Connecting the Dots

Connecting the Dots:

Mothers Weaving Stories of Hope

By

Dorit Redlich Amirav

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This book is dedicated to the memory of my parents, who both taught me what hope is. With wisdom, spirit, and hope, they paved the way for me, providing me with endless opportunities. Through their different ways of living, I became humble, generous, and a lifelong learner. I am thankful for them and will miss them forever.

One way or another we are living the stories planted in us early or along the way, or we are also living the stories we planted — knowingly or unknowingly — in ourselves. We live stories that either give our lives meaning or negate it with meaninglessness. If we change the stories we live by, quite possibly we change our lives.
—Ben Okri

TABLE OF CONTENTS

List of Illustrations x

Acknowledgments xi

Author's Note xii

Introduction 1
- Remembering a Childhood Kitchen Shared by Palestinian and Israeli Women 2
- Growing Up with Conflict 4
- Being the Daughter of a Mother with Mental Illness 5
- The Connection between Occupational Therapy, Hope, and Mental Illness 6
- Why is Hope Important? 7
- Mothers' Experiences and Their Occupations 8
- The Palestinian-Israeli Conflict 9
- Mental Health in the Palestinian Authority 9
- What is Hope? 10

Chapter One 14
The Origins of this Study
- Negotiating Entry 15
- Being in the Field 16

Chapter Two 20
Collecting and Sharing the Mothers' Stories
- Wondering How Best to Convey My Findings 21

Chapter Three 24
Narrative Account of Amal
- Letter #1 Living in This Country 27
- Letter #2 Home-Making 30
- Letter #3 Being a Mother 35
- Letter #4 Spirituality and Connection to Places 44

Chapter Four 47
Narrative Account of Hob
Letter #1 Traveling to the World of Hob's Childhood 47
Letter #2 The World of Becoming a Mother 52
Letter #3 Spirituality and Religion 58
Letter #4 The Political Landscape Shaped our Lives 61

Chapter Five 68
Narrative Account of Neta
Letter #1 How the Mother in Me Was Born 68
Letter #2 We Had to Build a Life 74
Letter #3 Moments of Creativity 78
Letter #4 Fear in our Eyes 83

Chapter Six 85
Narrative Account of Anna
Letter #1 First Memories of Hope 86
Letter # 2 One Day, Returning To, and Living in My Homeland 94
Letter # 3 Hope in Your Family—the Family You Were Born into, the Family You Created 96
Letter # 4 Keeping Hope Alive in the Political Landscape 102

Chapter Seven 105
Themes of Hope
Theme 1: Conflict Markedly Threatened Experiences of Hope 106
Theme 2: Mental Illness in a Family Member Challenged Hope 109
Theme 3: Hope Was a Process in Motion 112
Theme 4: Hope Reverberated through Generations 114
Theme 5: Hope was Experienced by Doing Daily Occupations in a Spiritual Way 117
Summary 119

Chapter Eight 120
Hope is Embodied and Embedded in Our Lives
Implicit and Explicit Hope 122
Hope Reverberated Across Generations 123
Undertaking Occupations in a Spiritual Way 126
The Impact of Socio-Political Conflict 127
Hope and Hopelessness in Micro-Medical and Macro-Social Contexts 128
The Impact of Mental Illness on Hope 130

Finding Hope Amidst Challenges: A Personal Journey 131
Embracing Hope: Lessons Learned 131

Epilogue 133
Reflections: Knitting Our Relationships 133

Bibliography 138

Appendix 1 Amal's Notebook: Original Arabic Content 145
Appendix 2 Amal's Notebook: Content Translated into English 151
Appendix 3 Hob's Notebook: Original Arabic Content 156
Appendix 4 Hob's Notebook: Content Translated into English 161
Appendix 5 Neta's Notebook 165
Appendix 6 Anna's Notebook 169

Index 173

LIST OF ILLUSTRATIONS

Image 1 “Life is Sweet” 24
Image 2 “Tatreez,” a type of embroidery 40
Image 3 Hob’s hope collage 65
Image 4 Part of Hob’s hope collage 65
Image 5 Beach, part of Hob’s hope collage 66
Image 6 Flowers, part of Hob’s hope collage 67
Image 7 A family, part of Neta’s hope collage 78
Image 8 Neta’s hope collage 79
Image 9 Cherries, part of Neta’s hope collage 80
Image 10 Pomegranates, part of Neta’s hope collage 81
Image 11 A child, part of Neta’s hope collage 82
Image 12 Family members, part of Neta’s hope collage 83
Image 13 Food making, part of Neta’s hope collage 83
Image 14 Flowers 98
Image 15 Hopelessness and hope 104
Image 16 Jerusalem train bridge, August 17, 2015 134
Image 17 Jerusalem train bridge, September 30, 2015 134
Image 18 The Incomplete Bridge, painted by the author 135
Image 19 Knitting pieces, by the author 136
Image 20 Painting and knitting 137

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AUTHOR'S NOTE

This book contains stories of hope as experienced by mothers living alongside adult children with mental illnesses in a socio-political conflict area.

Hope is increasingly recognized as an important factor for people facing difficult situations. Mothers whose adult children struggle with mental illness carry heavy burdens that are especially challenging to hope. Those burdens may be exaggerated in socio-political conflict areas. To date, there has been limited research about mothers' experiences of hope.

For this book, I spoke to two Palestinian and two Israeli mothers whom I connected with through community mental health centers and hostels in Jerusalem. All names, including those in my personal recollections, are pseudonyms. When meeting the mothers, I recorded conversations, took notes, and made hope collages over the course of four months. Five themes emerged from this process: (1) socio-political conflict markedly threatened the mothers' experiences of hope, (2) mental illness in a family member challenged their hope, (3) hope is a process in motion, (4) hope reverberates through generations, and (5) hope is experienced by doing activities and occupations in a spiritual way.

Living in a conflict area threatened hope for the mothers. However, they found hope in their daily lives, and connecting those dots of hope became a source of salvation for them. Sometimes they found hope by doing occupations in a spiritual way. Other times they did so by subconsciously drawing on experiences of hope or hopelessness from the past, using those experiences to transmit hope to their children. The mothers expressed experiences of hope in implicit and explicit ways that allowed them to move forward and gave them a sense of possibility amidst the uncertainty of their lives.

I wrote this book to help people understand how hope works in our lives, and how we can use it as a source to help us to move forward through and in difficult times. It is not intended as a model of perfection or the ultimate truth. Rather, it shows the reality of four mothers in their own voices. My voice—that of the daughter of a mother who lived with mental illness—is also present. All voices should be heard. There is much to be learned from the mothers, who weaved hope and never stopped hoping.

I hope you learn from this book, and that it will help you to understand how hope works in your life.

—Dorit Redlich Amirav, 2024

INTRODUCTION

The world we live in is fraught with instability, complexity, uncertainty, and ambiguity. When I began work on this book in early 2023, one of the most profound recent examples of that reality was the COVID-19 pandemic, which truly changed the world and everything about the way we live, upending what many of us once thought was certain. Other contemporary examples of uncertainty that I considered at that time included the global climate crisis, food shortages, and the war in Ukraine. And then, as if to underscore the reality that uncertainty is a constant in our lives, as I was making final edits on this manuscript, the Hamas attack in Gaza plunged my country into a place of instability not experienced in decades. Since I made those final edits, we in the Middle East have been living in the midst of a war that has filled the lives of everyone in this region with grief, sorrow, and uncertainty.

Each of these situations brings with it drastic and sudden changes for those directly affected: bereaved families, families torn apart, homes fled and destroyed, and a shredding of the once-familiar social fabric. The upheaval and uncertainty triggered by these events can amplify feelings of hopelessness. It is hard to hope when the ledge of stable terrain no longer seems quite as sturdy.

Yet hope is also a vital source of strength in these moments, sometimes the only route to survival. One way to introduce more hope in our lives and understand the role it plays in mitigating the negative feelings that surround uncertainty is through personal stories. This book presents stories of hope experienced by four mothers of adult children with mental illness who live in a socio-political conflict zone. The mothers' stories about facing these two distinct threats to hope illuminate the similarities in how they understand and navigate these challenges—a nationalist conflict, and the social and familial stigma of mental illness. Through these lenses, we can understand the psychological forces of hope and how it can appear as a tool in moments of need.

Hope is increasingly recognized as an important factor for people facing difficult situations. Living alongside adult children who struggle with mental illness is associated with a heavy burden, particularly on mothers (Wancata et al. 2008). This burden may become exaggerated in socio-political conflict areas, yet little is known about these mothers' experiences

of hope.

Mothering a child with a mental illness is a unique and challenging parenting experience. Mothering a child with a mental illness in the midst of violent political conflict is especially difficult. As an occupational therapist working in the area of mental health in Israel, I came to wonder more and more about how these mothers found hope even in the face of the persistent political conflict that surrounded them.

Working towards my master's degree I studied hope in family members who had a relative with a serious mental illness, an area of particular interest as my own mother lived with mental illness. I measured hope before and after a six-month cognitive educational intervention (called Keshet) for these family members. Keshet is based on a Dynamic Cognitive Intervention (DCI) program (Hadas-Lidor & Weiss 2005), which is used to view real-life situations from different perspectives. This program aimed to promote positive communication within the family (Weiss, Hadas-Lidor & Sachs 2011). The study I conducted for my master's degree showed that family members' hope for their ill child increased significantly after the intervention (Redlich 2010). It was that experience that made me want to conduct a more in-depth study about hope.

My goal in studying mothers' experiences of hope wasn't just to observe them from the outside, it was to get to know them and share experiences. I wanted to establish the kind of comfort level that would lead to intimate and open relationships that, in turn, would allow me to truly understand their lives and challenges. But before I could do that, I needed to take a closer look at myself. I come from a place where Palestinian and Israeli families share everyday life experiences, I have lived with mental illness in my own family, and I have lived in a conflict area. I began work on this book with a reflection on my own lived experiences as presented in the following three stories. The first is a childhood memory of respectful and trusting relationships between Palestinian and Israeli women. The second is about my experience with the Palestinian and Israeli conflict, and the third is about the experience of having a mother with mental illness.

Remembering a Childhood Kitchen Shared by Palestinian and Israeli Women

It is summer 1964 in Metula, a small village in the North of Israel. The smell of cakes and cookies spreads from the kitchen to the lobby of my grandparents' hotel. There are so many guests at this time of year. Everything is big. The pots and baking pans on the table are evidence of the many dishes made by Palestinian and Israeli women who work here

during weekends and holidays. Um-Saliba is a large, capable 65-year-old Palestinian woman. She lives with her extended family in Lebanon, just 500 meters north of the hotel. Every morning she crosses the border to come and work with my family at the hotel. She is always here with my grandmother. These two run the kitchen, instructing all the Palestinian and Israeli workers. There are so many guests to feed. Sitting quietly in a kitchen corner, I see and smell the food. Here are the stuffed cabbage, stuffed grape leaves, and an Arabic kubbeh *dish.*[1] *I want to grab one kubbeh but I am afraid, because if they see me, a four-year-old girl, they will tell me to stop interrupting, to go away and play with my cousins. But I want to stay here. I am fascinated by the smells, the voices, and the activity. I stay silent. High above the oven, I can see the cookies cooling. Maybe I can sneak in there and grab one? No one sees me. I grab one cookie and hide safely under the table. I am invisible but I can smell and hear everything. All the kids are trying to steal cookies from the big pile. Every day Um-Saliba and my grandmother make new cookies and new cakes. Delicious smells come out of the kitchen. There are noises from the pots and baking pans and other kitchenware; the women are talking to each other, sometimes loudly and sometimes in whispers.*

Today, as I think back on these moments, I understand the places and relationships I have learned to love over the years and I recognize how they have influenced me. I loved the gathering, planning, talking, and working which often took place in our family hotel. I could spend many hours just watching those women cooking under the direction of Um-Saliba, who was like another grandmother to me.

I had not realized until recently how much Um-Saliba influenced me. During my time with her, I was exposed to a relationship based on acceptance, caring, and nurturing in a safe place. This is one of the relationships that, over time, formed my understanding of community. The kitchen and the big white table under which I loved to hide represented a safe environment. Perhaps this was because I could stay silent under the table while around the table there were women—mothers and grandmothers—who were busy. Under the table, I found a sense of security. With Um-Saliba I felt even more safe and secure than I did with my real grandmother, my father's mother. My grandmother was always busy and did not pay much attention to me. I came to think of Um-Saliba as a second grandmother. The trust that developed with her nurtured my soul and my mind with a belief in

[1] A fried *kubbeh raas* with peppermint.

togetherness and in a multi-cultural community.

I used to be shy and silent and I did not talk much. Talking in my family was not a trivial activity, especially for girls and women. Yet women used to talk around that white kitchen table at my family's hotel. Thus, that table became a symbol of hope for me. I think of how Um-Saliba cared for and loved me. Even when she saw me under the table, she never talked about it out loud. Once, when I was hiding, a cookie "fell" just in front of me. I grabbed it. I thought it had fallen by accident but later that day Um-Saliba told me that she had dropped the cookie on purpose after seeing how longingly I had looked at the cooling cookies before I had disappeared under the table. Remembering her now fills me with feelings of care, love, and trust. Viktor Frankl noted "that love is the ultimate and highest goal to which man can aspire." Um-Saliba understood me without words. She did not judge me and did not compare me to my mother, who struggled with mental illness. She built trust between us in a respectful way.

Things have changed since my childhood with Um-Saliba and my grandmother in the hotel's kitchen. The Lebanese border is no longer open and Um-Saliba's children are not allowed to cross it anymore. My family still comes to my grandparents' hotel every holiday, even though there were, and still are, times of insecurity and war. Traveling into my memories, I remember a story of such a time—another story that has filled me with a sense of both hope and hopelessness for the future.

Growing Up with Conflict

My cousin and I were almost the same age and used to sleep in the same room in our family hotel. One Saturday night when we were already in bed, we heard the whistling of rockets and bombs.

"I'm scared!" I said to my cousin.

She looked at me with her big brown eyes and said, "Don't be afraid; it is always like that here. It is okay."

Still terrified, I jumped onto her bed. From two floors above we heard my aunt calling us: "Hey girls, hurry into the security room!"

Every building in the village had a concrete security room. But now I wasn't the only one who was scared: my cousin's bravado had evaporated with the sound of her mother's voice. The two of us covered ourselves with blankets and refused to move. My aunt came into the room, shouting and peeling off the blankets.

"Bring the blankets!" she ordered. "Hurry! We must go! It's not safe here."

As we wrapped our blankets around ourselves and ran into the security room, I wondered, Are Um-Saliba and her children doing the same thing?

Living in a war and conflict area means that there is no routine. It also means that every activity has to be planned with the thought of access to a concrete security room.

The Palestinian-Israeli conflict that surrounded my life was and continues to be among the most complicated and unique conflicts worldwide. Its uniqueness stems not only from its history and global impact but also from perceived and real inequalities associated with a severe lack of hope for the future. Indeed, there are significant differences between the parties in this conflict. Different perceptions of asymmetry between the parties create different realities. While Israelis see themselves as a small state surrounded by hostile Arab and Islamic regimes, the Palestinians perceive themselves as victims, focusing on the prevailing inequality between the occupied (Palestinian) and the occupier (Israel).

Being the Daughter of a Mother with Mental Illness

It is 1967. We are living in the city of Haifa. My older brother, who is 14, is in boarding school. I am seven years old. I am standing in our kitchen in front of our light green breadbox. The kitchen is the most illuminated room in our apartment on the second floor of our building on Mount Carmel. All the other rooms are so dark. There are tall trees in our backyard, which prevent the sunbeams from reaching our apartment. From the kitchen window I can watch the sea to the west, and on days with good visibility we can see Mount Hermon (the highest mountain in Israel) to the north. Every morning I make myself a sandwich to take to school. But this morning is different. I look at the distant sea and ask myself, "How come in other homes mothers prepare their children's sandwiches and in my house I make them?" I open the breadbox, take out the loaf of bread, and cut two thick slices. Glancing out the window and hearing the distant sea and the sound of cars on the road below, my thoughts pull me away from my task. I wish my mother were like all those mothers. I wish she were healthy. Because if she were healthy, I would be the one who was still in bed and she would be the one standing in front of the breadbox making my sandwiches to take to

school. At the same time another thought weaves into my mind: I want to find a cure for my mother's illness. "That is what I will do when I grow up," I think as I spread chocolate on the sliced bread. I finish making the sandwich and quietly leave the house without saying goodbye. I am preoccupied with these ideas: "I want and I hope to help my mother to recover. Shall I become a doctor? A nurse? A teacher?"

Nobody ever used the words "mental illness" when describing my mother when I was a child, but I knew she was different from the other mothers. She spent most of her time in bed, though she never seemed sick. She did not cough or blow her nose. She was not crippled. There was no reason that I could see that she could not get out of bed. But she did not and I knew not to question it.

Despite her illness, we had good times together. My mother was warm, gentle, and kind. I would climb into her bed and cuddle. She taught me how to knit. She loved fashion. We went shopping and we also went to the dressmakers together whenever there was a special occasion. She loved to have clothes made for herself and for me. When I think of her my heart fills with love, but I cannot help wondering how the experience of this kind of a mother, one who was so obviously depressed, has shaped me. I wonder what it was about our relationship that taught me not to judge or to blame people—in particular, those whose lives are shaped by mental illness.

The Connection between Occupational Therapy, Hope, and Mental Illness

The goal of occupational therapy is to help patients engage in daily life by giving them the opportunity to engage in "occupations" that improve their health and well-being.

Occupations are defined as those clusters of activities and tasks in which a person engages to meet his or her intrinsic needs for self-maintenance, expression, and fulfillment (Law et al. 1996). Recently, Townsend and Polatajko (2013), who developed official practice guidelines for the Canadian Association of Occupational Therapists, defined occupation as "an activity or set of activities that is performed with some consistency and regularity, that brings structure, and is given value and meaning by individuals and a culture" (p. 19).

Basically, everything we do can be classified as an occupation, from the jobs by which we earn a living to the recreational activities we participate in for our enjoyment and/or mental and physical health to basic activities of

daily life such as bathing, brushing our teeth, and doing laundry.

It was not only my professional life as an occupational therapist in Israel that led me to the mothers whose stories are at the heart of this book. There were aspects of my personal life and childhood that intersected in meaningful ways with my desire to learn more about their lives—specifically socio-political conflict, mental illness, hope, and what it means to be a mother.

Why is Hope Important?

Hope is a vital and fundamental force of the human condition, a process and an outcome that is grounded in the present and the future (Dufault & Martocchio 1985; Farran et al. 1995). There are many definitions of hope, most of which overlap at least to some extent. There is significant research showing that hope is beneficial to physical and mental health (Onwuegbuzie & Snyder 2000). Many studies support the notion of hope for individuals experiencing difficult situations such as loss, uncertainty, and suffering (Bright, Kayes, McCann & McPherson 2013; Dorsett 2010), as well as in many areas of mental illness (Resnick, Fontana, Lehman & Rosenheck 2005; Roe, Chopra, & Rudnick 2004; Russinova, Rogers, Ellison & Lyass 2011), especially in the recovery journey of patients and their families (Bland & Darlington 2002; Redlich et al. 2010).

Mental illness accounts for 11 percent of the disease burden worldwide. According to the World Health Organization (WHO), about 450 million people suffer from some mental disorder or brain condition. It is anticipated that one in four people will meet the criteria for a mental disorder at some time in their lives (WHO 2003). People of all ages, incomes, educational levels, and cultures may be affected.

Mental illness is treatable. Many interventions are now recovery-oriented. Recovery does not necessarily mean that the disability disappears; it means that the individual engages in productive interests and activities or occupations that provide meaning and purpose to her or his life (Anthony 1993). This relatively positive view of mental illness did not always exist. During the 1960s, persons with mental illness were marginalized and health care professionals did not believe that recovery was possible (Anthony 1993). However, while mental illness is now recognized as a major health problem, its impact on families is poorly understood. With the trend to deinstitutionalize patients and move them into community care, family members have increasingly become caregivers. This has been associated with numerous adverse effects on caregivers' quality of life, such as time lost from work, financial loss, and limited time for leisure and socializing,

as well as adverse health effects such as elevated symptoms of distress (Möller-Leimkühler & Wiesheu 2012). Mental illness carries burdens associated with chronic illnesses, but it also carries unique burdens that often cause greater difficulties for the family, especially mothers (Elmahdi et al. 2011).

One of those unique burdens is the social stigma. In many parts of the world, including the developed world, people with mental illnesses are victimized for their illness and become targets of discrimination; as a result, they have little or no access to housing, employment, social welfare, or health insurance. Their families also bear this burden. To protect themselves and their reputations, they keep quiet about mental illness (Connor et al. 2016). The stigma leads to unmet needs, diminished family support and, at worst, isolation. In the past, families, especially mothers, were blamed for their child's illness, causing feelings of guilt, shame, and avoidance. Despite changes in social attitudes over the past few decades, recent studies suggest that shame is still prevalent in families of people with mental illness (Jönsson, Skärsäter, Wijk & Danielson 2011). Furthermore, the occupations of mothers of adult children with mental illness are significantly disrupted and restricted (White & Unruh 2013).

Mothers' Experiences and Their Occupations

Mothering occupations consist of specific tasks, activities, and routines of daily life such as nurturing, teaching, and educating a child to become a functioning, independent adult (Esdaile, Farrell & Olson 2004). Mothers have the power to give their children energy, to hug them, and provide them with feelings of safety and security. A mother can be the vehicle of strength, nourishment, care, love, wisdom, and spirituality. Mothering an adult child with mental illness can add layers of complexity. According to Johannes Wancata (2008), more than half of the caregivers of children with mental illness are mothers. Furthermore, even without a child with mental illness, mothering is an occupation with a heavy burden: mothers are at high risk for psychiatric illnesses such as depression and anxiety. Anita Johansson and others (2015) found that mothers report carrying a heavier burden than fathers do, and they also have a poorer quality of life in terms of health. The burdens and problems of a mother whose child has a mental illness are much higher in regions of war and armed conflict.

Women, children, and youth living in armed conflict zones are especially vulnerable to post-traumatic stress and hopelessness. The protracted Palestinian-Israeli conflict continues to disrupt the social and cultural fabric

of both societies, making it especially challenging for mothers to hold everything together as they juggle their needs with those of their families and children (Quota, Punamäki & El Sarraj 2005; Robertson & Duckett 2007).

The Palestinian-Israeli Conflict

The Middle East has been a site of controversy and violence for centuries. The roots of the present Arab-Israeli conflict are over a century old with developments in both Arab and Zionist national movements. For the Palestinians, these years brought trauma, social exclusion, and eviction, along with related socioeconomic and political problems and military occupation (Jarrar 2010). For the Jewish people of Israel, the return to the land of their forefathers, intended largely as a solution to the widespread oppression of Jews due to anti-Semitism in Russia and Europe, failed to bring safety and security (Younes 2007). The traumatic impact of violence and war continues to touch every person in the area and has evolved into an armed conflict that has led to a sense of hopelessness and a lack of trust (Zeleznikow 2014). The Palestinian-populated areas in the Gaza strip and West Bank, including East Jerusalem, came under Israeli rule after the 1967 war. Over the years, there have been a few unsuccessful attempts to resolve the conflict, resulting in more hopelessness on both sides. Palestinian resistance to Israeli rule has taken the form of violent attacks on Israeli soldiers and civilians, which are perceived by Israelis as a daily threat to security. Israel has responded with measures including physical barriers. These measures have greatly complicated daily life for Palestinians in Gaza, the West Bank, and East Jerusalem: their freedom of movement, access to medical treatment, and right to work and receive education are all limited (Canetti et al. 2010; Giacaman, Rabaia & Nguyen-Gillham 2010; Shalhoub-Kevorkian 2003). When Hamas terrorists massacred and kidnapped Israeli citizens on Oct. 7, 2024 a new, unsettling chapter was added to this ongoing conflict, one that shows no signs of ending.

Mental Health in the Palestinian Authority

On an individual level, the chronic and severely stressful socio-political circumstances in the Palestinian Authority have led to increased symptoms of anxiety, depression, and PTSD. On a societal level, there is a significant shortage of mental health services, not only in the community but also in hospitals (Giacaman et al. 2009). At the time this book was written, there were only two mental health care units in the Palestinian territory. These

facilities served a population of around four million people, who faced many barriers such as a lack of transportation, families living apart, and disruptions to social supports normally available in a collective society. These barriers have only grown since the Oct. 7 Hamas attack. Such complex situations cause difficulties for Palestinians in general, and particularly for mothers with a child struggling with mental illness. There is not enough mental health support in the Palestinian territories, not only for the patients themselves but also for their mothers. The situation is bleak, with reasons for hope in seemingly short supply.

What is Hope?

Hope has been studied from many perspectives: psychological (Snyder 1995), theological (Moltmann 1975), philosophical (Godfrey 1987), sociological (Fromm 1968), and educational (LeMay 2014). Social psychologist Erich Fromm (1968) defined hope as a state of being, a state of a greater aliveness, and a psychic commitment to life and growth. According to Rona Jevne, founder of the Hope Foundation at the University of Alberta in Canada, "Hope involves believing, feeling, and doing—and much more" (Jevne & Miller 1999, p. 11). Philosopher Joseph Godfrey (1987) noted that "to hope is to risk," (p. 221), while William Lynch, a scholar and a Jesuit priest (1965), wrote that hope relates to the "sense of the possible." Jevne and James E. Miller (1999) described hope as looking forward with both confidence and uncertainty to something good:

> Hope is amazing. You can't touch it but you can definitely feel it. You can't physically see it by itself, but you can hold it and carry it. Hope doesn't weigh anything, but it can ground you and anchor you. (p. 6)

In his early comprehensive theory of human development, Erik Erikson (1950) described hope as so foundational that it was thought to occur when an infant learns basic trust. For this reason, Erikson integrated hope into his first stage of human development. Charlotte Stephenson (1991), a registered nurse who conducted a systematic review of studies about hope, concluded that "Hope can be defined as a process of anticipation that involves the interaction of thinking, acting, feeling, and relating, and is directed toward a future fulfillment that is personally meaningful" (p. 1459).

Theories of Hope

By far the most common conceptualization of hope, particularly in the field of psychology, is the one developed by Carl Rick Snyder (1991), whose research showed that there are two key components to hope: successfully planning routes (what he called "pathway thoughts") to meet goals, and goal-oriented motivation (what he called "agency thoughts") to achieve these goals. According to Snyder, people with high levels of hope have many pathways to reach their goals, but they also need agency. Snyder also found that positive emotion was evoked when people perceived success in achieving their goals, and negative emotion was evoked when they perceived failures.

Snyder's conceptualization of hope is uni-dimensional and focuses on goal attainment. However, he does not address the social connectedness, the spiritual quality, or the context in which hope may appear. Other theories, such as that developed by nurse-researchers Karin Dufault and Benita Martocchio (1985), offer deeper and more complex conceptualizations of hope. Dufault and Martocchio united the findings from their individual doctoral dissertations to develop an early and highly influential multi-dimensional conceptualization of hope in the medical sciences and other disciplines. Dufault's work focused specifically on hope experienced by elderly cancer patients, Martocchio's on how dying individuals negotiated their social worlds. Together, they developed a model with two spheres and six dimensions. They identified the spheres as general and particular hope, and the dimensions as affective, cognitive, behavioral, temporal, affiliative, and contextual. In their model, generalized hope has no specific outcome; it offers a "broad perspective for life" (Dufault & Martocchio 1985, p. 380) and promotes a person's ability to face challenges with "flexibility and openness" (Dufault & Martocchio 1985, p. 380) even when the person is unaware that he or she is experiencing hope. Particularized hope is hope that a person is aware of; it has specific outcomes and is meaningful and valuable to the hoping person. Together, generalized hope and particularized hope preserve and maintain the meaningfulness and significance of life.

The dimensions can be seen as a system to categorize the different ways in which hope functions. The affective dimension of hope relates to sensations and emotions, specifically how someone feels about desirable outcomes, e.g., confident (happy, uplifted) or uncertain (anxious, sad). The cognitive dimension relates to the processes by which the person thinks, wishes, imagines, wonders, perceives, remembers, interprets, and judges in relation to hope. The behavioral dimension relates to actions the person takes to achieve hope (actively thinking, exercising, meditating, praying, painting, shopping). The affiliative dimension relates to relationships

ranging from intimate to casual, with higher powers, family, friends, co-workers, acquaintances, and others. The temporal dimension relates to the experience of time and how one can convey hope from the past to the present. The contextual dimension relates to life situations that surround and influence a person's hope; context can include a person's physical environment or social situation. For example, if a person derives hope from walking on the beach and a conflict or natural disaster cuts off access to the beach, a person's contextual hope will be threatened. The mothers in this book experienced hope in both spheres and in every dimension.

Other Relevant Conceptualizations of Hope

Carol Farran, Kaye Herth, and Judith Popovich (1995) developed a multi-dimensional model of hope that overlaps in some ways with that of Dufault and Martocchio. The two major constructs in their model are hope and hopelessness. But rather than being opposites, hope and hopelessness are on a continuum in which one is always informing the other: the more a person learns about hope, the more he or she understands hopelessness and vice versa. If one's expectations do not occur, hope still exists. Hopelessness functions through feelings of despair and thoughts without any future expectations and may lead a person to take inappropriate action. Hope and hopelessness are rooted in intrapersonal, interpersonal, and contextual elements and share four attributes: an experiential process (*pain of hope*), a rational thought process (*mind of hope*), a spiritual process (*soul of hope*), and a relational process (*heart of hope*).

The pain of hope can be revealed in extreme situations when a person has no control—such as living in a conflict area or with chronic illness. The experiential process of hope occurs when individuals can accept these challenges as part of who they are and still imagine future possibilities that extend beyond what may initially seem feasible.

The mind of hope is the cognitive component—the rational thought process, which Farran, Herth, and Popovich (1995) describe using the acronym GRACT, for goals, resources, action, control, and time. Goals are the combination of subjective desire and some realistic expectation. Resources can be physical, emotional, or social factors that influence hope. In order to achieve a goal, the person who hopes needs to take action and have some sense of control over his or her future. A dynamic process, the cognitive component is often composed of past experiences. The soul of hope is a spiritual process that allows people the opportunity to alter their present reality, becoming more connected in a way that makes them feel more alive. For some people, this process is linked to religion and faith. The

heart of hope enables people to give hope to each other.

In contrast, Eliott and Olver (2002), who work in the health field, purposely did not define hope. After interviewing cancer patients about end-of-life decisions with particular reference to "do-not-resuscitate" decision-making, they concluded that defining hope and determining its meaning should be left to individuals themselves. One of their more interesting findings had to do with the discursive use of hope. When the patients in their study used "hope" as a verb, it was because they had hope—their outlook was positive and future-oriented, even if they knew they were going to die. For example, one of the patients told Elliot and Olver, "What I do hope most sincerely is that the path leading up to [my death] is one of dignity" (Delia, as cited in Eliott & Olver 2002, p. 184).

However, Elliot and Olver found that when "hope" was used as a noun, it was neither future-oriented nor positive. It was a sign that the patients were allowing the doctor to decree their outcome, assess their future, and confer hope as the doctor saw fit. As one patient told the researchers, "If there is hope . . . [it] is an open question which could be answered better by medical profession[al]s than the patient" (Alex, as cited in Eliott & Olver 2002, p. 179).

A growing body of research has found that hope is important for individuals experiencing mental illness (Kardas et al. 2019; Resnick et al. 2005; Roe et al. 2004; Russinova et al. 2011). There is increasing evidence that it is crucial in the recovery process for both families and patients (Bland & Darlington 2002; Redlich, Hadas-Lidor, Weiss & Amirav 2010; Schrank, Bird, Rudnick & Slade 2012).

Hope has been positively associated with self-esteem, spirituality, quality of life, and social support; some studies have found that it was a major factor in a family's ability to cope with mental illness.

Most of the research about hope in the face of conflict (particularly the Israel-Palestine one) views hope as a path to resolution. In that respect, it is examined not as a personal experience but as a societal and public issue, a vehicle or a cognitive tool to develop methods for reconciliation (Cohen-Chen, Crisp & Halperin 2017; Jarymowicz & Bar-Tal 2006).

When I began studying hope, I could find no work examining the personal experiences of hope among people living in a conflict zone. I wanted to learn more about hope so that I could begin to fill that gap. While my study sample is small, I believe that the four mothers whose stories are the foundation of this book nonetheless provide an important picture of what it is like to have your hope challenged daily by forces both outside of your home (a socio-political, armed conflict) and inside it (a child with mental illness). The mothers' experiences, their determination, and the ways in which they bring hope to their daily lives is both inspiring and instructive.

CHAPTER ONE

THE ORIGINS OF THIS STUDY

As an occupational therapist in Israel, I had worked at hospitals and community mental health hostels and clinics in Netanya, Haifa, and the north of the country. But given the practicalities of dealing with the Israeli government in matters of publicly funded health care, it made more sense for me to focus on mothers in Jerusalem. In 2013, I reached out to directors of community hostels and community centers in East Jerusalem (the Palestinian side) and on the west side of the city (the Israeli side), as well as to the director of an East Jerusalem mental health center that provided work opportunities for adults with mental illness. I explained that I needed to speak to Palestinian and Israeli mothers of mentally ill adult children with a medical diagnosis of serious mental illness. It was important to me that those adult children lived, were living, or worked in a community hostel or centre for adults—I wanted to know that they were engaged in their community in some way. I also told the directors that it was important that the mothers could articulate their feelings and thoughts and were willing to talk about hope.

In the region of conflict in which my study is set, I assumed that the Palestinian mothers might feel vulnerable and at high risk by meeting with me. I needed to establish an ongoing, trusting relationship with them; one or two interviews would not have been sufficient for me to understand the world from their vantage point. For that reason, I chose a framework of narrative inquiry developed by Jean Clandinin (2013) because I knew it would give me the time and space to build trust. In Clandinin's framework, the researcher makes a commitment to living alongside participants in collaborative and respectful ways, making it possible to negotiate, co-compose, and re-compose stories (2013).

My plan to build trust almost didn't get off the ground. The first participant who enrolled, a Palestinian mother, balked after our first meeting: she told the community center director who had connected us that her adult children would not allow her to be part of my project because they did not want her to talk to a Jewish Canadian student about hope. I am an Israeli who was studying in Canada (and have since become a Canadian

citizen) but either they didn't understand the distinction or didn't care. I spent two weeks wondering if my project had fallen apart. And then the same community center director came through for me. I managed to recruit four participants: two Palestinian mothers (ages 41 and 45 years) and two Israeli mothers (ages 68 and 72 years). One mother (Israeli) had been divorced for many years. The other three were married. The Israeli adult children lived in a community mental health hostel in West Jerusalem, while the Palestinian adult children lived at their parents' homes and were engaged in community mental health day activities in East Jerusalem.

Negotiating Entry

Flying from Canada to Israel on June 15, 2015, I was excited and happy, anticipating my first experience as a novice inquirer in the field. The last communications I had received from the mental health community hostels and centers in East (Palestinian) and West (Jewish) Jerusalem assured me that everything should be ready for me to begin my study as soon as I landed on June 16. As it turned out, that wasn't quite true: the political landscape and cultural differences in the region had much more impact on my research schedule than I could have ever imagined when I planned the study from Canada.

For starters, I had not considered that the Palestinian Muslim mothers celebrate the Ramadan holidays, nor had this notion been drawn to my attention by the hostels as I negotiated dates for the start of my research. In 2015, Ramadan took place during the month of July. The Muslim mothers were fasting during the day and having family gatherings for dinner each night. All my previous arrangements with the Arabic translator, Palestinian hostel directors, social workers, and particularly with the mothers had to be postponed because nobody was available. Therefore, in July I started my inquiry meetings with the Jewish mothers. As I am Jewish and speak Hebrew, there was no need for translators or an intermediary, nor were there barriers to accessing the Israeli mothers' neighborhoods. When the first week of August arrived, Asa, the director of the East Jerusalem Community Center, contacted a couple of Palestinian mothers who were interested in participating and found me a translator, Alan. But after meeting with our first Palestinian mother, Hob, Alan quit. He said he did not have time for the work and his wife was pregnant. I wondered if he was uncomfortable listening to women's stories. I wondered if the women had been uncomfortable talking to him. I never asked. I was faced with a culturally sensitive situation. In the end I found my own translator, a woman.

Being in the Field

I was in the midst of my research conversations when violent clashes between Israelis and Palestinians erupted in Jerusalem in the middle of September 2015. These clashes were fueled by rumors among Palestinians that Israel had attempted to take over one of the most sacred Muslim religious sites, the Al-Aqsa Mosque. Two Israelis traveling with their four children were shot and killed by Palestinians. Soon afterward, numerous stabbing attacks began.

On September 20, 2015, I wrote the following note in my research journal:

> Driving my car on my way to the village in Eastern Jerusalem.
> 7 am Sunday morning
> Breaking News on the radio–
> "Family, parents and their two children, were injured from shooting . . .
> no clear details yet
> The surrounding roads are blocked by the army.
> Curfew in all surrounding villages until further notice
> Molotov bottles were thrown"
> *My heart is beating*
> This is exactly the road leading to the village of my participants!
> Will I be able to make it safely?
> Will I be able to make it at all?
> Amal is waiting for me.
> What if I am not able to meet with her?
> Will she lose this fragile trust in me–
> An Israeli Jewish woman
> Am I safe at all?
> Pictures from my life float before my eyes–
> my children, my husband,
> my daughter-in-law, who is pregnant
> What am I doing here?
> I stop the car for a few minutes.
> Decide to take a few deep breaths.
> I breathe
> Back to my self
> *This is all about hope*
> I am telling myself
> I will be fine
> I need to meet with her.