that events, behaviors, and attitudes of women can only be understood in relation to their socio-cultural contexts, power relations and subjective meaning of their experiences (Creswell, 2007). 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 women’ lived experiences (Christensen & Jensen, 2012).

**Sample and recruitment**

The data used in the current analysis was part of a larger study examining the experiences of family caregivers from the FSU in Israel (Author, 2022a). The current article specifically focuses 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; (2) being an FSU immigrant who arrived in Israel after 1990.

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 (FCCs) that assist family members of individuals with SMI. The recruitment process was carried out by the mental health providers who worked in FCCs. They identified potential participants who met the inclusion criteria and informed them of the study and authors contact information. In addition, snowball sampling was utilized by authors to recruit participants were not affiliated with FCCs (n=6).

**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. These questions included the following: “Please tell me about your experiences as a family caregiver.”; “What difficulties have you experienced as an immigrant caregiver?”; "Tell me about the attitude you or a family member received from the immediate environment (ספר לי על היחס שאתה או בן משפחתך קבלתם מהסביבה הקרובה (סביבה הקרובה);" "Has you or your family member experienced stigma or discrimination? "What helps you cope?"; What are your sources of support? and et. (וכו')

The interviews were individual and conducted in the participants’ setting of choice (home or FCC). Each interview lasted between 60 and 150 minutes. All the interviews were conducted by the first author in Russian - the participants’ native language. The interviews were audio-recorded, transcribed, and subsequently translated into English.

**Ethics**

An institutional ethics committee approved the research. Informed written consent was obtained from all participants prior to beginning the interview.The study’s purpose, interview format, confidentiality,recording, and right to withdraw were explained toparticipants by the interviewer and stated in the consent form. To preserve confidentiality, the participants’ names as well as any other identifying information have been removed.

**Data analysis**

The data analysis utilized a directed content 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 and their relevance to intersectionality theory. The transition from an 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.

**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. The authors then met to compare codes and categories and discuss any discrepancies that emerged until coding agreement. 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. Consensus coding was achieved when no new codes or categories emerged from the analysis. 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**

Both authors are immigrants from the FSU. The first is a male who possesses expertise as a mental health social worker specializing in working with family caregivers, including FSU families. The second is a woman who possesses expertise as a social worker and family therapist specializing in working with immigrant families. Sharing a culture and language with the research participants creates an "insider" position of closeness to the experience, which helps interpret the findings and recognize contextual nuances present in the data. However, it may also color the power relationship (or relations) between researcher and participant, for example, create for the participant a feeling of comparison and competition (Berger, 2015). Also, social distancing of authors from participants, as they are middle-class highly educated social workers may emphasize a hierarchy or create power relations (Olmos-Vega et al, 2023; Muhammad et al, 2015; Rai, 2020). The issue of distance particularly relevant in the process of researching health stigma topics as 'outsiders', when authors may be in a position where they have social influence or power that extends beyond those who have been stigmatized (Wigginton & Setchell, 2016). But at the same time, a certain level of naivety of outsiders may potentially benefit the research process made it possible for them to ask trivial questions and made the participants the experts of their experiences.

**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. Participant's ages ranged from 40 to 72 (*M*=59.23). In 69% of the cases, the participants were single mothers (divorced or widowed). The average number of years since arrival in Israel was 18.11 (range 5-25). The psychiatric diagnoses among the individuals with SMI were schizophrenia spectrum disorders (17), major depression (4), bipolar disorder (3), and borderline personality disorder (2). The average number of years since receiving the psychiatric diagnosis was 14.46 (range 3-34).

**Intersecting stigmas and exclusion experiences or**

**Intersectional experiences of stigma and exclusion**

The participants’ experience of stigma and exclusion is reflected in several intersecting categories: 1) Economic marginalization of immigrant single mothers; 2) Ethnic and gender-based stigma of Russian-speaking women; 3) Gender-based domestic violence; and 4) Mental health stigma by professionals.

***Economic marginalization of immigrant single mothers***

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. The economic marginalization is especially prominent among single mothers who lack broad familial and social support in a new country. For example, Kira, who immigrated to Israel as a single mother, was forced to live in a hostel for homeless people for several months:

*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...*

The economic marginalization 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:

*I used to get 1,700 shekels, 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.*

Economic hardship is also salient among older immigrants who came to Israel as middle-aged single mothers and 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)*

***Ethnic and gender-based stigma of Russian-speaking women***

Some of the participants noted that after immigrating to Israel they were discriminated against by native Israelis or more veteran immigrants due to their ethnicity and gender, i.e., being "Russian" women. Some of the participants remember specific incidents of being rejected due to their cultural-lingual otherness. For example, Olga talked about an episode that took place in her neighborhood:

*She started shouting something at me, of course in Hebrew. I told her: “Sorry, I don’t speak Hebrew.” She told me and I understood it. I am a translator by profession, I understood that she was saying: “Back to your Russia! And if you're here you need to know the language".*

Other participants were not able to clearly distinguish whether they had been rejected due to their ethnicity or for some other reason. 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. 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. (Vera)*

Some of participants spoke about the negative attitudes that exist in Israeli society toward women from the FSU:  *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)*

The discrimination and sexism directed toward "Russian" women by native Israelis were especially reflected in the experiences of the participants’ daughters with SMI. 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... 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.’” She came and told me that, and my daughter has never lied to me. So many people have harassed her because of her beauty. When she looked good, people would immediately give her these jealous looks, saying she was a Russian whore. (Bronislava)*

Marina shared that her daughter had been sexually harassed in the vocational rehabilitation service 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-based domestic violence***

Most of the women (n=18; 69.2%) described incidents of violence perpetrated by the men in their lives, specifically their husbands and sons coping 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 lives. Nelly described her ex-husband’s violent behavior, which stemmed from his addiction to alcohol:

 *He was able to not drink for a year, or a year and a 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)*

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 adult children with SMI. The participants attributed these traumatic events to their children’s illness and the madness that suddenly took hold of them, which made them dangerous and unpredictable. The participants’ accounts indicate that the probability of violent incidents increases when sons with SMI live with single mothers, as was the case with Alina and Vera:

*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. He’s a really good boy, but with me he’s different – a real tyrant. (Alina)*

*To tell you the truth, I was living in constant fear… ten years of constant fear... 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… (Vera)*

***Mental health stigma by professionals***

The participants elaborated on their role as family caregivers for people with SMI. Many emphasized family obligations as a core value that guided them in their caregiving work. Alexandra highlights the gender aspect of caring: *"Men often either avoid or run away from the problem... You see that it’s mainly mothers who take care of the children".*

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 cope with family stigma. This stigma is directed towards the parents, 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 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 she tells me that this is how I raised my daughter! (Yana)*

The participants noted that stigma directed at families coping with mental illness is especially prominent in relation to single mothers, particularly among professionals and institutions. As a result, these women lose trust in the healthcare and welfare 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 female caregivers is not only prevalent among professionals from the mainstream culture, but also among public service workers who share the same cultural background as the women. 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)*

**Coping resources**

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

***Spirituality and religious faith***

Some of the participants (n=14; 53.8%) emphasized spiritual processes such as faith, prayer, and a relationship with God as part of the coping resources that help them in times of distress and crisis. Sima shared that she prays for herself and her son with SMI:

*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 son]...*

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.*

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.*

***Support groups***

Most of the participants who had previously turned to mental health FCCs elaborated on these centers’ unique contributions to enhancing their coping resources and resilience. Many participants noted that participating in psychoeducational support groups for Russian speakers (n=18; 69.2%) was the most significant intervention for them, as it helped them acquire new mental health knowledge and make changes on the cognitive and emotional levels.

*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... (Tamara)*

The participants reported that the Russian-speaking support group was a unique setting 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 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 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... 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***

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. For ten months, we received guidance from doctors and psychologists who spoke to us about medications and social rights. 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 peer 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... (Bronislava)*

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 people with disabilities and their families:

*I have a friend who organizes meetings in the Knesset [Israeli parliament] 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 exclusion experiences and coping resources of immigrant women from the FSU in Israel caring for a family member with SMI through the lens of intersectionality theory. The findings reveal that the FSU women experience intersecting stigmatized and excluded identities based on their status as female immigrant caregivers. Specifically, situational social identities such as single-parent immigrants, Russian-speaking women, mothers/spouses, mental health caregivers and service users living in economic hardship in Israel were perpetuated at community and institutional levels by intersecting systems of oppressions such as classism, ethnocentrism, sexism, patriarchy, and ableism. An interaction between multiple social identities with structures of power produce and reproduce social loneliness and health related inequality for immigrant caregivers and their family members with SMI. The most vulnerable to structural oppression and discrimination are single mothers, who in addition to their intersectional social inequalities/identities experience lack of family connections and intense stigma associated with their marital status. In line with recent studies in informal healthcare research (Green et al., 2018; Hengelaar al., 2023), the findings demonstrated that focusing solely on issues of caregiver burden or acculturative stress may blind professionals to those intersecting stigmas and marginalization related to being a female immigrant caregiver of a person with SMI.

Alongside this, the findings have also uncovered new resources, such as religious faith, participation in support groups, and social activism, which helped women cope with their social and health related adversities. The coping resources that found in the current study are less culturally identified/characterized with middle-aged and older FSU immigrants (Dolberg et al., 2019; Ulitsa & Ayalon, 2024) and it seems that accumulative experience of intersectional stigma, social loneliness and health inequalities paradoxically prompted these women to acquire new religious, clinical, and social activities. These resources enable FSU women to regain a sense of social belonging and support, and even engage in proactive initiatives for change, reflecting a sense of empowerment and intersectionality of resilience (Njeze et al., 2020).

The social marginalization of female caregivers from FSU 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 middle age, 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 occupational challenges faced by single mothers, which constitute the majority of their objective burden (Soskolne, 2001; Kim & Kim, 2020).

The experience of exclusion associated with the ethnic and gender-based stigmas 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 (Remennick & Prashizky, 2019). In light of this, women from the FSU 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 due to cultural-linguistic gaps, which have made their occupational and social integration more difficult. This is compounded by exposure to racist and sexist expressions toward first-generation or younger 1.5-generation Russian-speaking women, such as being labeled a “Russian whore” or “easy to get” (Lemish, 2000; Remennick & Prashizky, 2019). In few cases in our study, participants described encountering such attitudes toward their daughters with SMI, which made it difficult for them to maintain employment in the open market as well as within rehabilitation services, 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. Many of the women reported often suffering physical and psychological violence perpetrated by their ex-husbands and adult children with SMI. In most cases, the violence was more common and recurring when the adult children were men living with single mothers. These findings confirm previous evidence that female caregivers are more frequently subjected to violence and abuse based on patriarchal gender power hierarchies, the prevalence of treatment nonadherence among people with SMI, and a previous history of violence in the family (Labrum et al., 2021; Wildman et al., 2023).

Mental health stigma is a central component of the subjective burden of family members (Corrigan & Miller, 2004). 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 courtesy 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” care during their childhood (Charles et al., 2021; Shiraishi and Reilly, 2019; Yu et al, 2020). The current findings suggest that the level of courtesy stigma against women, especially single mothers, is particularly strong. As a result, many of them experience self-stigma, feelings of guilt, shame, loneliness, and a sense of “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 public service workers to whom women turn for help in times of crisis and distress (van der Sanden et al., 2015). Even service workers 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. This reflects a structural discrimination and oppression indicating that institutions that are supposed to assist these women often exclude them due to their intersectionality of stigmatic identities (Viruell-Fuentes et al., 2012).

Alongside marginalization and the loss of vital symbolic and material resources, the findings reveal how immigrant women cope with these adversities. 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. 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 & Prashizky, 2012). This can be explained by the perceptual shift experienced by female immigrant caregivers. 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 (Author, 2022b). 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 single mothers, turn to spirituality and religion to find strength, meaning, and a sense of control over events that are entirely beyond their control (McAdoo, 2013).

The most of their emotional and socio-cultural resources FSU women in our sample receive from their participation in Russian-speaking groups conducted in FCCs. These findings align with extensive literature describing the association between participation in culturally tailored support groups and a reduction in feelings of burden and stigma (Hackethal et al., 2013; Kung, 2016). However, the participation of FSU women in support groups contradicts previous reports from professionals about the difficulty of recruiting them for consistent participation in therapeutic groups (e.g., Berezkin, 1999). It is possible that the intersectional exclusion these women experienced made these specific support groups more meaningful and valuable to them (Njeze et al., 2020). The strong stigma within the Russian-speaking community toward mental health problems (Author et al., 2023), the lack of family support 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 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 (Author, 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 the mental health literature, this approach has been documented as an advanced stage of the family recovery process (Spaniol & Nelson, 2015), social activism among FSU immigrant women is known to be much rarer. Previous research has identified various factors contributing to the lack of participation of FSU immigrants in volunteer activities such as long working hours, language barriers, and social isolation in the host society (Aleksynska, 2011; Ulitsa & Ayalon, 2024), 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. Moreover, from intersectionality perspective social activism is a socio-political act of resistance for multiple axes of oppression and active promotion for social justice (…..).

**Theoretical and practical implications**

The current study has several significant implications at both the theoretical and practical levels. To the best of our knowledge this is the first study aimed to examine the exclusion experiences and coping resources of immigrant women caring for a family member with SMI through the lens of intersectionality theory. At the methodological level, most studies conducted from an intersectional theory tend to focus on the negative aspects of excluded identities, with less attention given to the gains and opportunities this situation creates for women (Liu 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 caregiver experience.

The main theoretical implication of the current article is that traditional concepts in informal caregiving, such as burden and rewards, can be examined from the intersectionality perspective or at the very least alongside it. This is especially crucial for research focusing on disadvantaged groups, such as immigrants, refugees, the LGBTQ community, and ethno-racial minorities, who suffer from multiple social adversities that go beyond the scope of standard situations of caregiving for a family member with SMI. In some cases, the concepts of burden and rewards are insufficient to express the variety of interwoven categories, threats, barriers, and opportunities that caregivers from minority backgrounds encounter in their daily lives, and an intersectional approach can provide a more comprehensive and critical understanding of their experiences and coping.

At the practical level, the research highlights the importance of integrating evidenced-based family psychoeducation with the feminist and anti-oppressive approach. The subjects of reducing power relations, pathology concepts and family-related stigma with promoting human diversity, active and collaborative position against poverty, racism, and violence as well as critical reflectivity of mental health providers are vital part of these interventions (……). Especially immigrant single mothers, need active advocacy from social workers and healthcare providers to protect them from domestic violence and help them access relevant healthcare and welfare services for themselves and their family members with SMI.

In the case of FSU immigrants, the study emphasized some specific contextual adaptations. For example, in light of the limited family structure of FSU immigrants and mental health stigma, it seems that support provided by the Russian-speaking group can serve as a partial substitute for family and social support lacking in the community. Therefore, we recommend that upon completing the standard format of group meetings, efforts be made to encourage the establishment of self-help groups or family clubs that can continue to provide ongoing emotional and socio-cultural support to FSU immigrant women. This platform may also create and encourage sense of agency and social activism among more empowerment women.

 At the policy level, the findings indicate that family caregivers of people with SMI are still excluded from social and health services (Martin et al., 2017), and that their disadvantaged status is further exacerbated in the case of immigrant families. 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 professionals to change these judgmental attitudes and reduce intersectional stigma. 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. In terms of policy design informed by intersectionality, it is essential that cultural competence policy does not only focus on reducing specific cultural-linguistic gaps but also takes into account the hierarchies of power and the broader sociopolitical context in which immigrant caregivers and professionals find themselves (Nadan, 2017). Without a critical examination of the systems and mechanisms that create and perpetuate health inequality and social injustice, it will be challenging to effectively sustain a practice of cultural competence in social and healthcare services.

**Limitations and 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: FSU immigrants. Second, the majority of participants had previously engaged in activities at FCCs, and many were recruited through these servicers, which may potentially bias the findings related to the participation in support groups and organization of self-help groups. Specifically, the interviews that were conducted in FCCs may affect the participants’ positions and experiences (for example the tendency to emphasize their clinical and social engagement). Future research should further utilize the concept of intersectionality to trace negative and positive caregiver experiences as well as connected systems and structures of power that leads to inequities in informal healthcare. Specifically, we recommend that future studies compare the experiences of female caregivers from different cultural and geographical regions for a better understanding of the universal and contextual mechanisms of intersectionality.

**Conclusion**

The study provides new insights into how intersectionality framework can be applied to address health disparities among female immigrant caregivers of persons with SMI.Based on the case of immigrant women from the FSU in Israel, the study demonstrates how multiple intersecting dimensions, such as immigrant status, ethnicity, gender, and mental health stigma, interact with each other and influence caregivers’ experiences and ability to cope. The most vulnerable to intersectional stigma and exclusion are single immigrant mothers of adult children with SMI, who lack broad familial and social support network, and who often experience structural oppression. Professionals in social and healthcare services must recognize the contextual characteristics of female immigrant caregivers, minimize intersectional stigma, and assist them with accessing valuable resources.

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