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The Vernacular Ethics of Stigmatized Care: Reinterpreting Acceptance and Confidentiality for Social Work in the West Bank, Palestine

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ABSTRACT Social workers in Palestine routinely navigate issues of stigma with their clients without formal ethical guidance. This constructivist grounded theory study examines how Palestinian social workers in the West Bank organize themselves ethically to provide stigmatized care—where social workers supporting people with socially rejected conditions and experiences can face community scorn by extension. We conducted focus groups and individual interviews with 99 social work supervisors in 12 cities over a 2-year period. Our analysis reveals localized reinterpretations of acceptance and confidentiality as ethically grounded principles for stigmatized care. These practice principles have emerged under strain in cases involving substance use, sex work, sexual variance, sexual violence, and child abuse allegations but reach a limit around accusations of collaboration with the occupation. Our findings reflect a dynamic vernacular ethics: a politicized field of shared concerns and debates that social workers use to guide their practice without a codified ethical system.

Social workers in Palestine, as in other places, are often tasked with forms of stigmatized care work—efforts to support clients with psychosocial conditions and experiences that are devalued and derided within their communities (Lindsay, Faraj, and Baidoun 2007; Kokaliari et al. 2016;

Haj-Yahia and Btoush 2018; Al-Kilani 2019). As this study shows, some conditions are so forcefully rejected that related care work, and the social worker providing it, can face stigmatization by proximity. Stigma is often framed as a universal but locally specific barrier to mental health and psychosocial support (WHO 2013; Pescosolido and Martin 2015; Koschorke et al. 2017). Addressing stigma has been identified by the World Health Organization as a key challenge for promoting access to care worldwide, and the International Federation of Social Workers (IFSW) points to the need for social workers to resist stigma in its statement of social work principles (WHO 2013; IFSW 2018). However, stigmatized care is also characteristically undervalued, underresourced, and undertheorized, positioning social workers in potentially creative as well as ethically challenging roles in improvising stigmatized care. There is currently no widely used codified system of ethical principles and standards to guide social work practice in Palestine.

This constructivist grounded theory study examines how Palestinian social workers in the West Bank organize themselves within an emergent field of vernacular ethics—shared concerns, feelings, experiences, and debates through which social workers come to deliberate on their everyday practice work in relation to what matters locally.[1] Our findings show how broadly circulating social work ethical concepts, designed by and for people in other places, are abstracted and localized by social workers in Palestine. Here and elsewhere, we contend, these concepts are mediated and redeployed according to the vernacular ethics of a particular place, especially when care work is contested. In the Palestinian case, social workers reinterpret strategies of acceptance and confidentiality for stigmatized care; simultaneously, the possibility of care is limited most sharply by allegations of betrayal and helping the enemy. We conclude by discussing how these often implicit ethical negotiations might be formalized for dialogue.

BACKGROUND AND LITERATURE
SOCIAL WORK AND SOCIAL WORK EDUCATION IN PALESTINE

Palestinian social work is taking shape today in response to more than 70 years of occupation. Even before the formal end of British colonial control

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1. See Kleinman's (2006) theorization of moral meaning making as a response to local danger.

of Palestine and the declaration of the Israeli state in May 1948, Zionist paramilitary groups began attacking Palestinian people in an effort to secure territory (Berry and Philo 2006). Between April 1948 and a United Nations-brokered truce in January 1949, hundreds of Palestinian villages were destroyed and at least 750,000 Palestinians were expelled or forced to flee their homes—a period called the *Nakba*, or catastrophe, by Palestinian people. Roughly 280,000 people fled to the West Bank, then under Jordanian control (Berry and Philo 2006; Bregman 2016; Albanese and Takkenberg 2020). With the Six Day War in 1967, Israel occupied still more territory, including the West Bank, East Jerusalem, and Gaza, displacing hundreds of thousands more Palestinian people. Since then, control over the West Bank has remained contested. From 1967 to 1993, Israel maintained direct military rule of the West Bank, at the same time building settlements for Jewish-Israeli citizens. The Oslo Accords in 1993 and 1994 granted partial control of some areas of the West Bank to the newly formed Palestinian Authority.[2]

Everyday life in the West Bank is shaped by the legacy of the Nakba, two *intifadas* or uprisings from 1987 to 1993 and 2000 to 2005, and ongoing occupation. As of 2018, roughly 800,000 of the 2.95 million Palestinians living in the West Bank are registered as refugees, including descendants of refugees from 1948 to 1967 (Albanese and Takkenberg 2020). The crisis extends beyond officially registered refugees. As of December 2020, 36 percent of Palestinians in the West Bank live below the poverty line, with 600,000 facing food insecurity. Movement within the West Bank is severely restricted, resulting both from the construction of the Israeli separation barrier beginning in 2000 and military checkpoints throughout the area, most recently numbered at 593 (UNOCHA 2020). Since 1967, Israeli military and police forces have also routinely detained Palestinians in the West Bank, imprisoning hundreds per year without charge for several months or years (B'Tselem 2021). Rita Giacaman, Hanan Abdul-Rahim, and Laura Wick (2003) have pointed out that prior to the mid-1990s when the Israeli government administered health care in Palestine, they did so through the Department of Defense rather than the Department of Health. Care was grossly underfunded and chaotic, promoting dependence on Israeli hospitals and

2. For detailed histories of Palestine and the organization of Palestinian social work over this period, see Al-Kilani (2019) and Khalidi (2021).

the sense that health care and social services in Palestine were intractably unstable and unreliable. Judith Butler (2015) has described these types of conditions as a facilitated state of precarity—a politically orchestrated mode of material and psychological uncertainty intended to wear down and disorganize a targeted and disregarded group of people.[3]

The growth of professional social work in Palestine stems in part from the long-standing presence of international humanitarian organizations and, paradoxically, the movement for Palestinian independence. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) was initially established in 1950 to provide only food, housing, and education, organizing camps in the West Bank, Gaza, and East Jerusalem, as well as the surrounding countries of Lebanon, Syria, and Jordan. The camps were designed to be temporary, but more than 70 years later there is no political answer to the crisis in sight. Since the 1980s, the UNRWA has significantly expanded its work to support a wide range of community programs, including services aiming to support women, people with disabilities, young people, and seniors (Rosenfeld 2009; Abu-Ras and Faraj 2013). As an international organization that officially maintains a stance of neutrality, UNRWA initiatives have often been met with skepticism by Palestinian people, although it also employs approximately 30,000 Palestinians as aid workers, making it the largest employer of Palestinian refugees (UNRWA 2019).

The Palestinian Authority inherited responsibility for health and social services beyond the UNRWA camps in the early 1990s, following the Oslo Accords, and has since made important strides. In the West Bank, there are presently five bachelor of social work degree programs, currently the standard practice degree in Palestine, as well as two master of social work programs, the first founded in 2008 (Kokaliari et al. 2016; Ibrahim 2018). Social work in the West Bank today includes a complex array of services managed directly by the Palestinian Authority, Palestinian and international nongovernmental organizations (NGOs), and UNRWA. Social workers manage and allocate aid and benefits; investigate violence and exploitation of children and try to intervene; develop new programs, like substance use clinics, shelters for women facing intimate partner violence,

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3. See also Calis's study of the Israeli military's practices of "ordering and disordering" (2017, 66) policies and systems to induce an everyday sense of dissonance.

and supports for people with disabilities; and provide mental health services like support groups and psychotherapy.

Building the soft infrastructure of social work is widely understood in Palestine as foundational to the future state, but health and social work programs have been stymied by the ongoing occupation, uncertainty, and limited resources (Giacaman et al. 2003; Al-Kilani 2019). Recent research has focused on the stress and toll of practicing social work in Palestine, including vicarious and shared trauma (Blome and Safadi 2016; Veronese et al. 2020). At the same time, social workers in Palestine may show a high level of organizational commitment even in the context of heightened stress (Safadi, Easton, and Hasson 2020). A shared sense of ethical purpose to their communities and the future of Palestine in opposition to occupation may indeed be a protective factor (Sousa et al. 2013; Veronese 2013; Veronese et al. 2017).

STIGMA AND STIGMATIZATION

"Stigma" refers to conditions, identities, and experiences generally rejected and met with shaming within a given community, including psychiatric symptoms and named disorders, medical illnesses, disabilities, substance use, and social dislocations such as divorce and variant genders and sexualities. Erving Goffman framed stigma as a relationally and contextually charged attribute of a person or group that "disappoints" a group's expectations, something "deeply discrediting" ([1963] 2009, 3). It is fixed to a person, the person's family, or to an identity group in response to a contextually constructed source of disgrace, but it is socially rooted and can be modified. A particular stigmatization "has a history of its own," Goffman writes, and can therefore be changed ([1963] 2009, 138). Inspired by Goffman's foundational work, research on stigma—mainly from the fields of sociology and social psychology—has described both a global phenomenon and one with diverse local and sociocultural attributes, expressions, and implications (Pescosolido and Martin 2015; Koschorke et al. 2017).

Stigmatization is an oppressive process that depends on inequitable power distributions and—beyond its interpersonal manifestations—can be systemically and institutionally structured (Link and Phelan 2001; Corrigan, Markowitz, and Watson 2004). Although often manipulated and reinforced by state and institutional powers, stigma operates most directly among

and between people with less relative power.[4] The stakes of stigmatization are highest for people with already marginalized or contested statuses and identities. Lawrence Yang and colleagues proposed that what is at stake for people facing stigma is "what matters most" to them locally (2007, 1528). The process of stigmatizing someone is "a highly pragmatic, even tactical response to perceived threats, real dangers, and fear of the unknown. . . . Both the stigmatizers and the stigmatized are engaged in a similar process of gripping and being gripped by life, holding onto something, preserving what matters, and warding off danger" (Yang et al. 2007, 1528).[5] Yang and colleagues observe stigmatization as an essentially "moral experience" (2007, 1525), a struggle over shared vulnerability. In this sense, stigmatization can be a tactic used by people who are structurally disempowered to obtain a sense of control. It involves oppressive moral manipulation in a competition for scarce resources of power. A society's stigmas can point to its "fault lines"—the inevitable distinctions between those deemed deserving of care and those seen as undeserving (Pescosolido and Martin 2015, 91).

Colonized people may reject some behaviors and conditions because they attribute them to imperial power or associated settlers. For example, Sa'ed Atshan (2020) shows that homophobia in Palestine is connected to a still widely held view that sexual and gender liberalism stems from cultural imperialism, even as queer activists in Palestine may be cautious to name homophobia for fear of perpetuating rationalizations for the occupation.[6] Conversely, the patriarchal regulation of gender and sexuality through stigma is often misrepresented as inherent to Sharia law but can be variously traced to competitions over authority with European powers, disidentification from representations of Western values, and struggles by local leaders to maintain power.[7] The fault lines do not emerge discretely

4. For more on state uses of stigma, see, e.g., Tyler and Slater (2018) on stigma as a state-sanctioned strategy of shaming people who receive public assistance and Bayer (2008) on uses of stigma in antismoking public health campaigns.

5. Yang and colleagues' (2007) use of the term "tactical" suggests sociologist Michel de Certeau's (1984) distinction between strategies (responses by those with relative control over a given territory) and tactics (more improvisational responses by those with fewer resources).

6. See also Hoad's (2007) discussion of homophobic discourse and colonialism in the southern African context.

7. See Said's (1992) criticism of binary portrayals of Palestine and the West; see also Massoud's (2018) study of Sudan, where leaders chose to continue to govern using English common law rather than more progressive interpretations of Islam.

within societies or in response to some vague or static sense of culture or bias against social differences (Koschorke et al. 2017). They are cut, recut, and exploited in geopolitical oppression, the rationalizations of the state, and competitions on the ground over resources and authority.

In Palestine, systems of stigmatization and moral competition inevitably emanate from the long-standing Israeli occupation. Discussions about stigma (*wasma*—وصمة) in Muslim-majority contexts such as Palestine often conflate stigma with religious taboo (*muharam*—محرم). But in our observations in Palestine, the most highly stigmatized behaviors tend to raise questions about whether an individual or family might be associated with the occupation. For example, a stigmatized behavior like alcohol and substance use or gender and sexual variance might relate in part to religious taboo but takes on particular sociopolitical charge for an association with isolation and secrecy from family and community, implying susceptibility to extortion by the occupation force.

Secrets in Palestine are a source of fear and danger in a context of constant threat and encroachment from the Israeli military. The process of stigmatization and the isolation of people being stigmatized form a reinforcing feedback loop under occupation. In cases of substance use, several studies have identified stigma and distrust about confidentiality as barriers to seeking substance use treatment in the Palestinian West Bank (Massad et al. 2016; UNODC 2017; Damiri 2020). Intoxicants are forbidden in the Muslim tradition, but there is also a broadly accepted view that the Israeli military encourages substance use among Palestinian youth (Massad et al. 2016). A potential tie to the occupation force is likely to be seen as more acutely dangerous than the religious admonition itself (Dudai and Cohen 2007; Kelly 2011).

Recent scholarship on stigma in Palestine has not tended to draw the connections we are suggesting between stigmatization, colonization, and occupation. In addition to substance use, recent research examining stigma in Palestine has explored responses to mental health symptoms and disorders (Merhej 2019; Marie, Shaabna, and Saleh 2020), autism (Dababnah and Parish 2013), HIV and AIDS (Soffer 2020), other physical disabilities and medical conditions (Elissa et al. 2018; Shawahna 2020; Nahal et al. 2021) and intimate partner violence (Bacchus et al. 2021; Fitzgerald and Chi 2021). In each of these examples, however, it appears that stigma is closely tied to the perception of increased vulnerability and precarity, which in some circumstances can signal desperation on the part of an individual or family and imply risk of collaboration.

GLOBAL AND VERNACULAR SOCIAL WORK ETHICS

The "Global Social Work Statement of Ethical Principles" (GSWSEP), revised in 2018, points to the challenge of stigma in its first principle: "We respect all persons, but we challenge beliefs and actions of those persons who devalue or stigmatize themselves or other persons" (IFSW 2018).[8] Since the first attempt at a universal system of social work ethics in 1976, the framers have tried to acknowledge, on the one hand, social justice concerns as matters of social work ethics—for example, regarding the autonomy, status, and treatment of marginalized women and gender and sexual minorities. On the other hand, they have sought to recognize meaningful local and religious differences, including patriarchal traditions, policies, and practices (Congress 2012; Banks 2018; Sewpaul and Henrickson 2019). Vishanthie Sewpaul and Mark Henrickson (2019) contend that the latest revision of the GSWSEP (2018) represents a renewed effort toward decolonizing social work. At the same time, they reject ethical relativism and essentialist claims of difference used by people with relative local power to rationalize discrimination, violence, and oppression. A universal framing of professional ethics is inevitably fraught, however, especially in formerly colonized and occupied places where efforts by Western powers to combat stigmatization are often viewed and experienced as cultural imperialism.

An older strategy for interpreting dominant social work theory for local contexts has been termed "indigenization," or sometimes "localization" (Ferguson 2005; Gray et al. 2013). These terms have been used in many ways in social work scholarship but have generally referred to opposition in decolonizing societies to social work theory from the Global North that does not center their communities, values, or needs (Gray et al. 2013). Sometimes these terms refer to the process of modifying theory and treatment models to suit local needs—as with Frederic Reamer and Jayashree Nimmagadda's (2017) recent call for indigenization of social work ethics for India. Indigenization has been broadly criticized as well, mainly for concerns that it encourages overly simplistic and static understandings of culture and indigeneity and relies on a reductive polarization of East and West (Ferguson 2005; Yunong and Xiong 2012).

8. The IFSW and the International Association of Schools of Social Work (IASSW) jointly adopted the revised GSWSEP in 2018, but with two different versions. See the IASSW's longer version here: https://www.iassw-aiets.org/wp-content/uploads/2018/04/Global-Social-Work-Statement-of-Ethical-Principles-IASSW-27-April-2018-1.pdf.

Efforts to theorize social work in global terms—even with an expressly decolonizing agenda—tend to be limited by the conceptual challenge of situating knowledge and practice within both local and abstract, vernacular and global domains. Even highly situated local intervention projects cannot be neatly separated from the flow of values and ideas exported from the Global North. Sahar Al-Makhamreh and Mary Pat Sullivan (2013) have pointed out that social work education, training, and supervision in Middle Eastern countries rely heavily on textbooks from Egypt, which are themselves simply translations of social work texts written in the United States, the United Kingdom, and Australia. In this way, students and social workers in Palestine learn about ethical concepts from the GSWSEP (2018), as well as the *Code of Ethics* (NASW 2017) of the US-based National Association of Social Workers. They must engage actively in the work of abstracting and translating concepts across complex differences in epistemology, moral theory, scale, and resources.

The current study draws on three ethical frameworks, or sensitizing concepts (Padgett 2017), for thinking through the bridging of vernacular and global social work ethics. First, eschewing overreliance on principle-based approaches, Banks has introduced the term "ethics work" to describe the routine, often prosaic ways social workers and other care workers engage in questions about right and wrong, guided less by deontological principles than by the attempt to see themselves as "good practitioners" (2016, 36). Banks (2018) situates ethics work within a learned capacity for ethical wisdom, calling on the practitioner to weigh reasoning and feelings as well as abstract and contextual factors. Paul Brodwin (2013) reveals similar dynamics in his ethnography with case managers working with people with chronic psychiatric symptoms in an industrial midwestern US city. The case managers develop a "tactical wisdom" for balancing such issues as their clients' self-determination and safety while maneuvering within restrictive bureaucratic regulatory demands and inadequate resources. "Everyday ethics," as Brodwin puts it, come to bear in practice as a break from the learned assumptions of crisis management, in moments of doubt, and in conflicts between coworkers on the treatment team. It is at once a highly contextual negotiation and a reflection on values from outside the most local and immediate concerns. The current study attends primarily to these types of active ethical deliberations because our interest is in individual and collective agency in decision-making; however, from the perspective of ethics work, even conscious and creative ethical calculations must be understood as relationally and contextually enabled and constrained.

Second, our interest in ethics is guided in part by a broader focus on what has been termed "clinical activism," where social workers and other care providers take on, adapt, and redeploy clinical theory and practice strategies for stigmatized and undervalued care (Byers, Vider, and Smith 2019).[9] In doing so, they organize around community ethics, often guided by their own experiences of vulnerability and interdependence. Clinical activism is a focused and collaborative antioppressive appropriation of social workers' discretionary space within street-level bureaucracies (Lipsky [1980] 2010). Following Michael Lipsky's foundational work, street-level organizational theory has tended to emphasize the ways social workers and other care workers on the ground manage chronic resource constraints by withholding care to some potential clients, often in alignment with broader societal prejudices (Brodkin 2008; Spitzmueller 2016). At the same time, representational bureaucracy theory has shown that social workers who share marginalized social identities with clients can often navigate organizational constraints and contribute to more equitable outcomes for organizations and clients (Watkins-Hayes 2009, 2013). Clinical activism frequently involves care providers actively and collectively organizing around a politics of solidarity and a sense of shared struggle with clients.

Third, through our analytic applications of ethics work and clinical activism, for the current study we have arrived at and depended on a conceptualization of vernacular ethics. By "vernacular ethics," we mean to suggest a situated and emergent field of reflection about moral concerns taking form in everyday commiserating, sharing feelings, consulting, debating, and critiquing. The vernacular ethical field is the particular root system for a group's ethics work and their potential clinical activism. People and groups inevitably contribute to and draw upon a vernacular ethical field as they consider situations with a limited range of agency and power, in this case through care work. Rather than a stable, preexisting, and external ethical framework, we argue that the field of vernacular ethics takes form dynamically through the work. It is also not exclusively local—it interacts with ethical ideas being circulated from elsewhere, including religious and social work values. Still, these ideas are mediated by what matters locally.[10] Mel

9. See also Vider and Byers (2021) on clinical activism among lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) affirmative foster care service providers in the United States in the 1970s and 1980s.

10. Here we distinguish vernacular ethics from what has been termed "Indigenous ethics," which imagines a more stable and enduring relationship between a group and the

Gray and Jan Fook suggest, in fact, that overarching principles of social work, such as social justice, may be useful across very different contexts around the world "not as defining discourses, but as tools for developing grounded perspectives" (2004, 639). Still, it is the vernacular field of ethical engagement that sets the terms of acceptable, least harmful, good, and caring practice. We will suggest, based on our findings, that vernacular ethical fields form alongside and may be informed by formalized processes like professional codes, yet they also form in their absence.

METHOD

The present analysis is part of a larger study about the role and processes of clinical supervision in forming the profession of social work in the Palestinian West Bank since the early 1990s. Beginning in our initial focus group interviews in summer 2017, we noted that participants frequently drew our attention to the ethical concerns they experience related to stigmatized care. In response, we added an additional research question, our focus for the current article: How do social workers in the Palestinian West Bank engage in stigmatized care without formal and locally grounded ethical guidance?

EPISTEMOLOGY

Rather than focus on normative ethics, concerned with right and wrong from a perspective of abstract moral authority, our interest in this study is how social workers make clinical decisions, approach care, and organize themselves, constructing social work ethics as they go. We are guided in our approach by Jing-Bao Nie and Ruth Fitzgerald's (2016) call for a cosmopolitan "transcultural" analysis, with reflexivity to differences within and across borders, which they argue must be constructed through detailed descriptive research that contextualizes ethical processes as they

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moral ideas it promotes through its practices and stories, referring to and affirming group identity before, despite, and alongside the violence and losses of colonialism. See Feitosa (2015) for more on Indigenous ethics, as well as Gray, Yellow Bird, and Coates (2008) for their discussion of Indigenous social work. Our understanding of vernacular ethics is not intrinsic to a group of people but can develop anywhere—within a unique social and political context—for a group of people with shared interests and concerns.

are playing out in the field. As such, we have taken an inductive approach in study design, sampling, data gathering, and analysis, aiming to explore situated knowledge and dynamic ethical processes on the ground with constructivist grounded theory methods (Charmaz 2006). In a departure from more traditional grounded theory approaches, our analysis draws on the above-discussed sensitizing concepts of "ethics work" (Banks 2016) and "clinical activism" (Byers et al. 2019), as well as a new construct from the current analysis, vernacular ethics. Although we have not approached this study with static or singular views about the ethics of social work in Palestine or elsewhere, we are guided by what Iain Wilkinson and Arthur Kleinman (2016) call "moral feeling" in social science inquiry—a commitment to research that matters for people pursuing justice and recognition in response to suffering.

RESEARCHER REFLEXIVITY

Our project was co-led by three social work researchers, including two Palestinian scholars who have been faculty members at a Palestinian university in the West Bank since the 1990s and one social work academic based in the United States who has taught in the West Bank during visits since 2012 and completed two summer research fellowships in the West Bank in 2018 and 2019. We conducted most of the interviews together as a group. Our differences as researchers in terms of insider and outsider status, personal history, gender, ethnicity, language, research training, and epistemological assumptions also informed our project at every stage. Some participants were more comfortable discussing stories with known insiders with shared identities and experiences, whereas others appreciated an opportunity to discuss their experiences with researchers they identified as outsiders. Many found it challenging as well as useful to explain concepts and ideas that are often internally assumed.

RECRUITMENT AND SAMPLING

The study analyzes data collected with social work supervisors ($N = 99$) from a larger study that also includes social work students. Once the project was approved by the institutional review boards for both Bryn Mawr College and Al-Quds University, we recruited an initial convenience sample by advertising in social service agencies, clinics, hospitals, and schools

throughout the West Bank. The advertisement welcomed participation from anyone with a practice degree in social work (at the bachelor's, master's, or doctoral levels), at least 5 years of direct practice experience, and experience supervising social work students for at least 2 of the past 5 years. All 142 social workers who expressed interest and said they met criteria were invited to participate in focus groups local to them, although some did not show or meet inclusion criteria when they arrived for the groups and were invited to share comments informally instead. We ultimately conducted 15 focus groups with social work supervisors in 12 cities throughout the West Bank during summer 2017, winter 2018, and summer 2018. Demographic data from the sample are included in table 1.

From this sample of focus group participants, we then gathered a theoretical sample for individual interviews. As we analyzed the focus group interviews and identified emergent themes, we invited participants from the focus groups who had spoken to these themes to also be interviewed individually to discuss their perspectives in more depth. Twenty of these social worker participants were interviewed individually.

TABLE 1.   Demographics of Social Work Supervisor Participants

	No.	%
Gender identity:		
Female	77	77.8
Male	20	20.2
Highest degree:		
BSW	70	70.7
MSW	21	21.2
PhD	3	3
Years supervising social work students:		
10+ years	38	38.3
5–10 years	24	24.2
2–5 years	16	16.1
2 years	16	16.1
City or nearest city where practicing:		
Nablus	16	16.1
Bethlehem	15	15.1
Ramallah	15	15.1
Tulkarem	8	8
Salfit	7	7
Qalqilya	7	7
Jericho	7	7
Hebron	6	6
Yatta	5	5
Jenin	5	5
Abu Dis	5	5
Tubas	3	3

Note.—N = 99. Not all participants responded to all questionnaire items.

DATA COLLECTION

After discussing and signing informed consent forms, participants completed a brief demographic questionnaire before beginning the interviews. Most of the focus groups and individual interviews were led by all of the researchers and took place in clinics and agencies. All of the interviews were conducted in Arabic. An interpreter, who holds a master's degree in translation and teaches English at a Palestinian high school, was also present for most interviews, performing simultaneous interpretation into English for the US-based researcher—a reminder to participants that what they shared mattered to people in other places and would travel from the room.

The focus group interviews ranged from 74 to 136 minutes ($M = 95.86$) and individual interviews from 61 to 128 minutes ($M = 80.7$). All interviews were semistructured and guided by an interview protocol with questions such as the following: "What are your goals as a social work supervisor?" "What are the greatest challenges in supervising?" and "Do you try to address these challenges—if so, how?" These questions were just starting points, however. The interviews were spirited and vigorous, taking us in unanticipated directions. Although our initial interest in this project was supervisory processes, our questions about supervision quickly engaged social workers to talk about their own concurrent experiences of direct practice, as well—the focus of the current article.

Our open-ended approach to data collection allowed us to modify our interview protocol at each stage, adding questions to explore coding schemes and to seek out counterexamples. For example, after our first five focus group interviews, where challenges around stigmatized care were already rising as a central concern, we added additional questions to the protocol, including "How do you respond when your clients have problems that are stigmatized in the community?"

All of the interviews were audio-recorded and transcribed in English by the same interpreter who had participated in the interviews. One of the researchers whose first language is Arabic also listened to the recordings to check and edit the translated transcriptions. The researchers also kept logs of observations during visits. In addition to the formal interviews, we visited dozens of clinics, agencies, and orphanages, shadowed workers in between their clinical sessions, and conducted dozens of informal interviews with clinic administrators, social workers, agency staff, and students.

ANALYSIS

One author conducted open coding for all transcripts throughout data collection using NVivo (Version 12)—a software program for qualitative data analysis. After each cluster of two to three interviews had been coded, we met to review and challenge these initial coding schemes and discuss how possible themes could be further explored with the next cluster of focus groups and individual interviews. We gradually worked to identify axial codes and theoretical categories using memo writing and group and individual member checking (described below) to facilitate a constant comparative method (Charmaz 2006).

To enhance the rigor of our analysis, two of the study participants, Asma and Basma,[11] participated in three additional member-checking interviews each over the course of the 2 years of data collection (Padgett 2017). As part of these additional interviews, we shared emergent themes from our analysis and invited their comments and questions. These two participants were invited to take part in the member-checking interviews because they showed particular investments in the project and have clinical specializations in substance use and violence against women.

In summer 2018, we also recruited 13 student research consultants, all undergraduate social work students at Al-Quds University, and shared excerpts of anonymized raw data and axial codes, assembled into a codebook. The students' questions and feedback were critical in several ways—for example, in broadening some of our analyses about confidentiality. We also organized a community meeting in summer 2018, inviting all 99 social workers who had participated, and 40 were able to attend. After presenting preliminary findings, we asked the participants to form small groups to identify areas of agreement and disagreement with the analysis to date, as well as additional questions and ideas. Their feedback affirmed and helped to refine and identify connections between many of the findings.

To further assess that we were understanding and using our identified codes consistently as we built the final categories of analysis, the first and second authors used Dedoose (Version 8) to test interrater reliability

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11. To improve clarity and readability, we use pseudonyms to identify individuals who participated in individual interviews, and participant numbers and locations to identify and contextualize focus group participants. We do not list locations of individual interview participants to better protect confidentiality.

with 50 excerpts of text from the full sample of social worker participants. We found high agreement using Jacob Cohen's (1960) kappa coefficient ($\kappa = .95$). We judged that our findings related to ethical responses to stigmatized care had reached saturation once we were no longer able to identify divergent perspectives from our interviews, observations, coding analyses, efforts to seek counterexamples, or consultations on our findings.

FINDINGS

This article reports findings on how Palestinian social workers organize themselves in ethical terms to provide care for needs that are commonly stigmatized in Palestine. These types of stigmatized care include, for example, treatment related to substance use, mental illness and physical disabilities, and women facing violence and rape or engaging in sex work. Both what Banks (2016) calls "ethics work" and what Byers and colleagues (2019) describe as more focused solidarity efforts in "clinical activism" are rooted in a vernacular ethical field shaped by the moral struggle against the Israeli military occupation. Social workers reinterpret global social work ethics, redeploying ethically grounded principles for practice conceived and intended for other places.

REINTERPRETING SOCIAL WORK ETHICS: ACCEPTANCE AND CONFIDENTIALITY

None of the participants ever directly mentioned any formal system of social work ethics, but they frequently referenced "acceptance" and "confidentiality" as key practice principles. Many participants explained that acceptance and confidentiality are taught in abstraction in social work programs and often referenced as if self-evident in trainings and supervision, without consideration of the context. They are largely left to elaborate and improvise the meanings and implications of these principles for practice on the ground.

Acceptance

Participants generally used the term "acceptance" (*altaqabul*—التقبل) to refer to their responsibility to work empathically with clients who are being shunned or rejected within their communities or who are engaging in activities that offend the clinician personally. A focus group participant in Tubas described this general principle:

We have to accept the cases, the families, no matter what the case is. If I don't accept them, there is something wrong with me as a social worker. . . . Having a client means having a responsibility, and that means even if what the client has done defies the society, like for instance having sexual relations outside wedlock or having a relation on Facebook. These things are not accepted at all in our society, but still I have to accept the clients and give them the help needed because I am the one responsible for this client. I have to study all the sides that made this problem come to the surface. There are family, social, and personal aspects that I need to understand. This is me in my job. Outside my job I don't have to accept this issue, but as long as I am at work I have to accept all the cases. (Participant 97, Tubas focus group)

An example of ethics work, acceptance in this sense is often framed as essential and constitutive of the relationship between a social worker and client. In Yatta, a focus group participant similarly explained, "Acceptance is the basis of our professional relationship. We have to accept the client as a human and treat him as a human and not as the behavior he did. If we don't accept the human we cannot work with them" (Participant 86, Yatta focus group). Participants repeatedly explained to us in interviews, and to each other in discussions of cases, that the practice principle of acceptance allows them to remember that their clients are human (*inssan*— إنسان) and therefore deserving of their care regardless of their actions or conditions.

Many participants also strategically draw on this practice principle of acceptance as a tool in more focused deployments of clinical activism: they organize their care work around a sense of connection and commonality with their clients, an understanding of their problems and experiences as part of their larger, shared Palestinian experience. For example, in their work with clients in substance use treatment, Asma and her colleagues and students try to encourage a shared community of peer acceptance and support, interrupting and resisting stigma through their work as a matter of Palestinian solidarity. In one of the group therapy rooms in the clinic where Asma works, we found ourselves surrounded by the recent work of some of the clients. They had been asked to write down their hopes for the therapy: honesty and truthfulness, humility, confidentiality, acceptance, respect, trust. There was also a list of group rules created by the participants: be on time, show mutual respect, keep confidentiality, cooperate and share

experiences and opinions, trust each other, exchange ideas and listen, shut down phones, be flexible, and be passionate. A client's drawing of Palestine hangs on another wall. The outline of the land is framed in cacti and barbed wire. There are eyes across the map with tears, and the land is pierced with a large syringe. The meaning is clear to Asma and to other social workers we ask: people use drugs to cope with the pain of the prolonged occupation and violence by the Israelis. Although many Palestinian people are fearful that people with addictions are vulnerable to collaborating or spying for the Israeli military, clients here are told that their work toward recovery is an act of resistance against the occupier. Positioned directly alongside the drawing was a fixture of every clinic we visited, a poster of young people from the area killed by the Israeli military, a source of respect and grief.

The approach at this clinic is premised on the assumption that mitigating the shame of social rejection can facilitate recovery and ultimately allow their clients to rejoin their own families and communities with respect. Asma explained that they train staff and students to feel this sense of commonality with clients at a personal level, understanding that addiction can affect any family. She described nudging her colleagues and students to confront and unpack their fearfulness and judgments toward clients. By helping clients to feel valued, known, and cared about, they hope they can ease the sense of threat their clients are otherwise thought to represent, thereby lessening the risk that they might in fact resort to collaborating with the enemy. Inside the clinic and within the group treatment room, they create a temporary alternative to family and community support, a different kind of connection made possible within this clinical space.

From another perspective, however, some pointed out that showing acceptance for clients does not mean that they necessarily agree with or condone their clients' behaviors. In the group in Yatta, a participant explained, "It is true I sometimes have some inner feelings of dislike for what they did, but I don't show them. I only show my acceptance, and I try to maintain the professional relationship" (Participant 85, Yatta focus group). Acceptance does not negate the clinician's own feelings and judgments but relegates them. In our individual interview with Faida, she made the point more sharply: "There are certain things in society which I can be opposed to. . . . A social worker can have their own views and thoughts and their own personality within the frame of the culture and habits of the society we are living in. But I also must accept a person who comes to me for help.

Accept her as she is and not think of what she should be like." Over time, clinicians learn to internally counter their own feelings of rejection and judgment with empathy.

For many participants, this process involves reframing the client's experience in terms of victimization or attempting to understand clients as people apart from actions they disapprove of. Amal offered the following reflection: "Let me tell you something about women who earn their living from sexual services. Before I became a social worker I used to be disgusted by them. I never thought they were worth even a simple hello. I thought they were dirty and disgusting. But when I started working I discovered that they are victims and I work with them. I take these cases and work with them."

Clinicians are often acutely aware of their own discomfort, even as they compartmentalize it. Dalal later discussed making home visits with a woman accused of adultery: "I was a little bit disgusted from her house. I did not know how to sit down in that place. But I did because I have to deal with her as a human without showing my inner feelings." Basem, too, privileged acceptance as a fundamental principle of his work, though he pointed out that it was not always practiced by colleagues: "I accept all clients with all their details. And I tolerate more than others."

Some of the social workers try to change their clients' stigmatized attributes or behaviors even as they draw on these techniques of acceptance. Batool recalled a recent client who identified as a lesbian: "I accepted her because acceptance is important. She told me that she was attracted to her female friend and did not know what to do. . . . I worked with her. Others refused, but I accepted her as a human being and worked with her. I helped her find alternatives to keep her mind away from that." As with clinicians affirming clients using substances but working to motivate a change, for Batool and others, acceptance of marginalized gender and sexuality has its limits.

In adapting and integrating a principle of acceptance conceived elsewhere, some are guided in part by Islamic virtue ethics—working to see themselves as agents of kindness, charity, and tolerance of differences in others. A focus group participant in Tubas explained, "Every person who chooses this field has the seed of good deeds within him, and we are living in a society that suffers from the occupation and from poverty. The community needs all the help it can get. This includes the marginalized people" (Participant 97, Tubas focus group). Amal explained, "This is a human being who might be a victim for certain things. And you know God the Almighty forgives sins. If a human repents, then God forgives him." Situating acceptance

in religious terms could also give rise to internal conflict. In discussing other cases, Amal explained, "Now as a social worker I have to work with the clients, but sometimes this client has performed adultery, and I wish I could not because what she did was against our religion, and it will be as if I am defending a sin."

A central tension arises in that the principle of acceptance can put social workers at odds with the larger society. Many embrace this challenge and connect their work with their clients to a larger political project of building a more inclusive and pluralist Palestinian state. Many see their work, especially with marginalized and stigmatized clients, as crucial to resisting Israeli occupation. Mona explained, "When a social worker helps a group or empowers one, that means he is developing this group, which leads to the development of our society." Amena said that the social worker's role in society is "helping it move forward, and that requires staying away from old and inherited thoughts that could be related to religious issues."

Some of the participants also described working in their everyday interactions to resist stigmatization of their clients. For example, Asma explained she often has opportunities to publicly demonstrate her acceptance of clients by acknowledging their greetings in the street. She recounted the concern of her parents and neighbors when she first began working in addiction:

> Some people came to my father and asked him, "Why do you let your daughter do this kind of work?" . . . I told him that this is what I believe in and what I like to do. . . . They are humans, and maybe one day one of my family members will be in their shoes. . . . My oldest brother said angrily to my father: "Why do you let her do this work?" Sometimes I saw the clients in the streets, and they would call me by my name. There were some from my village, and when they saw me at Damascus Gate they would shout out my name: ["Asma, Asma"]! Their appearance gave them away as addicts; they wore dirty clothes, and anyone who saw them would immediately figure out they were addicts. So people would come to my family and tell my father how men call out my name in the street and that I stood and spoke with them.

Many social workers described facing scrutiny and scorn for their stigmatized care work. Asma purposefully shows her clients decisive and unambivalent acceptance, relishing opportunities both to support them and to challenge her family and community. Asma and several others argued to

us that shaming and shunning of vulnerability and difference holds the society back, creates needless harm and division, and makes Palestinians more vulnerable to extortion plots by the Israeli military. Her work is both to actively support her clients and to confront the traditions and perpetuating conditions of stigmatized vulnerability and marginality.

Some participants shared Asma's understanding of acceptance as a strategy to support their clients and challenge the society's stigmas at once, but they stressed in their interviews with us that they had not been prepared in school to navigate these tensions within their own communities. As Basma explained, "We learned in the university that acceptance is a must in our work and that we must accept all humans no matter what. But when I got to work, I found out that there are cases against the norms of the society, such as women involved in sexual relations without being married, and that was a big surprise for me. Not only that, but I found out that these women are threatened to be killed."

The surprise Basma described refers to a gap between idealized practice taught in school and the social workers' and clients' lived experiences of stigmatized care work. Many participants speculated that this jarring discrepancy is maintained by a disavowal of their stigmatized care work by the Palestinian Authority and by a failure of Palestinian social work academia to address and support them in the realities of practice.

Still, without formal guidance, the social workers organize themselves and each other in improvisational and emergent ethical terms—drawing on and adding to practice wisdom that circulates through networks of clinicians and in supervision of junior staff and students. They keep their deliberations contained, however, and the ethical challenges of stigmatized care are poorly understood and supported at a policy level. A social worker in Jenin recounted a recent incident of trying to escort a woman facing intimate partner violence from her home to a women's shelter she and others had worked to establish. She was met outside the house by men with guns. Anwar also noted that her acceptance of clients often puts her personally in danger, especially in her work with clients living with intimate partner violence and sexual violence. She argued that social workers need better legal protections for their daily work especially because of the work of acceptance: "You know we have a rule in social work which says to accept the clients as they are. I don't think this is a fair rule because it should be tied to a condition that no harm should come upon the social worker from that client, whether legal harm or social."

Ultimately, Anwar, Basma, and others cope with risk as part of their acceptance work with clients, but they do not agree they should have to. They believe, however, that acceptance is essential to care, even, or especially, in the context of stigma, and that care is foundational to the society they envision.

Confidentiality

Hinging on the principle of acceptance, confidentiality (*alseria*—السرية) generally refers to a clinician's responsibility to protect the privacy of their clients. Maintaining privacy becomes particularly charged, however, in the context of stigmatized care and in the absence of a codified ethical system where social workers have competing ethical and practical priorities. Acceptance and confidentiality can be understood here as interrelated and co-constitutive: Especially in cases with heightened stigma, the clinician works to show acceptance related to a client's concern specifically within the protection of confidentiality. The client and clinician are aligned in terms often seen on the surface as oppositional to the society. Basem said, "Frankly, we must be obsessed with the confidentiality principle," noting that they are usually the only people their clients can safely confide in. In Yatta, a social worker described her sessions with a woman who became pregnant after getting a divorce from her husband: "I worked with the case alone and all through her nine months of pregnancy. She was at her parents' house. When it was labor time I took her to an institute where she gave birth and gave up her baby legally. All this happened and no one knew about it except for her parents and me" (Participant 85, Yatta focus group). A focus group participant in Bethlehem explained, "It is human nature; people like to talk. But because I deal with cases of rape and sexual harassment, and any talk on these cases might lead to murder, I have to be extremely careful with the issue of confidentiality" (Participant 1, Bethlehem focus group).

Although frequently referenced, confidentiality is not straightforward in a close-knit and contested society living under occupation: keeping each other appraised by word of mouth (or what participants often referred to as "gossip") has been seen as key to survival, and social workers and other care providers frequently live within the same communities they serve. Many described using symbols rather than names on case records they viewed as sensitive. Asma said she advises her clients never to use their real names or to provide their real home addresses at the substance use treatment clinic

where she works. A focus group participant in Jericho reflected on her work with a client in treatment for substance use: "He saw the staff and students, and he told me too many are from his area. He did not want them to know his story. I told the client that he has every right to come to my office, and if he ever saw anyone who might know him, just to tell him simply that he is here to do paperwork for his grandparents" (Participant 38, Jericho focus group).

Many focused on the practical challenge of finding private space for confidential sessions. Basem explained, "There is not enough space. The space is narrow. We cannot sit at ease. Each room has four or five social workers. How are we to keep the principle of confidentiality? A widow comes and needs to talk to one social worker, but she finds four sitting and also other clients can be in the room." In Abu Dis, a focus group participant similarly said, "When you go to an office you find three employees sitting in the same office, and so you tell the client to swallow whatever they wanted to say, or we sometimes leave. There should be some privacy" (Participant 18, Abu Dis focus group).

Most social workers said they do not allow students to work with particularly sensitive cases, both to protect their clients and their students. The Ministry of Education does not currently allow social work student trainees to work directly with children in school-based practice. Some participants blamed the university for failing to teach students about the stakes of confidentiality in ways that relate to Palestine. Several participants described students who had been visibly frightened or disgusted by clients they had assigned them to work with. They contended that students could not manage confidentiality until they were able to show acceptance. Most of the participants took a developmental perspective, assuming that their students could not keep cases confidential simply because they lacked work experience. As Hadeel explained, "We are talking about the ethics of the job, and it is not to be taught; it is something that is practiced, and it takes more than a year to practice it. The ethics of the job needs years of training."

The social workers also commonly used the term "confidentiality" to describe the client's responsibility to protect the privacy of the clinician, who may themselves face community reprisals for providing stigmatized care. Many mentioned their recent attempts to gain hazard pay for clinicians who work with clients experiencing intimate partner violence, child abuse, sexual assault, and other issues where social workers can face harassment and violence. In Salfit, a focus group participant explained: "When I

get threatened it is something I have to accept because there is nothing I can do about it and there is no law to protect me. I have two choices, either to work with this woman or leave her. I choose to try to help her. But the first thing is to make sure no one knows I am helping the girl if it is a sensitive case. I tell the client please make sure no one knows that I am the one talking with you and telling you what to do" (Participant 84, Salfit focus group). Confidentiality as a reciprocal commitment can be viewed as a necessary protection against harassment and violence.

Social workers sometimes determine that a situation is so risky that it should not be documented directly in the treatment record, for example in cases of intimate partner violence and sexual violence. This is especially true when the work puts them at odds with laws of the Israeli occupation. Basma, for example, told us she is a "good kidnapper." There are large areas of the West Bank where the Israeli government retains administrative control and where the Palestinian Authority police are not allowed to accompany her to a client's home. Working with the Israeli police would not be considered a viable or ethical option, and doing so could bring danger for all involved and the community. "With these children the only solution is to kidnap them," she said. "That is the only way to help them and to remove them from danger. . . . They wait for me in a specific spot, and I go and take them without their family's knowledge. It is true I jeopardize their lives and mine too, but this is the only way to remove them from the sexual assault they face." For Basma, maintaining a strict line of confidentiality about her involvement with clients is crucial to the work and vital for their safety.

Confidentiality could also be a technique of differentiation for social workers when they need to set limits from their work. Asma remembered a client who began selling ice cream outside of her parents' home when she missed two days of work:

> He was standing in the front yard and saw my father. . . . To my dad's surprise he started praising him and told my father how much I helped him. At that moment my father was really proud of what he heard, and every time this man came to sell ice cream my father would send out my nephews and nieces to buy from him and to give him water. Of course, this man tried to pay more social visits to us and to introduce us to his wife and kids, but I refused because it is very important to keep a clear line between my work and my personal space.

The active negotiation of confidentiality is central to the work Asma and others are doing. In practice rooted in shared struggle, it is a dynamic and uneasy line between themselves and their clients.

ETHICAL RESPONSES TO COLLABORATING WITH THE OCCUPATION

A consistent limit to the practice principles of acceptance and confidentiality in the context of stigma was people suspected of collaborating with the Israeli military—for example, by selling land to them, working for the military, or actively spying on other Palestinians in their service. These highly stigmatized behaviors were generally held out as impossible to reconcile within a clinical frame, and most participants cited a larger ethics of Palestinian solidarity in these cases. They could not accept the sense of betrayal, and they could not trust that they could work with the person with the reciprocal confidentiality necessary to keep themselves or their families safe. Ahmed offered a scenario to make his point clear: "Listen, if I am to be given two cases, one working with a client who is gay and the other a client who is a collaborator, I will choose the homosexual client. But the collaborator who has harmed us: no." Ahmed did not share this scenario glibly. Both clients are stigmatized, but spying or collaborating with the enemy is impossible for Ahmed to reconcile with the ways he situates his ethics as a social worker alongside the ethics of Palestinian state building.

At the same time, the charge of collaborating with the Israeli military could also follow more implicitly in cases of heightened marginalization, even without proof, when the community struggled to integrate or assimilate an individual. Amal recalled a 20-year-old woman she had done an initial assessment with who faced frequent violence at home but was engaged in a romantic and sexual relationship with her husband's sister:

> AMAL: This woman was very forward and brave and spoke about the details of her marriage. She told me that her husband used to beat her up and that her father-in-law tried to rape her. All this talk is about a 20-year-old woman. Now this woman does everything to the point that I started feeling this woman was under the enemy's control.
> RESEARCHER: You mean with Israelis.
> AMAL: Yes, so I said it is impossible for me to work with such a case.
> RESEARCHER: You mean because she was collaborating.

AMAL: Yes, so I transferred her to someone else, but I still re-member her and what she has been through at a very young age.

This client's marginalization and vulnerability, on multiple levels, led Amal to fear that this woman was susceptible to extortion, if not already actively spy-ing, and too great a risk for her to work with. She spoke about her handling of this case with ambivalence and ultimately regret, returning to it repeatedly in our discussion, but said she could not have done anything differently.

Other participants made the point more directly that people are some-times accused of spying as punishment for social infractions, and they tentatively discussed openness to working to help their family members if it is ever safe enough to be possible. In Nablus, participants in one of our focus groups took up some of these differing perspectives:

PARTICIPANT 62: I deal with plenty of hard cases such as people with AIDS, women who have been abused, women who have worked in prostitution. I accept them all and listen to them. But I can never ever accept someone who has worked with the occupation forces.

PARTICIPANT 68: In the past the normal consequence for a spy was to be hanged on a pole, but nowadays it is acceptable and people do nothing about it.

PARTICIPANT 65: I have an opinion in this particular issue and I am going to be honest. How you deal with such cases depends totally on the social status of that person's family. If this person—the one called "spy"—is from a poor, unknown, weak family, everyone simply turns against them. But if that person is from a rich, known family, no one hurts them. I mean, by all means, you are going to be dealing with the family of that person and not with him. It is not their fault that their family mem-ber became a spy, so why do you punish them? If the father is a spy, why should his wife and kids suffer? If a brother is a spy, why should his sis-ter suffer? This is an issue I must struggle with.

PARTICIPANT 62: You are just saying theories. No matter what, we can never deal with this category. (Participants 62, 65, 68, Nablus focus group)

The point of disagreement among the three participants was whether the family members of a person accused of collaboration should receive their ac-ceptance. They agreed that the person actually accused could not be helped.

Jamila said she does in fact work with family members, though, again, never people accused of spying or collaborating themselves. She hopes that her work with family members keeps them from resorting to any further collaboration with the Israeli military. Like many of the social workers we interviewed, Jamila said she views collaborating as a consequence of societal stigma. From this perspective, collaborating is an act of desperation that often follows when people are rejected by their communities, isolated from emotional and material supports, and left with nowhere else to turn. Jamila explained that it was difficult for her to work with these families because her brother was being held in an Israeli prison. "But I work with them," she said. "Now, the society does not accept the work with them, but I have to because it is my job. We have to help the family; we have to help the wife and children so that they do not get to the stage that the father got to."

Thinking again about her 20-year-old client, Amal also offered a pragmatic perspective: "That collaborator might have something that caused her to do it; she might also be a victim." She reasoned, as others did, that the Israeli military seeks out people who are susceptible to blackmail, with the most common example being people with substance use addictions. However, she reasoned, "I have to think of myself. . . . The minute you meet with the collaborator, the society puts a stigma on you." Although she said she would not work with the person herself, she offered that "this person, the collaborator, must find some agency to work with him under some legal coverage. Now, if I am legally protected, then I will work with him." Amal assumes that someone would find out if she worked with a person accused of collaborating. She acknowledges taking other risks in her work but does not trust that a client accused of collaborating will, or will be able to, maintain reciprocal confidentiality.

Several participants noted that although they depend on supervision and the informal guidance of their colleagues every day to navigate their work with clients, they had never before discussed work with clients who have family members accused of spying. After a few participants raised the issue themselves, we began asking others. Many of the participants we asked appeared surprised by the question, even though they said the concern is commonplace in their work. Amena covered her face, sighing: "When you asked me about the issue of acceptance and spies, I actually got goosebumps because I have never learned about this issue. I told you immediately there are no cases, but then I took my memory backward

and remembered the cases I worked with, but I was never given theories about such cases."

 Many of the social workers responded to our questions about the limits of acceptance with pained affect, suggesting that the edges of their empathy are also shaped by their own traumatic experiences with the Israeli military. They reasoned that these clients should have care somewhere but not with them and not in Palestine. Faida said she had referred cases of people accused of collaboration to other social workers, sharing that her brother was killed by Israeli soldiers:

> I know that a collaborator is a human, and I know that he might be a victim. I also know that his family members are victims and are not to be blamed for what this person did, but by all means I can never work with them. . . . I cannot work with them at all. These collaborators have hurt so many people, and they have helped in the assassination of many of our people. They have helped in the demolishing of many houses, and they have caused the Palestinians loss and great suffering. But I am frank, and I say I don't want to work with them and I cannot work with them. . . . At some stage I cannot play the acting role of accepting a client. I cannot simply sit and act out that I understand the client and accept him and at the same time feel inside like I want to kill him. That is why I should leave the cases of the clients I don't accept and transfer them to other social workers. I must be clear with myself. And I don't care if they say I am weak.

Faida and the others described safeguarding the confidentiality of these clients and providing referrals, though we did not encounter any social workers who said they had or would accept such referrals to work with people accused of spying and only a few said they had or would work with family members. If any of the participants do work with them, they likely rely on an even stricter compact of reciprocal confidentiality and did not feel prepared to discuss it with us.

 Principles of practice, we find, are deeply rooted in a vernacular ethics, which in the West Bank means that people accused of helping the occupation fall outside of the potential for care and acceptance. To refuse care in these cases, usually even to family members, points to the deeper struggle against the Israeli occupation. Social workers are organizing themselves within and through this vernacular ethical field to serve the current needs of their communities and a vision for the future Palestinian state.

DISCUSSION

These findings point to an always-emergent vernacular ethics, where "what matters most"—to draw again on the language of Yang and colleagues (2007)—comes to inform not only the local moral configurations of stigma but also how social workers engage in the appraisals and negotiations of ethics work and clinical activism. Stigmatized conditions and experiences are often unacknowledged or unnamed in Palestinian society, but social workers are tasked with addressing them with each other and their clients. Social work ethics begin to cohere within a diverse field of responses to challenges of acceptance and confidentiality. This vernacular ethical field takes shape under pressure, pragmatically, and dialogically.

These ethical processes on the ground emerge in our analysis as a central mechanism of localization of professional social work. It is up to direct practitioners to contend with the ethical questions they confront, often implicitly in conversation with and reinterpreting Islamic virtue ethics and professional ethical frameworks circulating more broadly. Rather than scholars and policy makers importing and adapting theory and research and passing it down to clinical settings, localization depends on direct-practice social workers negotiating the specific local valences of ethical issues as they confront them.

The vernacular ethical domain we are describing is likely not exclusive to Palestine. Even in places where social work ethical principles and standards are codified, such as in the United States, they must inevitably be translated, interpreted, and deployed within the contours and constraints of a local context.[12] Efforts to identify global social work ethics and universalizing perspectives on stigma fail to center how social workers negotiate ethical practice for stigmatized care on the ground and misunderstand local community mechanisms of moral organizing.

In Palestine, our findings show how stigmatized care takes shape against the community's moral struggle against the occupation. Beyond the client's presenting conditions or experiences, the social worker and the care provided often become stigmatized in themselves—not just because of the social worker's close proximity to people whose behaviors are rejected but also because the attempt to help them may be understood to signify

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12. See Smith's (2017) related study about how site-specific local knowledge informs practice in a residential treatment center in the midwestern United States.

the social worker's complicity with the occupation by extension. Vernacular ethics may have particular relevance in the interaction of stigmatized care and clinical activism when social workers and clients recognize a shared sense of precarity and struggle. Brodwin (2013) points to the instance of a practitioner's moral reflexivity as departing from the local to draw on farther reaching values, yet our findings also show a field of local, relational, and political contingency that cannot be easily parsed from an individual's questioning.

In this moral context, many of the uses of acceptance and confidentiality in Palestine demonstrate tactics of clinical activism. In a setting of highly coherent opposition to the occupation, social workers in Palestine often work to reframe stigmatized conditions and experiences in politically intelligible and empathic terms. Or, as many described it in the interviews, they work to see their clients as human. Clinical activism in this light involves an active renegotiation of who belongs within the society. In framing substance use as a traumatized response to the occupation, for example, Asma and her colleagues create a reintegrative framing, actively aligning the interests of their clients' recovery work with the antioccupation resistance movement. Similarly, Anwar, Basma, and many of their colleagues see patriarchal oppression and violence, including sexual assault of women and abuse of children, as supported by the occupation and serving its interests.

Nevertheless, in a competition for scarce material and emotional resources, clients facing stigma may be more often excluded from care. Although clinicians repeatedly exhort the need for acceptance of stigmatized clients, many shared cases where they questioned the worthiness of a client to receive care. Some expressed this ambivalence, for example, in relation to women engaging in sex work and people identifying as gender or sexual minorities. Participants discussed these clients with difficulty, uncertainty, and a range of outcomes, suggesting an unsettled and unsettling process of negotiating social work ethics in these types of cases.

The social workers make a sharper distinction regarding people accused of spying and collaborating with the Israeli military. In these cases the necessary outcome of denying care is unambiguous. These stigmatized experiences are seen as impossible to integrate. It is important to note, however, that with our study design we cannot determine whether any of these cases actually involved spying or collaborating. The accusation of spying may sometimes reflect a saturation of stigma. Ron Dudai and Hillel

Cohen (2007) point out, for example, that charges of collaborating are some-times made against people because they are thought to be vulnerable to extortion by the Israelis, such as gender and sexual minorities or people using substances. Or, they point out, it may be that these marginalized iden-tities and behaviors are viewed as "weakening the national struggle, thus inherently collaborationist by themselves" (Dudai and Cohen 2007, 44). Following this argument, the charge of helping the enemy may sometimes function as a catchall diagnostic for straying too far, a threat to a politics of solidarity. Our study design did not allow us to observe the nuances of these determinations. Regardless of the truth of the charge, it designates an exclusion from care. Even so, it is evident from the data that, as with other cases, contemplating refusal of care is often difficult and painful for the social workers, even when the outcome is certain, self-evident, and unavoidable.

The vernacular ethics of stigmatized care is shaped not only by what matters locally but also by political possibility. Palestinian social work-ers are reinterpreting and redeploying principles of acceptance and confi-dentiality to meet the current needs of their communities and what they imagine will be necessary for the future state. At the same time, their ef-forts are constantly restricted and undermined by the erosion of trust and the threat of violence from the occupation they live with alongside their clients.

LIMITATIONS

There are several limitations to this study. First, we did not interview cli-ents, so we do not know about their experiences of the social workers' at-tempts to show acceptance and hold their stories in shared confidence. Second, our study design depended primarily on the recollections and re-flections of participants, often about highly sensitive content. Our observa-tions in clinics helped us to contextualize and situate what participants chose to share, but in most cases this did not offer a means of triangulating specific findings. For this reason, we were sometimes unable to explore more detailed processes when they seemed self-evident to participants—for example, how they determine whether a client is spying. Third, as two of the researchers are known in the West Bank and associated with social work academia, some participants may have anticipated what they thought we wanted to hear. We attempted to minimize this possibility by asking

follow-up questions, conducting longer interviews and member checks, and spending informal time in clinics to develop more credibility with participants and a shared sense of investment in the research.

IMPLICATIONS FOR PRACTICE

This study found social workers already highly engaged in informal but productive ethical discussion, drawing on global social work ethics and models from abroad only indirectly and implicitly. Going forward, they may choose to formalize their processes for dialogue about social work ethics. After many of our focus groups, participants commented that the discussion felt similar to the ways they talk through problems each day with colleagues, but that it was also a relief to have dedicated time and space for focused reflection. Regardless of whether social workers in Palestine choose to codify a system of practice ethics, they will need to continue to engage, debate, and shape a dynamic vernacular ethics for it to be relevant and useful. University programs and agencies might support them by facilitating regular local consultation spaces. Ideas and differences could be shared across groups with a working document and larger gatherings to further ethical dialogue. Formalizing some of the processes for vernacular ethical exchange would, we suggest, offer institutional recognition for what social workers already inevitably do as a matter of course. It would also enlist them in a more active and intentional dialogue with each other and with scholars, administrators, and policy makers as they work to build the field.

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