



Roundtable ON MENTAL HEALTH AMID COVID-19

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The Covid-19 pandemic has laid bare the devastating and disproportionate effects of structures of violence that produce vulnerability in communities of color globally, including with respect to mental health-care provision. While coping and resilience are dominant mainstream frameworks to understand mental health in crisis—both in Palestine and elsewhere—the three contributors to this roundtable were asked to offer a rejoinder to that approach. They reflect on the pandemic as an opportunity to revisit how we understand and advocate for critical approaches to mental health in Palestine in the midst of prolonged crisis.

WEEAM HAMMOUDEH: On 14 March 2020, Mai Alkaila, the minister of health of the Ramallah-based Palestinian Authority, was interviewed on Al Jazeera's Arabic-language news channel. Asked by the host if the limited number of Covid-19 cases in the Gaza Strip could be considered one of the "positive consequences" of the blockade—the implication being that living in a state of wide-scale isolation due to siege was protecting the Palestinian population of Gaza from the pandemic—she responded that there was of course nothing positive about occupation. In a global moment where lockdowns and quarantines have been instituted to protect people from the novel coronavirus, many memes and posts have circulated on social media with variants on one that read, "Dear world, how does the lockdown feel? Sincerely, Gaza." Such posts were presumably meant to serve as a reminder that the people of Gaza have been struggling with isolation for more than a decade and to elicit sympathy for Gaza's population. In addition, I began to notice more and more that Palestinians were being sought after for advice on how to deal with lockdown.

As a Palestinian woman social scientist working in public health and living in the West Bank, I found such social media, news, and mass media representations unnerving, notwithstanding the fact that they may have been well-intentioned. Within the context of the Covid-19 pandemic, such representations reinforce the notion that Palestinians are somehow less vulnerable to quarantine and closure, and they practically fetishize an assumed innate Palestinian ability to adapt to confinement that has suddenly become a useful trait during the pandemic. For once, it seemed like Gazans had a leg up! While such representations superficially allude to the broader conditions many Palestinians, especially those in the Gaza Strip, live under, they often reinforced the idea that Palestinians either had an innate superhuman ability to be resilient (read: passive adaptation¹) or that throughout the world, people were getting a taste of what Palestinian "victims"

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have grown accustomed to. Even in their most well-intentioned forms, such representations serve to strip Palestinians of their agency, reify the idea of Palestinian resilience as inherent rather than active, and reduce Palestinians to the state of victims in need of sympathy.

While this may be an oversimplification, the implicit pitfalls of such representations are reminiscent of some common characterizations of Palestinians in mental health research. Mental health researchers often engage with Palestinians as traumatized victims or take for granted their resilience. In what follows, I will reflect on the need to expand the scope of mental health research and praxis while drawing on some insights from ongoing research in Palestine. I argue that while it is essential to take context and people's subjective experiences into account, we need to move beyond the common tropes used to characterize Palestinians and the Palestinian psyche, engage with the complexity and contradictions of their conditions, and resist the urge to essentialize or reinforce Palestinian exceptionalism.

Mental health is a key area of concern for public health, and especially so in contexts of protracted conflict and chronic crises whose negative effects on mental health have been well documented in the literature.² Mainstream approaches to mental health investigations have focused on coping, on the trauma experienced by survivors, and on resilience as key areas of study.³ But despite their salience, scholars, practitioners, and activists have increasingly challenged the use of such concepts and, more broadly, the mainstream approaches they stem from, calling for *critical and contextually relevant* approaches.

In the Palestinian context, trauma and resilience in particular have been at the center of discussion and critique: on the one hand, the emphasis on trauma-based approaches, and particularly post-traumatic stress disorder (PTSD), which tend to pathologize individuals and render a large proportion of the Palestinian population as individually "traumatized" and hence in need of psychiatric treatments and therapies; and on the other, an overemphasis on Palestinians' resilience or invulnerability, which overlooks multiple forms of social suffering resulting from decades of occupation and settler colonialism and implies that the function of resilience is to improve the capacities of Palestinians to adapt to dire and unjust conditions rather than to resist them.⁴ Both the victimization and the valorization miss the target.

These binaries are also echoed in the representations I invoked at the beginning of this essay. Thinking through my own frustrations on the topic, I recognize that they stem in part from what has become an almost visceral reaction to the mischaracterization of my own subjectivity, a mischaracterization that I find suffocating and confining. I do not want to be portrayed as a victim, nor do I want to be tokenized. Such representations also miss the messiness and imperfections of struggle; the nonlinear oscillations between ease and disease, as Rita Giacaman has noted;⁵ and the subtle and not-so-subtle forms of communal agency and resistance that are essential to the contextually relevant conceptualizations of mental health that Nadera Shalhoub-Kevorkian outlines in her work.⁶

Experiencing the Pandemic in the West Bank

As part of ongoing research, colleagues and I began conducting interviews in the West Bank about the uncertainties around Covid-19. We heard from people about their fears, anxieties, and

worries concerning their own safety and, perhaps more importantly, the safety of their loved ones. They described feeling as if they were walking “into the unknown”⁷ or “through a forest filled with beasts.”⁸ Some talked about financial concerns, worries about reaching services or the adequacy of available services, the difficulty of being separated from loved ones, and of having to accept that one must stay away from them in order to protect them. As in many places around the world, there were many expressions of uncertainty about the future, about day-to-day survival, and putting food on the table, among others. In a context with limited institutionalized safety nets and chronic political uncertainty, such worries were only amplified.

At the same time, interlocutors talked about the reignited hope they felt as a result of blossoming local initiatives (many of them youth-led), of cooperation between local organizations that did not normally work together, and of partnerships centered on people helping each other—whether the provision of food and supplies to those in the greatest need, helping to organize the distribution of medications to people with chronic conditions, including mental disorders, or other creative ways of connecting without having to be physically within reach. One young woman remarked that such initiatives and the community response acted as a reminder “that good still exists.”⁹ For those who participated in them, such initiatives provided them with a sense of purpose and meaning, which in turn became a source of psychological strength.

Thinking through our interlocutors’ experiences, with all of their complexities in a context where “we have to tackle two pandemics,” as many put it—Covid-19 and occupation—the binary types of representation referred to earlier and the related mental health approaches that are generally deployed among the Palestinian population felt even more inadequate. Our interlocutors emphasized action, connection, and the right to justice and to a dignified existence in an equitable society free of corruption. Such an understanding in turn raises the following questions: Where do agency and social solidarities fit into mental health approaches and definitions? Are feeling down, anxious, or even depressed antithetical to resilience and resistance? What would a mental health praxis centered on justice and dignity look like?

As we have seen repeatedly in Palestine, the application of trauma-based diagnostic criteria to a population living in a context of protracted occupation, settler colonialism, racism, and apartheid renders whole groups of people “ill” and in need of treatment. Conflict, and especially protracted conflict, affects the very foundations of society, posing threats to human security and well-being,¹⁰ and causing damage or strain to social, physical, and environmental infrastructures.¹¹ Stressful social and material conditions, including poverty, malnutrition, and the weakening of social ties and networks, worsened by conflict, can lead to less visible forms of social suffering, ill-being, and deprivation, both collectively and individually.¹² Despite the pervasiveness of these forms of social and collective suffering, trauma-focused models ignore such manifestations of ill mental health because they do not fit diagnostic criteria. At the same time, preexisting diagnostic tools and measures are often used without questioning their relevance and validity. As Samah Jabr reminds us, when talking about the use of the PTSD label in the Palestinian context, “there is no ‘post-traumatic’ safety. The phenomena of avoidance and hyper-vigilance are considered to be dysfunctional psychological reactions in a soldier who has returned to the safety of his hometown. But for tortured Palestinian prisoners, such symptoms are reasonable reactions, insofar as the threat lives on; they may be re-arrested and tortured again at any time.”¹³

Covid-19 has in many ways become a global trauma. In a post-pandemic world, will we start labeling hypervigilance with cleaning practices as a dysfunctional psychological reaction? Would we approach the consequences of Covid-19 on our collective psyche through the individual therapy approaches that dominate mental health practice? Resilience implies steadiness, an ability to bounce back to where we were before the pandemic. Would that really be what is best for our mental health—especially given that this pandemic has shown that even a presumed biological “equalizer” such as this virus only lays bare and reproduces existing inequalities and disparities in health, as well as social and economic conditions?¹⁴

We frequently face multiple exposures and vulnerabilities, and we need approaches that allow us to examine the multiple layers and interactions between them. This is particularly true in contexts of chronic conflict like Palestine. In recent years, researchers have developed ecosocial and multilayered approaches to examining health outcomes, including mental health, whereby the multiple levels or layers of effects, including biological, ecological, and social organization are taken into account.¹⁵ In the Palestinian context, Giacaman has elaborated a similar approach that attempts to examine a web of causation that includes biological factors and social determinants, including the conditions in which people live, as well as the broader political determinants of health, which can include war, racism, political economy, factionalism, and colonialism—in other words, the broader structures that shape the conditions under which we are born, live, age, and die.¹⁶ Such approaches are important because they allow us to examine the intersections of vulnerabilities or exposures.¹⁷ As the literature has increasingly shown, people can live under multiple forms and layers of oppression, or have multiple sources of vulnerability at once.

In the Palestinian context, for example, emerging research is showing that people who are more exposed to acute forms of Israeli military violence may also be more likely to be poor.¹⁸ If we take an example from the United States, Black people are often found to have worse health conditions and poorer mental health. Many analyses that account for race tell us as much. But being Black is not the underlying condition that predisposes Black people to worse health outcomes: the structures of racism are. As Alyasah A. Sewell has shown,¹⁹ racial disparities in health are rooted in political and economic processes, such as redlining, for example, in the U.S. context. This is an important distinction because it allows us to put our finger on the root causes of ill health and disease, rather than merely observing that Black people exhibit worse health outcomes and statuses than their white counterparts. The same is true for Palestinians in Jerusalem, as compared with their Jewish counterparts. To recap, such approaches allow us to identify the structural conditions in place that continue to create disparities in health or produce ill health.

It is not adaptation to oppressive structures that we need but rather resistance to them. While the current moment is filled with uncertainties and challenges that can have negative effects on mental health and well-being, especially in the context of the ongoing Nakba, this pandemic has shown that adapting to oppressive structures only exacerbates disparities. We need critical mental health approaches now more than ever—critical approaches that allow us to engage with complexity without losing sight of structural causes. Rather than numbing the pain of our individual wounds, what is needed is a mental health praxis rooted in social justice, one that seeks to strengthen communal solidarities and that identifies and addresses the structural (political and social) causes of collective ill-being at their root. Healing in a mental health praxis embedded within social

justice and liberation becomes a call to action, an effort toward reconstructing a world that fosters our mental well-being.

SAMAH JABR AND MARIA HELBICH: Since the beginning of the pandemic-related crisis, the mechanisms of occupation have not let up in the occupied Palestinian territories (oPt). Both Palestinian livelihood and service-related structures have continued to come under attack by Israeli settlers, with incidents resulting in injuries or property damage increasing by 80 percent since 5 March 2020, when the first cases were detected in Bethlehem.²⁰ Anxieties and fears caused by the novel coronavirus have only exacerbated already-existing vulnerabilities.²¹ The current pandemic has further impacted the fragile health system, which is almost entirely dependent on international donor funding. Geographical and social fragmentation also impede the development of a coherent and effective response to the virus. The West Bank is fragmented by settlements, the so-called separation wall, and restricted military zones; the Gaza Strip is contiguous but sealed off by an ever-tightening blockade. Because different authorities are responsible for different parts of the oPt, this fragmentation has made a coherent, nationwide response to Covid-19 impossible in practice. Testing sites across the West Bank, for example, are regulated by the Ramallah-based Ministry of Health, while testing centers in East Jerusalem are operated by Israeli authorities.²² Communities and families are cut off from each other and from essential services, with fragmentation and isolation severely affecting the psychosocial well-being of Palestinians. Safety, community cohesion, and cultural identity, which are already deeply undermined by the occupation, are now even more tenuous as a result of the Covid-19 pandemic.²³ And given that the pandemic has neither changed the conditions of occupation nor even resulted in a let-up of violence against Palestinians, it has been particularly challenging to respond to mental health needs during the crisis. While the Mental Health Unit at the Palestinian Ministry of Health (MoH) came up with a five-step mental health response plan at the beginning of the pandemic, the MoH's most urgent priority was to ensure that the health system would not collapse under the weight of the novel coronavirus's rapid spread.²⁴ Thus, for example, the Palestinian National Rehabilitation Center, a major mental health services facility in Bethlehem, was transformed into a Covid-19 center, leading to the discharge of patients in need of the center's specialized services.²⁵ The measure was in line with the traditionally low political priority the Palestinian government accords to mental health issues.

Due to the diversified field of mental health care in Palestine, coordination between different actors has proven difficult, as demonstrated by the attempt to establish a national helpline, a proposal made by the Mental Health Unit to the MoH. By the time approval for such a helpline was secured, a number of hotlines were already being operated by local and international nongovernmental organizations, which, in the scramble to do something palpable, lacked standard operating guidelines as well as referral systems to guarantee that patients in need would reach specialized services. To address this issue and ensure that patients received quality services, the Mental Health Unit put in place a weekly open webinar in mid-March 2020 by way of offering mutual support and peer supervision to mental health professionals from both local and international organizations.²⁶ In an unparalleled situation such as the pandemic, it became obvious that there were no ready answers and that reflection and communication between

different mental health actors were essential to respond to mental health needs. Some thirty to thirty-five people participated in these open meetings. Participants were provided with newly emerging information and current data about the pandemic; emphasis was placed on ensuring that the interventions and suggestions of international actors were appropriate to the local context and challenges of Palestinians living under occupation; and an effort was made to support and strengthen mental health services and the competencies of those working in the field. To illustrate, in the case of Palestinian Bedouin communities that do not necessarily have internet access or even reliable phone connections, different approaches were necessary to reach patients in need of mental health services. Later on, the Mental Health Unit came up with a list of ten criteria that needed to be met in order for a hotline to be licensed.

Stigmatization and Blame

Having a forum for supervision and professional exchange was especially important as the effects of pandemic-induced stigmatization and blame became apparent in our clinical work. When faced with an invisible threat like this virus, which spreads due to the behavior of people, the social perception of the disease is likely to be expressed through prejudice, stigma, and blame of individuals and communities.²⁷ While most people banded together in solidarity and support, stigmatization was easily observed in the blame that was laid at the door of marginalized groups, in particular. Laborers working in Israel, who were already vulnerable due to the Israeli authorities' failure to test them and ensure their treatment before their return home,²⁸ were singled out by the media, which depicted them as "threats" to the general public inside the oPt whom others should avoid. Such depictions circulated anonymously on social media or the messaging service WhatsApp, making it difficult to hold to account those responsible for the reports. One laborer ended up isolating in his car, where he slept for fear of infecting his parents, to widespread media coverage and celebration.²⁹ Commending the behavior of this particular laborer might very easily lead to implying that those who do not take the same drastic steps were risking the lives of others. Another example of the devastating effects of stigmatization was the attempted suicide of a woman after a media spokesperson identified her publicly as breaking the quarantine and infecting thirteen other people.

Refugee camps, particularly Dheisheh in Bethlehem and Nur Shams close to Tulkarm, were also singled out as areas of unlawfulness where people were not adhering to physical-distancing rules.³⁰ The focus on refugee camps is interesting because they were not the only places where people did not follow mitigation regulations, by a long shot. However, the media, and particularly social media, shined the light on refugees, blaming them for spreading the virus while ignoring the fact that asking people in refugee camps to stay home and social distance placed an impossible burden on them, given overcrowded living conditions, both inside individual homes and within the space of the camp. Blaming refugees comes more easily because they are at a disadvantage and thus an easier target.

Another example of stigmatization could be observed during the recent spike in Covid-19 cases in the West Bank.³¹ When two jewelry stores in Hebron and Nablus were characterized as places of infection, Palestinian citizens of Israel (PCIs) were blamed, as it is customary to buy jewelry for weddings in the West Bank. In a statement to combat the spread of the virus, Palestinian

Authority prime minister Mohammed Shtayyeh appealed to such visitors not to come to the West Bank.³² His appeal provoked widespread social media reaction, blaming the PCIs for spreading the virus. The psychosocial effects of this phenomenon become apparent in the behavior of individuals: for instance, in light of the recent accusations, a PCI known to one of the authors changes his accent every time he is in the West Bank in order to hide his background.

The pandemic has also highlighted the need for a participatory approach and public awareness that is based on explanations and respect instead of orders and authority. A participatory approach involves working together with community or religious leaders in engaging people from a wide spectrum of expertise and social backgrounds to meet with the community and educate them about the necessary measures. This is particularly important in the context of Palestine due to the fragility of the health system and the lack of confidence in political figures. We would therefore argue that an approach by policy makers that focuses more on community engagement and that appeals to the individual's personal responsibility in fighting the virus would have been beneficial. While this was done relatively well at the beginning of the crisis, confusion resulted from a premature lifting of restrictions quickly followed by a reversal during the Eid al-Fitr holiday, which resulted in several confrontations and ultimately the injury of two men.³³

In an attempt to answer to the need for educating the public about the pandemic and to preserve maximum transparency in the issuance of regulations and restrictions, the Mental Health Unit has been speaking out in radio interviews and via other media channels on how to fight the misconceptions and rumors surrounding the stigma of contracting the virus. In regard to the stigmatization of laborers, the need for physical distancing was, for instance, stressed, while at the same time the public was advised to stay socially connected.

Toward a Solidarity and Advocacy Approach

The Covid-19 pandemic has called attention to the need for public health-related interventions founded in advocacy, solidarity, and prevention to deal with the pandemic and fight the spread of the virus. Mental health professionals in the oPt have long been arguing for a more comprehensive approach to mental health, one based on a model of professional solidarity that addresses not only individual suffering but its underlying causes. As I have written elsewhere, "A diagnostic approach [that] fail[s] to take the context into consideration, is short-sighted at best. It is cowardly because it attempts to 'treat' the individual and not the pathogenic context."³⁴

Mental health professionals have therefore been urging international organizations working locally to base their approaches on human rights and social justice, instead of solely on medical indicators, and to emphasize the role of cultural, socioeconomic, and political factors that perpetuate and reinforce social injustice and human suffering. In an environment of prolonged conflict and crisis, it would be negligent to focus solely on a diagnosis that individualizes and victimizes people suffering from collective trauma. A distinction needs to be made between the mental health of those that are mentally ill and in need of specialized treatment and responses to political violations that happen daily in the oPt due to the Israeli occupation.³⁵

The consequences of the Israeli occupation do not only have an impact on individual mental health but also encompass legal and geopolitical spheres. Thus, any attempt to strengthen the

mental well-being of Palestinians must consider interventions by moral and legal authorities of international stature, as is for instance the norm when working together with legislators and judges to enforce laws protecting victims of domestic violence. Justice for the Palestinian people and the restoration of dignity can only be achieved when the work is not done in a political vacuum but in cooperation with legal, political, and human rights organizations.³⁶

While national and international efforts to place greater emphasis on mental health needs during the pandemic serve as an opportunity to strengthen the mental health system in Palestine, we would argue that the virus should not distract from the political system of injustice that will remain even after this pandemic has passed. It is therefore essential to focus on the effects of the Israeli occupation on the mental health of the Palestinian people and to advocate for their national and human rights. Otherwise, the experiences of Palestinians will be pathologized and their responses medicalized while the status quo of the pathogenic context remains the same.³⁷

Demands for equal rights and justice need to be put at the center of health efforts. Given that we can see a discourse on advocacy and solidarity like never before in the public health sphere, we are hopeful that an approach that strengthens collective solidarity and advocates for those that have been subjected to all manner of violence will also be possible in the future.

CINDY SOUSA: Evidence is growing about the lasting effects of Covid-19 infection. It is not only the physically manifested components of Covid-19 that must concern us, but also the varied ways the pandemic influences mental health. It elicits a profound fear of death and illness for ourselves, our loved ones, and our communities; and it fosters within us suspicion of coworkers, friends, neighbors, and even groceries and packages as vectors of disease. This period has also incited massive uncertainty related to how long we will have to endure the virus and the economic, social, and psychological costs of the measures to prevent its spread and mitigate its effects.

Yet, there is so much more to the mental health sequela of Covid-19 than stress and grief on the level of one individual, or even of one family. To really consider the impacts of Covid-19 on mental health, we must understand the disease and the conditions surrounding it within critical approaches that move us away from individual pathology to an understanding of well-being as profoundly communal and deeply tied to politics.³⁸

When we talk about the collective crisis arising from this pandemic, one of the most crucial points is the variance of Covid-19 across lines of power and privilege. There are particular communal mental health effects arising from how the disparities related to the pandemic result not from accident, but directly from oppression and structural violence: assaults that are “built into the structure and show up as unequal power and consequently as unequal life chances.”³⁹ Access to health itself varies—as does access to the health care, food, childcare, education, and economic security that characterizes our experience of health in general, and especially during the pandemic. We are half a year into Covid-19, and it is clearer than ever: the collective and political contexts of health determine outcomes.⁴⁰

What’s more, the predictability of uneven effects across populations is at the root of the collective grief surrounding the Covid-19 crisis. I write this from the United States. Much like the context of many U.S.-based communities, within Palestine, contemplating the spread of the pandemic elicits tremendous collective despair and rage. These shared emotional reactions

stem from rightly situating the effects of the pandemic within its particular cultural and historical contexts of ongoing, deliberate structural violence. The disproportionate effects of both the illness and the social and economic costs of Covid-19 are yet additional collective assaults against populations that have already endured so many.

Indeed, the unequal distribution of Covid-19 infection and death is not new, and not surprising. It's been foretold.⁴¹ From a public health perspective, we know that the particular vulnerabilities specific communities face within this pandemic are not the result of accident or personal choices, but of deliberate arrangements of power—predictable parts of the structural violence many communities have confronted for generations. While most recently made visible by Covid-19, disparities are regularly seen in other patterns of disease.⁴² The ability to foretell disproportionate health consequences of disease—and have those assertions met with silence from governments and the global community—is itself a form of mass trauma.⁴³ This profound silence is, in the language of our times, a collective gaslighting with ramifications not only for the physical health of entire communities (as risks of disease are downplayed and ignored) but also for the mental health of populations.

So, what are the antidotes to the despair arising from yet another health crisis whose roots can be located within systematic oppression?

We must tell the truth about the ways disproportionate health risks are rooted in arrangements of power. To do so requires a staunchly political frame.⁴⁴ When we specifically turn to the mental health effects of Covid-19, we must consider how populations make meaning of the impacts of this disease, including the economic despair and social isolation that accompany it. In Palestine, differential access to factors that protect and promote health results from decades of Israeli occupation, which has included not only military occupation but also the deliberate de-development of Palestinian infrastructure,⁴⁵ including that of public health.⁴⁶ Settler colonialism also has direct psychological implications as a distinct form of historical trauma characterized by intentional, ongoing assaults on collective well-being, identity, and survival.⁴⁷

Using a lens of collective, historical trauma tied to settler colonialism inspires particular attention to resistance and the ways this resistance feeds collective resilience.⁴⁸ Elsewhere, scholars have called for an understanding of resilience that situates the concept within deep political, social, and economic contexts.⁴⁹ Resilience is not static, something to be achieved, or a trait that we have or don't have. Rather, as has become somewhat commonplace to conclude, resilience is a process. Waking up every day in a pandemic has made clear the dynamic nature of resilience, as people the world over face continual health and economic crises and uncertainty, as well as profound loss: of community and socialization, of place, and of schedule. Particularly within the Palestinian context, resilience is best understood as a lively, highly political, intensely communal process that does not represent an aberration, but rather a part of the dynamics of oppression and resistance.⁵⁰

Daily acts of survival in Palestine have always reflected and built agency, power, and connection.⁵¹ These factors—solidarity and action—underlie healing, as liberation psychology instructs.⁵² From the rapidly expanding body of liberation psychology scholarship,⁵³ we can derive many lessons. Collective resilience depends on community characteristics such as cohesion, group identity, and a shared history and culture—rooted and reflected in stories, songs, poetry, food,

customs, and cultural symbols. Particularly, but not only, when we consider the massive individual and collective stressors posed by the Covid-19 pandemic, we must take heart in the power of endurance, built on trust and collectivity across multiple, highly permeable levels—personal, family, neighborhood, cultural, and political body—and work to bolster these.⁵⁴ The work of early anticolonial mental health scholars such as Frantz Fanon and Ignacio Martín-Baró (one of the pioneering minds in liberation psychology) reminds us of the redemption of political struggle, and of the mental health benefits of asserting collective power, sovereignty, and health.⁵⁵

For all kinds of well-being, we must not let the Covid-19 crisis be another opportunity for health imperialism and the disaster capitalism that already proliferate in locations of ongoing occupation.⁵⁶ On the contrary, as we are seeing, the political dimensions of disease also give rise to renewed opportunities for action and solidarity—as illustrated by the most recent Black Lives Matter protests that originated in the United States and quickly became global. This movement, like the ongoing movement for freedom in Palestine, very much brings to the fore the dynamic push-and-pull of grief and healing, and the potential to counter despair through insisting on collective dignity, action, accountability, and care.

About the Contributors

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Samah Jabr is a psychiatrist practicing in East Jerusalem and the West Bank. She is currently the head of the Mental Health Unit at the Ramallah-based Ministry of Health. She is also a mental health and development consultant to international organizations and the author of *Derrière les fronts: Chroniques d'une psychiatre psychothérapeute Palestinienne sous occupation* (Paris: Hybrid Pulse, 2018).

Maria Helbich is a clinical psychotherapist who specializes in gender-based violence and trauma and was working in the oPt until recently. She has offered mental health services to survivors of violence in a victim protection facility, as well as in child protection and women's centers, and has also worked in Lebanon.

Cindy Sousa is associate professor of social work at Bryn Mawr College. In her scholarship, Sousa promotes understanding about the conditions of underlying health, using a lens informed by feminist and critical race theories that prioritize the social, environmental, and political contexts of well-being. Currently, she has several ongoing projects focused on the challenges, strengths, and strategies of families during war and the refugee experience.

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