Chapter 4
Ethical Psychological Practice with Geographically Mobile Individuals and Groups

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Abstract The chapter offers a detailed analysis of the competing interests evident in contexts of new settlement and other forms of geographical mobility, including conflicts that occur between the welfare interests of direct recipients of research and professional services, the interests of the communities to which they belong, employers' expectations, and the welfare of the wider community. It also analyses dilemmas confronting researchers and professionals who work with mobile populations, which relate specifically to the conflicting ethical responsibilities of autonomy, beneficence, non-maleficence and justice they hold toward direct recipients of these services. Contrasting models of cultural competence as a relevant, related ethical precept are also considered. The chapter then suggests a model of ethical reasoning and decision making in the form of *prima facie* duty theory, as well as some training models that might assist researchers and other service providers in learning to make responsible ethical decisions when ethical dilemmas such as those described above are present. Finally, the chapter identifies and analyses various types of distress, such as burnout, ethical distress and vicarious traumatization, which workers may experience when working with vulnerable, mobile individuals and groups, and it briefly describes some ways in which researchers and other service providers may inoculate themselves against, and deal with, such distress.

Keywords Vulnerable clients · Conflicts of interest · Ethical decision making · Professional distress

Abbreviations

APA	American Psychological Association
APS	Australian Psychological Society
CPA	Canadian Psychological Society

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This chapter considers some of the ethical challenges that confront psychologists and allied professionals working with individuals and groups of people who are contemplating, or forced to consider, leaving the community in which they are living *or* who are in between communities of residence *or* who are settling into a new community. The complexities of practice and accompanying ethical responsibilities are immediately evident in the mobility trajectory from the point of pre-departure (in many instances pre-flight), through the transit stage, which for some individuals and groups may last months or years and involve temporary relocation, to resettlement. Those complexities are further exacerbated by often competing legislative and other legal constraints and community norms through which psychologists must navigate in their efforts to practice ethically. Then there are questions about whose ethics apply – psychologists', other professionals' or service recipients' – and in what circumstances? It is also important to consider whether the nature of the practice involves research, community engagement, organizational development, or individual or group therapeutic services, not because one should apply different ethical standards when the nature of the practice changes, but because different forms of practice often involve different stakeholder entities, each of which may bring its own ethical prism and set of expectations to the service setting. Finally, but by no means exhaustively, different geographical, geo-political, local political, cultural, and community contexts in, and between, which mobility takes place may present psychologists with specific ethical dilemmas which must be resolved in the best interests of service recipients. Considering all these competing, often conflicting, circumstances, constraints, expectations, and vested interests, it is important for psychologists who practise with mobile individuals and groups to adopt and apply a philosophically defensible model of ethical reasoning and decision making.

This chapter is not designed to be an exhaustive review of research with mobile individuals and groups; nor does it attempt to provide a comprehensive ethical guideline for practitioners in these settings, which covers all of the ethical standards that one would apply in the normal course of practice. It looks instead at some of the competing interests that are evident in contexts of new settlement and other forms of geographical mobility, and it addresses some of the dilemmas confronting researchers and professionals who work with mobile populations, including cultural competence as a relevant, related ethical precept. It suggests a model of ethical reasoning and decision making in the form of *prima facie* duty theory, as well as some training models that might assist practitioners in learning to make responsible ethical decisions when ethical dilemmas are present. Finally, it discusses various types of distress that workers may experience when working with vulnerable, mobile individuals and groups, which could take the form of ethical distress, unresolved counter-transference and vicarious traumatization, and it briefly considers some ways in which they may inoculate themselves against, and deal with, distress.

By way of explanation, *practitioner* will be used to cover those who undertake work involving research, supervision, therapeutic, organisational or other consulting services for mobile individuals and groups. It is argued that the model of ethical reasoning and decision making and the conditional principles or duties that underscore ethical psychological practice apply equally to research, supervision, therapy and other forms of psychological consultations, although it is understood that specific standards of conduct may apply in these different types of practice. Use of the practitioner term is also inclusive of other allied professionals and researchers who may be mandated to practise in accordance with their profession-specific codes of conduct or research, but whose professional and research codes are principle-based. Research, supervision, therapy and other forms of professional consultations are labelled inclusively as *services*. Where appropriate, the terms *service recipient* and *parties to a service* respectively are used inclusively for patients, clients, research participants or supervisees, and for other stakeholders in a service.

Ethical Dilemmas of Service Provision

Competing Theories of Ethics

Selecting – or, more correctly, advocating for – a specific ethical reasoning and related decision making model in psychology is a fractious exercise. Formulation of professional codes of ethics, such as the American Psychological Association (APA, 2002), Australian Psychological Society (APS, 2007) and Canadian Psychological Society (CPA, 2000) codes, has drawn on principle, virtue, utilitarian, and normative ethical theory (Davidson, 2006). These different philosophical paradigms pose different, often contradictory, ethical questions (e.g., see Miner, 2006) about discernment of one's ethical responsibilities to individual service stakeholders, the profession and the community. Furthermore, while professional associations, research bodies, and licensing authorities may set, and insist on, minimum ethical standards for psychological research and professional practice, they cannot insist that practitioners think deontologically, characterologically, consequentially, or normatively when deciding the ethical course of action they must take in a given situation.

Even when different practitioners operate within an implicit ethical decision-making model (Ross, 1930), as opposed to a Kantian, virtue or utilitarian model, there can be disagreement about the order and importance of one's *prima facie* ethical duties to the parties to a service. For example, in the APS (2007) Code of Ethics the *prima facie* principles of respect for rights and dignity, propriety and integrity are equally weighted. The CPA (2000) Code of Ethics states that, while its four ethical principles of respect for dignity, responsible caring, integrity and social responsibility are equally weighted, in situations where there are conflicting responsibilities the principles should be weighted in that order, giving priority to interested parties' autonomy and related rights. Practitioners, therefore, are none the wiser because of these codes about whether, in a given situation, they should give priority to service recipients' autonomy, or to their benefit, or to preventing harm from occurring to them, or to maintaining strict professional boundaries with them. These dilemmas are evident in the different emphases that codes place on social action and other forms of advocacy, with some codes eschewing practitioners' engagement in direct advocacy on behalf of individual clients and other codes prescribing direct advocacy where the circumstances require that type of support for service recipients (Davidson, 2010).

Competing Ethical Responsibilities

Research ethics codes highlight a similar dilemma about the rank ordering of researchers' duties. The ethical guidelines for research practice published by the Refugee Studies Centre (2007) at the University of Oxford have listed eight broad principles (and 21 sub-principles) that should form the basis of researchers' relations with research participants, starting with (1) Protecting research participants and honouring trust, and ending with (8) Participants' involvement in research. The remaining principles cover concepts of harm avoidance, privacy and confidentiality, fairness, intellectual ownership, and autonomy. Additionally, the guidelines identify a number of responsibilities that researchers have to employers, sponsors, funding bodies, colleagues, their discipline, host governments and society in general. The guidelines state that researchers often deal with "competing duties, obligations, conflicts of interest, and with the need to make implicit or explicit choices between values and between the interests of different individuals and groups" (Refugee Studies Centre, 2007, p. 163), but they make the point that researchers "cannot resolve difficulties in a vacuum nor allocate greater priority to one of the principles over another" (Refugee Studies Centre, 2007, p. 172). Notwithstanding, resolving dilemmas without harming research participants and maintaining integrity are principles to which special reference is made.

Consequently, it is unsurprising that there is some disagreement about the rank order or ethical responsibilities among researchers who work with groups such as refugees and asylum seekers, internally displaced persons, poor communities, etc. For example, when writing about the confrontational nature of conducting research with people and communities from refugee backgrounds, Mackenzie, McDowell, and Pittaway (2007) maintained, in cases where researchers are witnesses to human rights violations and criminal acts of sexual and other violence, that "when a human being is in need and the researcher is in a position to respond to that need, non-intervention in the name of 'objective' research is unethical." (p. 316). Responding ethically in such circumstances, according to Mackenzie et al., may require direct intervention in the lives of research participants or associated parties, active moral protest against human rights violations, or direct assistance for victims or associated parties who wish to advocate on behalf of themselves or other victims. Furthermore, research which does not offer some form of benefit to vulnerable research participants directly through skills development, personal and community capacity building, improved social and health conditions, or changes to unjust public policies and practices, is unethical.

Mackenzie et al. (2007) acknowledged that giving priority to direct social action or other forms of advocacy designed to produce an immediate benefit and prevent immediate harm presents researchers with the difficult ethical dilemma of how to do so while showing respect for vulnerable research participants' rights to decide what *they* should or could do. Beneficent action that takes the form of direct assistance and non- maleficence in the form of direct harm prevention have precedence over the latter in the form of *do no harm* and may also have precedence over individuals' limited right to autonomy. In contrast, Núñez and Heyman (2007), who worked with undocumented Mexican new settlers in the United States, made a strong case for adoption of a stringent application of the *do no harm* rule and they prioritize this duty over the duty of beneficence. Their alignment of ethical duties was a clear reaction to the possibility of research participants' identities being revealed to authorities as a result of the inadvertent actions of the researchers and the realities of those participants being incarcerated and deported as undocumented new settlers. Weighing the immediate, direct risks to individual participants themselves of their engagement with the researchers against the potential benefits of the research for current and future hidden persons and groups remained an unresolved dilemma (Núñez and Heyman, 2007).

Ellis, Kia-Keating, Yusuf, Lincoln, and Nur (2007) examined restrictions that may be placed on refugees' ability to consent knowingly and voluntarily to research participation. Such restrictions on individual autonomy may result from limited comprehension of the process or activity for which the research is sought, cultural values that subjugate the rights of an individual to those of the collective, hierarchical cultural decision making processes, and learned political and bureaucratic subservience. Furthermore, individuals may be exposed to a range of social, cultural, financial, and new settlement pressures that place limits on their rights to decide about research participation and other types of service reception. As was also the case for Mackenzie et al. (2007), the community research experience raised for Ellis et al. (2007) the question about individual, collective and broader social costs and benefits of their research, therein again creating the dilemma between autonomy, immediate benefit, harm prevention, and making a contribution to the greater good. Both commentaries sought to resolve these ethical dilemmas through participatory engagement with the communities with which they worked. Mackenzie et al. argued that social action designed to benefit or prevent further harm to vulnerable participants, to be ethical, must be negotiated with those who stand to benefit or be harmed by the researcher's actions. This involves, where possible, obtaining participants' consent for the researcher to intervene, protest or provide advocacy support, as well as the consent required for the initial research activity or service delivery. Ellis et al. engaged the community leaders through establishment of community advisory boards and community meetings that provided members of the community with opportunities to participate actively in the research, have a thorough understanding of the research aims and objectives, understand how research outcomes may best be put to use, and volunteer as research participants.

The participative research approaches adopted by Mackenzie et al. (2007) and Ellis et al. (2007) are not inimical to the philosophy and practices of shared decision making in health and medical services (Dy, 2007; Patel, Bakken, & Ruland, 2008; Schauer, Everett, del Vecchio, & Anderson, 2007; Whitley, 2009). Shared decision making models of health care provide for mutual exchange of information between the practitioner and service recipient, and both parties deliberate jointly to reach a decision about the most suitable, preferred service option. The practitioner offers professional knowledge and opinions that demonstrate respect for the recipient's decision making capabilities and allow for expression of the latter's wishes before a mutual decision is reached. Although Ellis et al. considered the need to balance the competing ethical duties of respect for individual and collective rights, individual welfare, and the greater good, how such a balance might be achieved is never clearly evident or simple. Community engagement, collective decision making, and respect for the rights of individual service recipients do not always lead to service provision that is in the best interests of the collective as well as of individual recipients. The collective decision may also not be commensurate with best practice from the practitioner's perspective. In fairness to the efforts that Ellis et al. made to achieve balance between individual and collective good and harm, utilitarian models of ethics that search for such balance are philosophically flawed (Ross, 1930).

Blurring of boundaries between the role of researcher and the roles of professional advocate, personal advocate, and possibly even treating practitioner, in addition to calling into question the autonomy principle, also directly challenges the integrity principle. While the focus of Mackenzie et al. (2007) was on the ethical dilemmas arising from research with politically and economically vulnerable individuals and communities, similar dilemmas may be present for practitioners offering therapeutic and other consulting services. How should practitioners prioritise service recipients' rights to decide what they should or should not do, or who should decide and act on their behalf, beyond the immediate service being delivered, with the practitioner's imperative duty to bring about immediate good and prevent immediate harm? In other words, how might practitioners act ethically at all times toward the various recipients and other parties who have a stake in services being provided? How might practitioners proceed when it is clearly evident that individuals and groups with whom they work have limited opportunities to exercise their human and civil rights in circumstances where their rights to decide are compromised by political, legal or economic factors that are beyond their control (e.g., see Torczyner, 1991). At the very minimum, practitioners need to find ways of engaging service recipients in a linguistic medium in which they are fully competent and at a level that is commensurate with their educational experience. Practitioners should explain fully the possible, foreseeable risks and negative impacts that might result from recipients' participation in research and consulting services, including the possibilities that participation may be distressing and/or may have implications for their current sojourner status. If interpreters assist with service delivery, the practitioner should discuss informed consent documentation, processes and outcomes with the interpreter before the service is commenced.

Case Example – Dr N

Dr N and a team of doctoral researchers have been engaged in the development, implementation and evaluation of a comprehensive, community-based program designed to increase social inclusion and mental health status of women from refugee backgrounds. They have been working with a community organisation which represents the interests of specific ethnic groups, provides support for new arrivals and creates social networking opportunities for established citizens from those ethnic backgrounds. The team has been very careful to ensure that representatives of the organization have been involved in a meaningful fashion in program development and implementation, that the program has been explained thoroughly to organizational members and that organizational networks have been utilised as a means of recruiting women for the program. Agreed-on conditions for data collection, program evaluation and publication of findings have been negotiated with the community organisation and with individual participants, giving the organization and individual participants certain rights of access to evaluation data and rights of negotiation in deciding on the content of publications and the final report. In summary, Dr N and the team have made an earnest attempt to address their ethical responsibilities both to individual participants and to the cultural collectives with whom they are working. In the course of their research, the team becomes increasingly concerned about the incidence of intimate partner and other family violence in at least one of the cultural collectives and it forms the opinion based on patterns of family violence it observes that there is a high incidence of trauma-related psychopathology amongst male perpetrators of the violence. Its concerns are supported strongly by some women participants advocating for better personal safety for themselves, other women and their children. The team raises these welfare and safety concerns with office bearers of the community organization with the suggestion that the program be broadened to include community-based mental health assessment services and a treatment program for perpetrators. The office bearers, many of whom are male, unexpectedly voice their concerns about the possibility of members of the cultural collective being stigmatized as violent and prone to mental illness, and about the effect this might have on government support for immigration under family reunification provisions. The organization subsequently withdraws from the research partnership and vetoes the team's publication or reporting of its work. The team continues to receive support from some of the more vocal women participants, with whom it has worked, to publicize the need for family violence and child protection services.

Similar discrepancies between collective and individual consent may occur for other practitioners delivering community interventions. They may arise, as they do in this case example, from different perceptions of community members' safety, security and mental health needs (also see reported case studies by Kluttig, Owdenwald, and Hartmann (2009) and Savy and Sawyer (2008)) that link refugees' prior trauma with self injurious and other dangerous behaviour), but they might also result from community representatives' sensitivities about majority culture perceptions of ethnic and religious fundamentalism amongst members of ethnic minorities (e.g., Warne-Smith & Rintoul, 2009). Although not specifically related to mobility, what has become known as the Barrow Alcohol Study (Klausner & Foulks, 1982; Foulks, 1989) is a classic example of a serious disagreement between host community leaders and the researchers over reasons for observed, excessively high levels of dysfunctional behaviour (alcohol abuse) within the community and about which stakeholders' interests would be served by reporting the findings on community dysfunction. The disagreement resulted in repudiation by community leaders of the researchers' methods, findings and social motives (Davidson, 1999a). Balancing the interests of individual service recipients against those of the cultural collective and broader community to which they belong can result in a dilemma for practitioners.

Competing Levels of Responsibility

Practitioners may be confronted not only by the challenge of managing competing ethical responsibilities to recipients and other stakeholders to whom a direct service is provided, but also by a sense of duty to the wider community. At times those wider duties may appear to be incongruous with the practitioner's implied and stated responsibilities to service recipients and other direct stakeholders. Examples of these incongruities are evident in the literature. For example, English, Mussell, Sheather, and Sommerville (2005) reported on a number of medical rights and services issues involving asylum seekers and new settlers to the United Kingdom (UK), weighing up the individual rights of persons with physical illnesses to suitable and appropriate medical treatment against the greater good of, and the risks to, the host community, and against the impacts on the communities of origin of refusing UK residence. Sherr and Farsides (1996) also raised questions about risks of increased levels of HIV infection that might be linked to immigration, arrival of refugees and asylum seekers, and other mobile groups such as military personnel. How practitioners weigh up their responsibilities to service recipients against questions about what is in the best interests of their communities creates an additional level of ethical uncertainty. The danger here is that practitioners may be unduly influenced or restricted by normative false beliefs about, community opposition to, and systemic discrimination against local ethnic minorities and new arrivals (e.g., Davidson, Murray, & Schweitzer, 2008; Every & Augoustinos, 2008; Kushner, 2003; Pedersen, Clarke, Dudgeon, & Griffiths, 2005; Pedersen, Watt, &

Hansen, 2006). Practitioners need to engage critically with legislative and policy perspectives that may influence their practice and should eschew any racial or other forms of systemic discrimination against service recipients individually and collectively. Practitioners also need to bear in mind the power differentials that exist between the cultural majority and culturally different new arrivals when engaging with the latter individuals and groups (Chang & Groves, 2000). How to do so is not an easy question to answer, given the dilemmas discussed above between respect for autonomy vs. beneficence and non-maleficence, and between maintaining the integrity of the service relationship vs. mixing service with advocacy.

Those systemic expectations and pressures are potentially greater in circumstances where practitioners work as employees or consultants for public sector agencies that provide services for, or process, new arrivals. Coffey (2006) has elaborated on the ethical dilemmas that arise in service settings, such as immigration detention centres, which are not conducive environments for providing assessment and treatment services for new arrivals who, in very many instances, have been traumatized by their pre-flight and flight experiences (Ager & Ager, this volume; Miller, this volume). Coffey also examined some of the dilemmas that arise in situations where practitioners provide services for multiple service recipients and/or at the request of third parties, where one of the service recipients is the person being assessed or treated and another is the employing/contracting agency. In the case of immigration detainees, the employing/contracting agency is established or sanctioned by legislation with a mandate to act in the best interests of the host community. Coffey quite reasonably questioned whether practitioners who have ethical and professional responsibilities first and foremost to direct service recipients, i.e., those being assessed or treated, must give undivided loyalty to employers whose job it may be to implement legislation and apply public policy in ways that are supposedly for the greater good. In these circumstances, practitioners need to consider carefully how they might respond when organizational arrangements require them to work under conditions that reduce the effectiveness of service delivery, and they should support the implementation of alternative models of service delivery, such as separating the roles of immigration agency contractors from health contractors who provide the services in agency facilities (Fazel & Silove, 2006; see also, Ager & Ager, this volume). It also means working to ensure equitable access to quality services, as well as developing new models of service delivery to match services to the needs of individuals in those settings (Ager & Ager, this volume; Hernández-Plaza et al., this volume; Kelaher & Manderson, 2000).

Similar conflicts of interest may occur in the conduct of cross-cultural research and other practices where the ethical standards to which practitioners are expected to adhere by research ethics committees, organizational ethics committees, and/or professional associations are totally at odds with local government, local organizational, or community standards. Davidson (1999a) highlighted a number of instances where research was terminated or ended acrimoniously, or should not have proceeded, because researchers were confronted by conflicts between self-imposed and systemic ethical standards to which western research is expected to adhere and different cultural expectations and standards applied by government agencies and community organizations. Both the delivery and the withdrawal of services, depending on the circumstances, may have equally serious, even fatal, consequences for direct service recipients. In these situations where second-culture bureaucratic and local community expectations are in conflict with established ethical practice standards, practitioners have to find ways of negotiating questions like who should decide which standards have precedence and how disputes about whether a particular aspect of practice is ethical should be resolved. Christakis (1992) suggested that practitioners and other-culture host communities confronted with these dilemmas, instead of seeking to remove the conflict, should seek to negotiate a course of action that allows the service to proceed because it satisfies each of the parties' minimum standards and expectations and sets tolerable expectation about the risks and benefits associated with the service. Such a negotiated outcome would normally involve some modification to the services that were originally sought and/or proposed.

Depending on the nature of the research or professional service, some practitioners will be confronted by the dilemma between acting in the ethical best interests of direct service recipients and acting according to the law. The work of Núñez and Heyman (2007) with undocumented Mexican new settlers to the United States, described above, and research by Cwikel and Hoban (2005) with trafficked sex workers are two recent examples of research contexts where lawful responsibilities as a practitioner and a citizen may directly contravene the practitioner's ethical responsibilities to service recipients or, in certain circumstances, render the service totally impractical. The same dilemma applies in relation to any service that involves working with individuals or groups involved in illicit activity, such as illicit drugs, welfare fraud etc. The dilemma is mainly manifest in three ways. There is the question about whether the practitioner is legally obligated to report illicit activity or has an obligation under workplace policy to report. Legislation and workplace policies requiring mandatory reporting of criminal or other illicit activity, at least in Australia, vary from jurisdiction to jurisdiction; except in very specific instances, practitioners are not legally obliged personally or professionally to report criminal activity (Davidson et al., 2010). Respect for service recipients' autonomy, as it is exercised in the form of rights to privacy and confidentiality, therefore, is the norm rather than the exception. Even if the practitioner is not legally obliged to report illicit activity or if the activity in question is not so morally repugnant as to cause the practitioner as a citizen to report it (e.g. as one might report sexual exploitation of minors even if one is not mandated to do so in one's jurisdiction), there is the question about whether participants' engagement with the service itself exposes them to the risk of detection (see Núñez & Heyman, 2007). Thus, the dilemma between providing a service that on the one hand potentially benefits recipients immediately, or benefits them and others like them in future, or has long-term benefits for the community at large, and on the other increases the risk of immediate harm for participants is apparent. Finally, as Cwikel and Hoban (2005) indicated, in situations where practitioners are working with recipients and other parties who are both operating outside of the law, reporting illicit activity might not only be impractical or impossible but, at times, might be downright dangerous.

Case Example – Dr S

Dr S works as an organizational psychologist providing consulting advice and organizational research for small scale commercial manufacturing and retail companies. Dr S is contracted by a well-known local clothing manufacturer with the request that she develop some recommendations for improving workplace efficiency. Her initial investigations identify a number of factors that appear to be influencing productivity including, on the negative side, higher than expected absenteeism in the on-site mass cutting department but, on the positive side, efficiencies in the assembly of clothing parts, which is done off-site by contract workers, to whom the factory delivers clothing parts. Outsourcing of the assembly process has been found to be much more cost-efficient than centralized assembly of garments, both on a per unit basis and because of the reduced factory space required. Further investigations reveal that the majority of contract workers who perform the cutting process off-site are from a particular cultural collective and that some of the off-site contract workers appear to be employed in breach of their overseas student and tourist visa conditions; a small number of them appear also to be in high school. In response to further questioning it becomes clear that the large proportion of those whose work status is questionable rely heavily on the income to pay the weekly bills. Dr S has committed herself contractually to a commercial-in-confidence reporting process, but she is concerned about whether her knowledge of, and inaction on, these apparent immigration breaches might affect her licensing as a psychologist and her reputation as an organizational consultant, and she is concerned for the wellbeing of the minors who appear to be working alongside adults on these assembly lines.

Similar issues to those encountered by Dr S may arise for researchers studying new settlement, acculturation, work practices, educational attainment, etc. of ethnic minorities or for research and professional practitioners who, in the course of their work, encounter illicit activity in the sex work, trafficking or migration industries (e.g., Cwikel & Hoban, 2005; Goździak & MacDonnell, 2007; Núñez, & Heyman, 2007). The study by Xin (2005) on work license exchange and rental amongst Chinese rural new settler workers emigrating to live and work in Beijing offers an interesting case example of complicity between local authorities, local law enforcement and new settler workers. Acting in a trustworthy manner to maintain confidentiality may compete with one's sense of lawfulness and the duty to prevent harm occurring to service recipients. I return to this case example in the subsequent discussion of a decision-making model.

Whose Ethics?

Mobility research has highlighted distinctions between the push and pull factors that motivate voluntary and involuntary new settlers to leave their homelands. Not all geographically mobile individuals or groups experience personal safety and security threats or political, cultural, or economic vulnerabilities. At one continuum extreme are individuals and families who flee their homelands within hours of determining that their lives are in grave danger. They often do so with fewer financial resources, less social support, no systemic support, less language training, and less intrinsic motivation on which they can fall back in the resettlement phases. At this end of the mobility continuum, motivation and circumstance may act as indicators of specific psychosocial and mental health needs (Davidson et al., 2008). Voluntary new settlers often attracted by the possibility of improved financial and social opportunities in a chosen host country are at the other end of the mobility continuum.

Two interesting ethical dilemmas emerge from the mobility research literature on the latter groups who are enticed, or eager, to relocate within their country of origin or to another country. The first dilemma emerges from "have" communities and countries that "want more" in the form of trained, qualified professionals. Inducements for trained health professionals from remote rural and low socio-economic communities or countries to relocate to large, higher socio-economic population centres give cause for questioning the morality of providing enticements and incentives that serve further to disadvantage already underserviced communities and cultures (Chen & Boufford, 2005; Connell, Zurn, Stilwell, Awases, & Braichet, 2007; Gadit, 2008; Little, 2007). The circumstances of this type of mobility are often that health professionals have been trained in large, higher socio-economic population centres or in overseas countries and are then actively courted by the host community or country to bolster the local workforce (Dauphinee, 2006). The ethical dilemma is one for educators, researchers and other health professionals who, in the course of training, supervision or research services they provide, may not encourage potential new settlers to examine all of the moral ramifications of not remaining in, or returning to practice in, their home communities. The moral debate for host professionals is about beneficence, non- maleficence and justice. The dilemma for potential new settlers is about these *prima facie* duties as well as fidelity (their informal contract with their home community or country) and their own freedom of choice. Questions about "fair, good, or bad for whom" need to be asked, therefore, about the morality of campaigns designed to attract skilled new settlers, as well as about campaigns that are designed to discourage asylum seekers and other undocumented new settlers (Nieuwenhuys & Pécoud, 2007).

There are related ethical concerns arising from local and international mobility of health practitioners where different ethical practice standards exist in different state jurisdictions and in different countries. How might national professional associations and related licensing authorities deal with practitioners' disparate ethics training when certifying practitioners who have been trained in other cultural contexts? One suggestion put forward occasionally is that ethics needs to be discursive in order to take account of cultural and other contextual differences in professional values. A more compelling approach is for national professional associations to collaborate in order to develop international standards for professional practice. This approach has received considerable support in recent years (International Federation of Social Workers, 2004; Pettifor, 2007; Sasso, Stievano, Jurado, & Rocco, 2008).

Competing Constructions of Cultural Competence

The concept of culturally competent practice has been explored extensively under the rubric of (a) *knowledge* about service recipients' cultures, including an appreciation of their social and cultural circumstances; (b) *awareness* about one's own attitudes and beliefs about their cultures, and appreciation of the impact of one's practice style on recipients' progress; and (c) *skills* of self-monitoring, communication, and counselling – a framework that reflected ethical debate about and empirical research into the precept (see Davidson, 1999b; LaFromboise, Coleman, & Hernandes, 1991; Ponterotto, Rieger, Barrett, & Sparks, 1994; also, Carr, Chapter 7 this volume). Each of these dimensions of cultural competence can be codified further into specific practices. Fowers and Davidov (2006) have argued that multiculturalism, expressed in terms of cultural competence, is a virtuous pursuit in the Aristotelian sense. The aim of being culturally competent is to bring about good for others, whilst eschewing the negative influences of racism and prejudice. Such competence fosters the virtue of openness to difference and otherness; it underscores the acquisition of practical wisdom, and it extols courage in the form of actions that are designed to bring about fair, just and beneficial outcomes for others. The endgame of analysing culturally competent practice is to: acknowledge value differences between the practitioner and service recipient where values may be incommensurate but equally fundamental and correct; understand social and cultural variations in behaviour; and exploit value conflicts and situational variations that strengthen rather than weaken the alliance between practitioner and recipient. This approach opens the door for prescribing conduct and practices that are universally acceptable and proscribing conduct and practices that are always culturally unacceptable, resulting in standards of practice to which both practitioners and recipients subscribe.

While cultural competence may be defined in different ways and while each definitional approach has its limitations, there is continuing support for the view that cultural competence embodies all three awareness, knowledge, and problem-solving skills dimensions (Sue, Zane, Hall, & Berger, 2009). Those dimensions of competence are articulated succinctly in the American Psychological Association (APA, 2003) guidelines on multicultural practice. Along with the APA (2002) code of ethics they also underscore that Association's ethical standards for research with ethnic minority young people (Fisher et al., 2002). Placing emphasis on the problem-solving skills dimension of cultural competence suggests that practitioners can learn to be culturally competent. Placing emphasis on the cultural knowledge dimension suggests that practitioners, having such knowledge and experience, can be culturally literate in the recipient's and in their own culture. Culturally literate practitioners with culturally appropriate problem-solving skills are capable of: having culturally appropriate and relevant communications with others; understanding others' needs; selecting suitable interventions to address those needs; selecting and administering culturally sensitive forms of assessment (Ridley, Hill, & Wiese, 2001); and ensuring that appropriate emphasis is placed on individuals in the family and community contexts from which they come. Nevertheless, Sue et al. (2009) acknowledge that the models of cultural competence have focused primarily on the practitioner – recipient dynamic mainly to the exclusion of institutional and systemic factors that influence service delivery. Vera and Speight (2003), in contrast, maintained that culturally competent services alone are insufficient demonstrations of practitioners' social responsibilities. They argued that social responsibility is only fully exercised within a transformational framework that is committed to systemic changes through social policy reform, designed to give greater emphasis to distributive justice than to autonomy, and to emancipate people and communities from social, economic and political oppression. They also argued for the adoption of a broad definition of the term "cultural" to encompass a range of social and lifestyle differences. Vera and Speight's construal of social justice is similar to Prilleltensky's (1997) notion of *emancipatory communitarianism*, and regards social action in the form of advocacy as an essential component of social responsibility (Hernández-Plaza et al., this volume). Prilleltensky (2008) has continued to champion the need for a *transformational* psychology committed to types of research and practice that have the express purpose of changing socio-political structures which perpetuate the iniquitous exercise of political power. All psychological research and practice, according to Prilleltensky, should therefore be *psycho-political*, or power-focused, when it comes to the question of enhancing individual and collective wellbeing.

Ethical Reasoning and Decision Making

Practitioners conducting research with, or providing professional services for, mobile individuals and groups may be confronted in the course of their research or service delivery with a number of ethical dilemmas. There is the question about whether their professional code of ethics provides them with clearly stated and ordered ethical principles as the basis for ethical reasoning and decision-making. Even when the relative stringency of principles is stated, applying those principles in specific circumstances, in which service recipients' autonomy may be further eroded in order to prevent direct harm occurring or effecting some direct benefit, presents as a dilemma. There are often multiple stakeholders to whom the practitioner is answerable ethically and professionally, each of whom may have competing, vested interests in the service outcome. In some instances, there are systemic responsibilities placed on practitioners. Those practitioners must balance responsibilities to direct recipients of their services with responsibilities to employers, third-party payers, and the public at large. In certain situations practitioners may be faced with the challenge of meeting their ethical responsibilities to direct service recipients at the expense of acting illegally, or disregarding service recipients' illicit activities that are arguably not in the public interest. Finally, being culturally competent may require practitioners not only to demonstrate appropriate, expert knowledge, skills and attitudinal predispositions, but also to embrace a social advocacy role with a view to changing discriminatory laws, policies and practices. The potential for conflicting principles of autonomy, justice, beneficence and non-maleficence and the negative impacts on service recipients of a wrong decision by practitioners are greater in instances when individuals or groups are displaced, their personal safety and security are threatened, or they are politically, socially and economically depowered. How might practitioners chart a way through these ethical dilemmas? The next section will explore a model of ethical reasoning and decision-making that considers ethical duties to be conditional duties and suggests an alternative priority ordering of duties that may assist practitioners to negotiate some of these ethical pitfalls.

Theory of Prima Facie Duty

The theory of *prima facie* duty (Ross, 1930) is offered as a basis for ethical decision-making in service settings where the practitioner has obvious, competing ethical responsibilities such as respect for autonomy, beneficence, non-maleficence and justice toward an individual service recipient, and/or toward service recipients collectively, and/or toward service recipients as well as other parties. Those ethical dilemmas are often present, as we have seen, if one is working with geographically mobile individuals and groups who may be personally, economically, legally or politically vulnerable.

Ross's ethical theory of *prima facie* duty was a reaction against the prevailing ideal and hedonistic utilitarian approaches of his time. It is based on deontological principles, but it differs from Kant's views of perfect duty in a number of ways. *Prima facie* duty theory maintains that "moral intuitions are not principles by the immediate application of which our duty in particular circumstances can be deduced" (Ross, 1939, p. 84). On the contrary, they are *considered* judgments about how one should act in a particular circumstance rather than judgments that are predicated on a fixed priority of ethical principles. It is as a result of this difference that Ross is regarded as an intuitionist (Dancy, 1991). This is not intuitionism in the form of pre-rationalism that Kitchener (1984) described. (Kitchener contrasted *prima facie* duty theory with intuitionism calling the former "principle theory". Her description of the latter may be more correctly labeled "subjectivism", but her theory of conditional duty is akin to Ross's theory of *prima facie* duty.) Second, Ross's theory makes a clear distinction between judgments about rightness and judgments about goodness. He maintained that rightness and wrongness are terms that refer to what we do, and that what we do should be the basis on which ethical judgments should be made. The confusion between goodness and rightness is dispensed with if a "rigid distinction between [what is] right and [what is] morally good" is maintained (Ross, 1930, p. 156). By clarifying this distinction, Ross's theory helps us to distinguish between our knowledge of a morally good principle, such as caring for another person, and a wrong act, such as failing to exercise due care for another in a given situation.

Ross regarded moral duties as coextensive and conditional, rather than as duties of perfect obligation. All duties are *prima facie*, meaning they are "conditional" (Ross, 1930, p. 19).

> When I am in a situation . . . in which more than one of these *prima facie* duties is incumbent on me, what I have to do is to study the situation as fully as I can until I form the considered opinion (it is never more) that in the circumstances one of them is more incumbent than any other; then I am bound to think that to do this *prima facie* duty is my duty *sans phrase* in the situation (Ross, 1930, p. 19).

Right acts, therefore, are those that are based on a consideration of all of the moral ramifications of acting in such a manner in a particular situation, and which result in discharging in one way or another one's *prima facie* duties relevant to the situation.

Ross (1930) listed seven conditional duties of fidelity, non-maleficence, beneficence, reparation, justice, gratitude, and self-improvement. To use one of Ross's often-cited examples of coextension and conditionality,

> It may be said that besides the duty of fulfilling promises I have and recognize a duty of relieving distress, and that when it is right to do the latter at the cost of not doing the former, it is not because I think I shall produce more good thereby but because I think it is the duty which is in the circumstances more of a duty. This account surely corresponds much more closely with what we really think in such a situation (Ross, 1930, p. 18).

Notwithstanding, Ross's theory also offers some indications about the stringency, or priority ordering, of conditional duties. All other things being equal, fidelity, i.e. keeping promises, has primacy over other *prima facie* duties. Ross argued that the consequences of breaking a promise in order to discharge another duty to the person to whom the promise was made, or to other persons, would have to outweigh considerably the consequences of keeping the promise and not discharging those other duties if the former course of action is to be contemplated seriously. Ross also argued, other things being equal, that the duty of non- maleficence, i.e., not causing harm to another, is more of a priority than beneficence, or making a person's condition better.

In order to discern our actual duty, i.e., how we *will* act, we must apprehend our *prima facie* duties to all parties and the likely consequences of fulfilling those duties in a particular set of circumstances. Then, prior to selecting our course of action, we must consider the consequences of those acts in relation to our other responsibilities and the consequences of fulfilling or not fulfilling them. Not to act in a manner that subsequently fulfills those *prima facie* duties to all parties, by Ross's account, is wrong. Therefore, a series of acts may be required in order for us to discharge all of our duties in the circumstances.

In Ross's theory, the foundation of any *prima facie* duty is the relationship between the actor and the concerned parties. Therefore, one's duty is determined by one's role *vis a vis* others. For example, one's *prima facie* duty of fidelity resides "in the relation of promisee to promiser" (Ross, 1930, p. 19). Practitioners' *prima facie* duties have as their foundation the morally significant relationship in which service recipients stand to them. In this respect Ross's theoretical framework focuses attention on the quality of service provider – recipient relationships. It is therefore an approach that requires practitioners to apprehend their conditional duties and contemplate their actual duties in respect to each service into which they enter or in which they are implicated, whether the situation presents the practitioner with ethical dilemmas or not. Those duties might be implied in the psychological contract (Schalk & Roe, 2007) between practitioners and service recipients or they may be stated explicitly in the research and other service agreements that practitioners negotiate individually or collectively with service recipients.

Davidson (2006) has suggested a step-wise system of ethical reasoning incorporating Ross's theory of *prima facie* duty. The first step involves an analysis of one's implicit and explicit promises toward direct service recipients. Implicit promises are inherent in the practitioner's psychological contract with the service recipient and explicit promises are contained in the service contract or agreement. Other ethical responsibilities to those recipients are then identified. Promises and other ethical responsibilities to other parties are identified. Fulfillment of specific ethical responsibilities to a party at the expense of not fulfilling another responsibility to that party or to other parties is then considered in the immediate circumstance and a decision about how to proceed is made, keeping in mind that fidelity (keeping promises) is a more stringent responsibility than non- maleficence, which takes priority over beneficence. Where the practitioner is unable to discharge a responsibility to a party, the responsibility is simply not negated but reparation must be made in order for it to be discharged. Davidson (1999a, 2006) argued that this approach to ethical decision-making, in which responsibilities can never be duties of perfect obligation, is equally valid for research and professional practice; has clear advantages over virtue, utilitarian, and discourse theories of ethics; and is not incompatible with professional models of ethical decision-making that incorporate an assessment of the legal and professional issues relevant to the circumstances and knowledge of relevant professional codes of conduct.

The initial implication of applying Ross's theory of *prima face* duty is that practitioners must be extremely careful to clarify the specific promises they make to all parties to a service and also to clarify what others may wish of the practitioner. Practitioners should not make promises they are unlikely to be able to keep or condone misimpressions of what they are able to deliver (see Cwikel & Hoban, 2005). Not to keep a promise is a wrong act and, therefore, is unethical.

In the case example above of the organizational psychologist, Dr S, the practitioner may avoid the ethical dilemma between maintaining commercial-in-confidence commitments, acting lawfully and exercising a duty of care to school age employees if, before commencing the service she has an accurate understanding of the ethical and legal limits of confidentiality, including legal requirements to report alleged criminal activity and suspected child exploitation (Davidson et al., 2010). Accurate knowledge of these issues should assist in drafting a commercial-in-confidence agreement with specified limits placed on confidentiality and a detailed statement of responsibilities to the company and to individual employees and other stakeholders to whom she owes a duty of care. Mechanisms for resolving issues arising from conflicting responsibilities to the various parties to the service and from differing perceptions of parties' interests and findings should also be specified in the contract. The "game plan" should be one of "no surprises", so that considered action results in the fulfillment of responsibilities to all stakeholders. Similar, careful contractual engagement is required between Dr N's team of doctoral researchers and the local community organization and individual women refugees involved in the social inclusion program. Although in that situation Dr N's team could possibly continue its work with the support of women participants if its agreement with the organization breaks down, the research team will need to be aware of possible future risks of harm to women who continue to collaborate with the researchers; therefore, there should be a duty of care clause as a reason for discontinuing the program in research agreements with individual participants.

Professional Development and Self Care

A variety of approaches to ethics education and training of health practitioners can be found in the research literature, including informal, vicarious supervision, formal training in moral philosophy, case study, role play, and code-based training (Davidson, Garton, & Joyce, 2003). Except for the informal approach, all of the other approaches have been shown empirically to improve trainees' ethical knowledge and reasoning, although there is evidence that interactive approaches such as critical incident analysis and role play are more effective, and perceived by students as such, than didactic approaches (Pettifor, Estay, & Paquet, 2002). Approaches that combine some formal education in the philosophical underpinnings of ethical reasoning with code-based education and/or experiential approaches involving critical incident and case analysis or role play have been shown to be more effective than lecture-only and code-based-only approaches (Davidson et al., 2003); these hybrid models are suggested in situations where practitioners are seeking further training and professional development in professional and research ethics.

However, Ross's (1930) *prima facie* duty theory imposes an additional, vitally important constraint on ethical reasoning and decision, which is not readily resolved in the context of critical incident and case analysis or role play. It has to do with the requirement that "what I have to do is to study the situation as fully as I can until I form the considered opinion (it is never more) that in the circumstances one of them is more incumbent than any other" (Ross, 1930, p. 19). In order to decide on the ethical course of action, practitioners require a more detailed appreciation of "the circumstances" than is normally offered in an ethical vignette or critical incident analysis. They require detailed knowledge of the expectations held by all parties to a service and the exact nature of the promises they have made to those parties. They must also be skillful in applying a comprehensive model of ethical decision-making that accounts for the nature of any issues or dilemmas, their ethical code of research or practice, related ethical guidelines and advice statements, legal and organizational responsibilities and, finally, scholarly accounts of related dilemmas. First and foremost, practitioners who conduct research or provide professional services in situations where ethical dilemmas are likely to arise on a regular basis should establish and maintain professional supervision relationships with other experienced, senior practitioners who are suitably qualified to offer independent opinions on the dilemmas confronting the practitioner and the latter's proposed course of action. Although professional practitioners are normally expected to establish and maintain professional supervision relationships (e.g., see Australian Psychological Society, 2007), this is normally not a core requirement for research ethics approval. Researchers working with mobile individuals and groups and, in particular, with research participants who may be at risk of harm as a result of their political, social or economic circumstances, are strongly advised to seek peer supervision from an experienced, independent senior researcher.

Despite the best efforts of practitioners to improve ethical decision-making in the context of their particular aspect of practice, and maintain peer supervision relationships, there is still the prospect of practitioners being distressed when they witness recipients of their services being harmed or being at risk of harm by other parties. That distress may take a number of forms. Practitioners may experience distressing thoughts and accompanying emotional reactions that arise in situations where they know what the right thing to do is but where they are constrained or coerced into following a less right course of action, i.e., they are compelled legally, professionally, politically or financially to their own detriment psychologically into acts or omissions that they consider unethical or immoral. This type of distress, known in the literature as ethical or moral distress (Jameton, 1984), has been examined extensively in other areas of health and medicine but is only just starting to be recognised as a source of distress for psychologists. It is a relatively unexplored concept in research. The symptoms associated with ethical distress include anger, frustration, guilt, depression, anxiety, intrusive thoughts and dreams, sadness, or a sense of worthlessness or helplessness. Recent research into ethical distress suggests, if distress symptoms are carefully managed, that mastery of the distress may lead to a sense of empowerment and moral growth (Hanna, 2004).

Repeated experiences of ethical distress may result in emotional exhaustion, commonly known as burnout. However, burnout may also be a consequence of overwork or of engaging in emotionally taxing work over a long period of time. Symptoms of burnout include perceived lack of control over one's workload, a sense of helplessness or hopelessness, physical exhaustion, irritability with clients and colleagues, objectification of work relationships, reduced work satisfaction, and body pains. Both ethical distress and emotional exhaustion have been associated with job dissatisfaction and reduced workforce retention.

If distress symptoms of ethical distress are not managed successfully, practitioners may enter a second, reactive distress phase in which the emotional, other psychological, personal or professional consequences of distress are exacerbated. According to Ross's *prima facie* duty theory, the unfulfilled duty causing the distress still remains. It does not cease to be a duty simply because one is prevented from acting ethically in the circumstance. Taking steps to make amends for not fulfilling a duty may relieve distress symptoms.

Case Example – Dr X

Dr X has entered Australia on a visiting scholar's visa. He is conducting research with newly-arrived refugees and asylum seekers funded in part by a fellowship given to him to conduct a comparative study of the impacts of refugee processing schemes on refugee wellbeing in his own country and Australia. The obvious major difference between the two systems at the time of his work is that all unscheduled new arrivals in Australia must undergo mandatory detention in an immigration detention facility while their claims for asylum receive an initial assessment, after which claimants may be awarded a temporary residence visa while further assessment of their claims occurs – or be deported.[1] In the course of his clinical work with temporary visa holders, Dr X assesses an asylum seeker (A) who, in his professional opinion, has been severely traumatized prior to and after fleeing a local armed conflict in A's country of origin, including the experience of mandatory immigration detention. These traumatic experiences have precipitated a number of psychotic episodes during which A was judged to be at serious risk of harming himself or others. A carefully planned medication regime and cognitive intervention have been successful in bringing about symptom reduction; however, A is assessed as being at high risk of relapse if the therapeutic interventions are removed. Dr X becomes aware that A's application for a humanitarian visa has been rejected and that A is to be deported pending an appeal of the decision. He is aware that A will not receive the level of care required if A is returned to his country of origin, and Dr X notices a significant deterioration in A's mental state following receipt of the tribunal decision. Along with some other concerned professionals, with A's permission Dr X advocates on A's behalf with immigration officials for a reversal of the decision, to be informed that he may be overstepping his visa conditions and possibly violating his fellowship agreement. Dr X is very distressed not only by the decision meted out to A but also by the bureaucratic and legal limits on the influence he is able to have as a professional acting in the best interests of his clients.

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[1] Australian immigration policy and legislation relating to universal mandatory immigration detention was altered in 2008 to make mandatory detention a last resort in cases of unauthorized persons who represent a health, identity, safety or security risk or who repeatedly violate their visa conditions.

There are various other strategies for managing ethical distress, which include on-going peer supervision with an experienced senior practitioner, sound knowledge of relevant codes of ethics and practice, and skillful use of a comprehensive model of ethical decision-making. Practitioners for whom ethical distress is a real possibility need to develop skills for self-monitoring; they need to examine their own personal values; they need to build and maintain a supportive network of collegiate relationships; and they may need to seek personal therapy. Dr X successfully resolved his ethical distress by studying the code of ethics, consulting with an experienced, senior colleague, and analyzing his motives for engaging in direct advocacy that was beyond the original clinical research service offered to the client.

Symptoms of burnout may be relieved by careful examination of one's personal values, finding a balance between work and other activities, fostering collegiate relationships, taking vacations, valuing friends and family support networks and personal therapy. Similar etiologies, symptoms and management strategies are apparent where practitioners may be traumatized vicariously by hearing service recipients' accounts of their ordeals or where the practitioner is vulnerable to counter-transference with vulnerable recipients (Freed, 2005; Thompson, 2003).

Conclusion

Practitioners who conduct research with, or provide professional services for, mobile individuals and groups are likely to encounter ethical dilemmas that arise from their competing ethical duties to direct recipients of their research or professional services and/or to other parties to their work. They may encounter circumstances where their ethical duties are in conflict with the law, or with organizational policy, or with the codes of ethics or practice by which they are bound professionally, or with public interest. They may be tested by the tension that exists from time to time between being a competent practitioner and being a social advocate. In these circumstances it is important that practitioners: have a detailed appreciation of the ethical issues with which they are likely to be confronted; have recourse to a comprehensive model of ethical reasoning and decision-making for managing competing ethical duties; are experienced practitioners of the model; seek peer supervision from an experienced, senior practitioner; recognize the symptoms of distress they may experience when working with at-risk individuals and groups; and deal effectively with their own symptoms of distress. Practitioners at all times should bear in mind that "success and failure [to fulfill an ethical duty] are the only test, and a sufficient test, of the performance of a duty" (Ross, 1930, p. 45).

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