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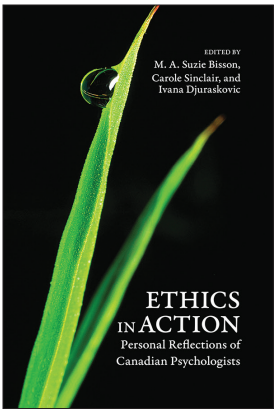

ETHICS IN ACTION: PERSONAL REFLECTIONS OF CANADIAN PSYCHOLOGISTS

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Ethical Challenges for Psychologists Conducting Humanitarian Work[1]

Nicole Aubé

Is it possible to maintain ethical standards while working on humanitarian missions?

Humanitarian work for psychologists, although personally fulfilling, is also full of professional challenges. While working with Médecins Sans Frontières on a number of missions, I was confronted regularly with ethical dilemmas that at times allowed for adaptive solutions but at other times remained persistent and unresolved. The key objective of this article is to review the types of ethical challenges that psychologists face when they are involved in humanitarian work on a mission. These challenges are presented in light of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2000).[2] To achieve this objective, the article offers real-life examples to illustrate some of the dilemmas the humanitarian worker has to face. The examples include how certain solutions were attempted, which might have been quite different if applied in the Canadian context at home.

Recently, a vast number of humanitarian crises have engaged the energies of international aid organizations, also referred to as non-governmental organizations (NGOs). These NGOs provide health care and support for physical and psychological needs to populations suffering from human-made or natural disasters. Little research has been done on the ethical challenges encountered by medical and nursing professionals participating in humanitarian aid work, and even less is available on the specific challenges faced by psychologists on a mission.

The involvement of psychologists in humanitarian missions is a fairly new concept. Médecins Sans Frontières was founded in 1971 after the Biafran famine by a group of French physicians and journalists; however, it was only in the late nineties that mental health workers were systematically recruited as well. A main target of mental health worker assignments was dealing with the sequelae of rape.

Rape tragically has become a weapon of war; an attempt to create disequilibrium. In recent years, this has applied to African countries such as the Congo, Sudan, and even more close to home, now in Haiti. Such a situation creates a role for mental health workers that goes beyond mere medical crisis management.

Psychologists' work on a mission can be quite varied. To provide a context for understanding the inherent ethical challenges, below is a list of the types of work I was engaged in; namely, when working one-on-one with patients:

- Identify target groups needing psychological services.
- Set up a triage system to assess and respond to needs.
- Assess available psychological resources and prepare intervention strategies.
- Provide psychological treatment and support to survivors.
- Co-ordinate outreach to the identified target group.
- Identify and maintain a local referral network.
- Provide psycho-education and social-education material.
- When working in hospitals or clinics:
    - assist and support the medical and paramedical staff of the hospital;
    - develop a culturally adapted training curriculum consisting of psycho-educational topics and counselling skills for local counsellors;
    - put programs and research in place.
- When working in a more administrative role:
    - help to strengthen collaboration with other NGOs by identifying any contextual issues or stressors that impact upon problems in service delivery;
    - help to find short- or long-term solutions;
    - record and evaluate clinical work.

When Canadian psychologists work outside of their country, they are likely to be guided by the *Code*'s ethical principles. However, these broad principles need interpretation and contextualization to be of use. The Canadian Psychological Association's *Code* is structured around four major principles:

I: Respect for the Dignity of Persons
II: Responsible Caring
III: Integrity in Relationships
IV: Responsibility to Society.

It is easy to agree with and commit to the values expressed in these four overarching principles. They reflect the philosophy and training that Canadian psychologists were raised with and are comfortable with. Yet, while doing humanitarian work with the best of intentions, these large principles and the specific concepts described within each can seem to take a beating. The humanitarian worker has to learn to live with some very flexible interpretations of what is much clearer and easier to apply at home. Below you will find descriptions of the many situations in which I or my colleagues experienced major challenges, organized around eight major themes.

Severe Limitation of Resources

On humanitarian missions, psychologists are confronted regularly with situations where the resources are utterly insufficient to meet the quantity of need. In addition, the level of service quality is also often greatly insufficient. The fact that resources are so scarce is not a surprise, but it is a recurrent source of ethical struggle for psychologists on a mission (Schwartz et al., 2010).

As psychologists are at times responsible for selecting which patients will receive health care and which will not (Hunt, 2010; Sinding et al., 2010), they need to learn the elements of triage. This role often results in an ethical dilemma insofar as we need to assure that triage thinking does not open the door to the kind of discrimination our ethical principles are trying to prevent. In Principle 1 (Respect for the Dignity of Persons), it is stated that:

> psychologists acknowledge that all persons have a right to have their innate worth as human beings appreciated and that this innate worth is not dependent on their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socioeconomic status, or any other preference or personal characteristic, condition or status (CPA, 2000, Principle I, Values Statement, para 2).

Psychologists should actively avoid and not support unjust discrimination based on any of these factors. Given that triage can open the door to discrimination, how can triage be appropriate?

In some situations, patient A may be chosen to the detriment of patient B, with a fair amount of time spent immediately with patient A because she may

never come back. For instance, if a mobile clinic reaches the patient once, it does not mean that the patient will be seen a second time. The patient's inability to return may be due to: (a) the fact that the patient lives in the jungle or in a remote area that has no road access; (b) the inability of the patient to return to treatment or to comply with the treatment; (c) the length of treatment required (e.g., for patients suffering from posttraumatic stress disorder) competes with the patient's other pressing needs, such as food, work, or shelter; (d) lack of an adequate support system, especially for victims of physical and sexual violence (e.g., when a woman victim of rape is not supported by her husband in her wish to be seen, she will not return because her visits to our clinic will be seen as a defiant gesture). Triage as a way of minimizing the impact of limited resources can be challenging for the psychologists on a mission. In helping those who are easier to reach and /or who have a better chance of survival, we may be neglecting those with even greater need who may be more of a priority to local government, but who are not easily accessible.

Another ethical challenge related to limited resources is Ethical Standard II.21 in Principle II (Responsible Caring) of the *Code*, which states that psychologists "strive to provide and/or obtain the best possible service for those needing and seeking psychological services." Often in a humanitarian work setting, there are no alternative services, no other forms of support or help. Once the NGOs go away, the patient is left to him or herself. Also, in Standard II.33, it is stated that psychologists "maintain appropriate contact, support, and responsibility for caring until a colleague or other professional begins service." The situation usually does not allow us to follow through with the intent of this Standard and we are stuck with the following ethically troubling thoughts and concerns:

- What happens to people when there is no one to help?
- What happens when the local resources are inadequate or incompetent?
- Should we provide humanitarian assistance if we cannot monitor or evaluate the quality or our services (Human Accountability Partnership [HAP] & World Health Organization [WHO], 2002)?
- Is it ethical to start treatment when we know that we will be long gone before the treatment can assist the patient? (By virtue of their role, psychologists set in place programs or hire people to carry on, knowing that they will not be able to supervise or evaluate the services because they will be returning to their home country.)

Local Political Pressure on NGO

Ethical challenges also can relate to social and governmental injustices. Local government may permit the humanitarian worker only to work with the government's chosen population, which often is based on ethnic, social, and/or gender inequalities (Schwartz et al., 2010). Such situations almost force the practitioner to engage in or contribute to discrimination. For instance, a psychologist working in a refugee camp may be directed by the local authorities to favour one group. If you don't comply, you are not allowed to work any longer in the camp. Sadly, in many countries of the third world, women's health is either disregarded or a low priority. The bias to favour men and limit the treatment of women is a regular challenge in many countries (e.g., east-central Africa). Despite such pressures, the psychologist is expected ethically to advocate for the vulnerable. If authorities do not respond to such advocacy efforts, they may need to be reminded that it is important to consider the needs of everyone and to value equality.

Local Cultural and Social Realities

The tension between respecting local customs and imposing values can be a great dilemma for humanitarian workers, especially when the local cultural values endorse unjust discrimination and the limitation of information for the purpose of political or gender control (Hunt, 2009; HAP & WHO, 2010). Family planning and abortion are sensitive topics on a mission, even more sensitive than they can be at home in Canada. There are situations that exacerbate tension between respecting the local customs and imposing our values (Hunt, 2010). The following examples delineate situations that exacerbate such tensions and describe some of the multiple, interwoven challenges to the way we interpret our ethical principles when in Canada:

1. In Congo, abortion is illegal. It is also socially and religiously condemned. What should a psychologist do when a victim of rape is asking for help to get an abortion, knowing that if she disclosed to her husband that she is pregnant as a result of gang rape by the militia, he will chase her out of the family and the village? She then would become a total outcast and very vulnerable for more victimization. With the agreement of the woman, the psychologist could negotiate with the medical staff another label for the medical procedure, such as calling it a "D&C" without further specification or "internal complication surgery." The value of finding ways to minimize harm takes on special importance in this type of situation.

2. How does the psychologist respond to a local staff member in a Burundi clinic who refuses to provide information to young mothers about family planning because of her personal views? In this case, a new staff member with more open and modern views on family planning was hired as a receptionist for the program. A new administrative system (including some personnel changes) was also put in place to monitor everyone's reason for referral to the clinic.
3. Is it ethical to teach a wife who is a victim of spousal abuse to speak her mind and not to accept the violence from her husband when one knows that if she confronts her aggressor she will be chased out, abandoned, and cast away? In reality, when thinking of providing such advice, a psychologist needs to be aware of the physical and emotional resources and supports available in the local culture for a woman who stands up for herself. There are no women's shelters in the bush. If the local support system is precarious, the psychologist instead needs to offer psychological support and suggest nonprovocative coping strategies. Most humanitarian work is carried out in countries where the rights of women are not only ignored but abused. For any humanitarian worker who meets this injustice every day, the ethical challenge is huge. The inability to effectively reduce such abuses becomes a source of much personal stress given that we value the individual's right to safety but cannot guarantee its implementation.

Challenges to Protecting Confidentiality

At home, we treat confidentiality as sacrosanct. In Principle I (Respect for the Dignity of Persons) of our *Code*, we are advised to ensure that the person who receives assistance is treated in privacy and that the information transmitted is kept confidential. However, in a crowded refugee camp consisting of a tent city, confidentiality is often an unfulfillable dream. On humanitarian missions, there often is one tent that is called "the mental health tent." Everyone knows who comes to ask for mental health support. What does a psychologist tell a husband who insists on an explanation for why his wife came to see a counsellor in the mental health tent, knowing that if the answer provided does not satisfy the husband, his wife won't be permitted to return to get services? This type of situation is even more difficult in a culture where health care workers are expected to obtain permission from the husband before his wife can receive services (Schwartz et al., 2010). I faced this situation in a refugee camp filled with Somalis in South

Africa. I chose to tell the husband a generic and non-threatening reason (a white lie) why his wife had come to counselling, saying that she was wondering about her children and wanted some simple advice about child development.

Keeping information confidential is similarly challenged when patients are unwittingly labelled while waiting for services. Many governmental and non-governmental organizations in Africa offer help to victims of sexual violence. The program is called "Sexual Gender Bias Victim" services and is announced with this title. For instance, when a young woman waits in a line-up at the clinic, everyone is cognizant that she is at the clinic for victims of sexual violence. Similar concerns pertain for HIV patients who are identified as such while waiting for service. This aspect has raised a great deal of ethical angst for psychologists, who are especially aware of the stigmatization of these two vulnerable groups.

When dealing with sexual violence, other challenges to protecting confidentiality include the regular lack of availability of female translators and the lack of translators who understand and are willing to commit to confidentiality. They also include the difficulty of providing private space when wards are so overcrowded that patients sleep on the floor between beds. Additionally, in our modern computerized world, psychologists need to remember that the ease of dissemination of information can readily lead to loss of control over information. This happens even in remote areas (HAP & WHO, 2002). Again, the role of the psychologist becomes one of advocating for ways to protect the patient's dignity.

Patient Consent

Under Principle I (Respect for the Dignity of Persons), obtaining informed consent includes telling people about the procedures, the benefits, and the risks. It also implies that the mental health worker will explain to patients that they have the right to decline. This process is very complicated for persons who are in movement and/or in war zones.

Humanitarian work often does not occur in a setting where one has time to ask and obtain truly informed consent from the patient/ client. The arena of work is often very spontaneous and brief. Psychologists need to recognize when truly informed consent is possible and when it can be waived in crisis situations when speed is paramount (HAP & WHO, 2002).

Many of the populations being assisted are illiterate or have limited reading abilities. In these cases, written consent cannot be sought and sharing a copy of a signed consent form is pointless. Alternatively, one could seek verbal consent, but then there is no written evidence of it from the patient, and bringing in a witness to the consent process is a threat to confidentiality.

Everyone knows that a picture is worth a thousand words. Despite the fact that a photo can serve to witness injustice and inequality, or is useful for

fundraising, taking pictures of the victims of natural disasters or war can challenge the values of consent, privacy, and confidentiality. For example, essential for fund-raising after the earthquake in Haiti on 12 January 2010, many pictures and videos of victims were transmitted all over the planet. Is it more important to obtain individual consent for the taking and use of photographs, or is it more important to have the ability to raise funds to help victims? This is another ethical dilemma faced by psychologists on a mission.

Colonialism and the "Superior Role"

Even in western health care there is an asymmetrical power relationship between healer and patient. This differential is amplified in the context of health care practice in crisis settings. The imbalance of power can be seen in humanitarian work, but it is amplified by a blatant racial issue. It is frequently observed in the third world that locals automatically grant special power to the White professional over the opinion, experience, and knowledge of the local non-White health care professional. In humanitarian work, mental health professionals need to be cognizant of this reality and need to consciously strive for respect of local expertise.

Individual Interests Versus Population Interests

Psychologists have a responsibility to care for the most vulnerable person(s). In humanitarian work, we at times close our eyes to the single vulnerable person in front of us, and instead focus our energy on tasks that may lead to greater long-term benefit for a larger group of vulnerable persons. For instance, pushing for constructive long-term policy change might ultimately benefit more persons than doing one-on-one psychological band-aid work.

Tolerance for Differences in Standards

In supporting Principle IV (Responsibility to Society), psychologists often struggle with deciding how little may have to be good enough. Trying to provide adequate supervision and training reflects such a challenge. To some degree, Principle IV is particularly relevant to the process of clinical supervision in humanitarian work. The foreign psychologist knows that his or her stay will be time-limited and she wants to leave a cadre of helpers who continue to honour this principle. In supervision, the psychologist will try to instill a sense of responsibility to the societies in which the supervisees live and work to ensure psychological knowledge will be used for beneficial purposes, to encourage the supervisees to convey respect for social structures, to encourage achieving consensus within societies through democratic means, and to speak out against structures or policies that ignore or oppose the principles of respect for the dignity of persons, responsible caring,

integrity in relationships, or responsibility to society (CPA, 2000, Principle IV, Values Statement).

Supervision and training can be a great challenge in precarious environments such as refugee camps. Due to lack of time, adequate facilities, and privacy, it can be quite demanding for the psychologist to provide proper supervision to his or her staff. This situation occurred in South Africa and in Chechnya, where it was at times impossible due to time pressures, an excessive number of supervisees, and geographical access constraints.

For some missions, the job description of the supervisor includes the administrative power to hire and fire staff. The duality of this role can be difficult. Firing somebody for lack of competence can make sense if a replacement resource can be found. In Chechnya/Ingushetia, there were no alternative resources available at all. I felt I had to stretch my own views of what were minimally acceptable clinical abilities for some of the counsellors. I justified this to myself by considering the local reality. After over 10 years of war, there were no other psychological resources left and even embarrassingly modest support might be better than no support.

Conclusion

Many ethical problems are universal. At home in Canada, psychologists can encounter similar difficulties in crisis situations, such as triage, quality of resource allocation, challenges to obtaining informed consent, and needing to cope with professional hierarchies. Nevertheless there is something acutely different and more cumbersome when the ethical challenges arise within the context of humanitarian aid work (Schwartz et al., 2010). The challenges are different because of the extreme precariousness of the population's situation, the political situation, and the extreme scarcity of resources. The utterance "My God, they have nothing . . . where do I start?" is often expressed by humanitarian workers.

There are a great many ethical challenges and dilemmas for psychologists overseas on a mission. One has to keep in mind that our *Code* was developed within and for a democratic society with equality, resources, and professional standards. The *Code* is not always applicable in the same way in a society torn by wars and longstanding inequalities. Given these limitations and the constant challenges, psychologists on a mission need to be even more flexible than at home. They will be pushed to the limits of their skills and tolerance, and many times they will perform activities that they never carried out before, all under a great deal of pressure.

The four major ethical principles of our *Code* are a valuable point of reference that we need to keep in mind wherever we work. Using those principles as a guide, psychologists on a mission may need to adapt the operationalization of the

principles to the contextual reality, using discretion and swift judgements. On a mission, our ethical principles help guide our professional work but often need to be seen as aspirational. They must be interpreted within a broader practical context of what is possible. My advice is clear: do not leave home without the guidance of your ethical principles, but please remain flexible. Do not look just at the tree in front of you but remember the forest that is surrounding you.

Sadly, there is no specific training for humanitarian workers in respect to the application of one's code of ethics. It is clear that NGOs rely on the workers themselves to decide how to do it. Further challenges occur as a result of psychologists working not only with other mental health professionals but also with local and international staff from around the world who may have divergent standards.

It is imperative that I end this article by explaining to the reader that although the challenging aspects of humanitarian work are plentiful for psychologists, the professional and personal rewards often exceed expectation. The solidarity psychologists can feel with the human race while on a mission often becomes one of the most invigorating experiences of a career. It is distinctively rewarding work as it forces one to retrieve and use one's full clinical, personal, and ethical resources. Sometimes this includes going well beyond the boundaries and the scope of our regular routine.

Questions for Reflection[3]

1. Do you think psychologists should be involved in humanitarian work? Why or why not?
2. Is humanitarian work as a psychologist something you would consider doing yourself? Why or why not?
3. You have just arrived on site as a humanitarian aid psychologist and have been asked to support a five-year-old child who was raped and is about to undergo surgical repairs of the physical damage that was done. She will be awake during the surgery and you are asked to go directly to the surgery room. What ethical issues do you see? What would you do? Why?
4. What do you think "choosing the best course of action" means? Is it making sure that you follow the ethical standards of the *Code*? Is it more a matter of doing the best you can ethically under the circumstances? Other? Explain.

NOTES

1 Aubé, N (2011). Ethical challenges for psychologists conducting humanitarian work. *Canadian Psychology, 52*(3), 225–239. Copyright ©2011 by the Canadian Psychological Association Inc. Reprinted by permission of the Canadian Psychological Association Inc.

2 Please note that, as this article was originally published in 2011, it is based on the third edition of the *Code* (CPA, 2000), not on the current fourth edition (CPA, 2017).

3 Please note that these Questions for Reflection were not included in the original article, but have been added here by the author.

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