PETITION
The APA’s Resolution on APA, Psychology, and Human Rights: ISEPP Critique and Challenges

August 5, 2021

Todd Dubose, Ph.D.
Professor, The Chicago School of Professional Psychology

Chuck Ruby, Ph.D.
Executive Director, International Society for Ethical Psychology and Psychiatry

We would like to put the issue simply and succinctly: The American Psychological Association’s (APA) February 2021 resolution on human rights (https://www.apa.org/about/policy/resolution-psychology-human-rights.pdf) overlooks its own oppressive practices that not only collude with, but prescribe as competent practice, forced treatment and involuntary hospitalization.

On behalf of the International Society for Ethical Psychology and Psychiatry (ISEPP), we are petitioning the APA to be consistent with the United Nations’ condemnation of forced psychiatric treatment and include in its resolution on human rights an acknowledgement of its own violation of human rights of the most vulnerable, those suffering extreme experiences, which to date has pathologically been called, “mental illness,” and to name involuntary forced treatment as a violation of human rights.

The latter action is predicated on a change in the former ideology: The mind is not the brain, and difficulties in living or extreme experiences are not illnesses to be treated medically. At last estimated count, 95% of psychologists believe that the mind is an extension or epiphenomenon of the brain, which, for many practitioners and researchers, allows for no more unfettered alliances between psychologists and the medical model of reductionism.

We cannot avoid the long history of psychiatric abuses merely by noting that we are not psychiatrists. We involuntarily commit others against their wills. We hand them over to institutional oppression.

Additionally, a grand irony continues to persist. Human distress and actions are likened to physical illnesses and forcibly treated. Yet, people who suffer from illnesses such as diabetes, cancer, and heart disease are not similarly forced into treatment (of course, unless they are designated “mentally ill”). Instead, they are given the right to self-determination and to refuse. Why is this? It is because medical reductionism has assumed authority, not over illnesses of mental life, but over personal choices regarding meaningful, yet painful, human dilemmas. Deciding to enlist the help of psychology is one of those choices.

What of times when involuntary hospitalization and forced treatment are claimed as caring acts? Is this question likened to telling a child that you are being beaten “for your own good”?

Justifying forced treatment and involuntary hospitalization as necessary to protect the public ignores a plethora of alternative options to address and deescalate crises that are made worse by using status and power to chemically, electrically, or institutionally incarcerate.

Involuntary forced treatment is likened to a police officer justifying that he had to shoot someone, when the one who is shot is vulnerable and unarmed. In a recent communication at a round table of the Soteria project, Voyce Hendrix, the former clinical director of the original Soteria house, who has worked his entire career in institutions, opined that, in his experience, most of the violence in such settings is inflicted by those forcing treatment.

In most cases, the alleged dangerousness of the person is without evidentiary foundation, but merely assumed because of meeting diagnostic criteria, which are openly admitted by the leaders of our profession as unreliable and invalid from a scientific standpoint.

We realize that in some extreme cases, a person's behavior can pose a threat to others or self. In those cases, there is robust psychological science that can be used to estimate and manage the person's relative risk, in addition to culturally sensitive attunement to decolonizing implicit biases about de-contextualized behaviors of concern. In cases when a scientific analysis concludes an appreciable risk, measures can be taken to reduce the risk. However, and this is of extreme importance, such measures are not medical treatment and there are other means to subdue people, if absolutely necessary, and then with the intent to do so only temporarily.

A diagnosis of a mental disorder is not by its nature a "risk factor" that automatically calls for the violence of forced treatment. Our concern is the all too ready algorithmic "if this, then this" immediacy of thought and action, which drives the erroneous stance that certain diagnoses necessitate explicitly forced and restraining interventions.

Moreover, we are concerned when this stance neither exhausts a critical exploration of alternative care, nor attends to damage done by forced treatment on the recipient and the recipient's family and community.

One of the hallmarks of virtue signaling is the unwitting, if not uncanny, habit of committing the very unethical comportments that are criticized. The ancient Greeks called it 'hamartia,' or missing the mark, which is incorrectly translated as "sin." Missing the mark is unwittingly thinking you are helping or caring when your care harms or inattends someone or some voice you think you have not overlooked. It is a particular kind of naïveté.

The APA's February 2021 resolution on human rights, based on a Five Connection framework, misses the mark in several ways. Below are our critiques of implicit biases in each Connection, and suggestions for revision. Italics highlight APA's resolution language for each Connection.

1. *Psychologists possess human rights by virtue of being human as well as specific rights essential to their profession and discipline*.

The implicit bias operating in this first statement is the essentialist room to privilege the rights of the psychologist over those seeking care. The psychologist has the right to treat or not, but the psychologist's rights do not supersede the rights and decisions of those seeking care. Clinical judgement has no supremacist legitimacy over alternatively valued (often called compromised in the medical model) decisions for his, her, or their care.

2. *Psychologists apply their knowledge and methods to the greater realization of human rights.*

   The implicit bias in this statement is the psychologist's (sovereign?) right to apply their knowledge and methods, as well as an ambiguity of which methods would be applied, towards which ends? Psychologists should not use their training or education to force treatment, either explicitly, or in emotionally manipulative ways (i.e., shaming someone for not being treatment compliant; threatening someone with involuntary treatment if they do not "volunteer"). The greater realization of human rights necessitates the freedom of informed choice.

3. *Psychologists respect human rights and oppose the misuse of psychological science, practice, and applications and their negative impact on human rights.*

   The implicit bias in this statement is one of omission. Although implicitly addressing the place of psychologists in torture, the APA overlooks and forgets its own torture by method of forced treatment of those seeking care. This statement should be directed at any kind of torture, which is defined as using power, without any consent from the recipient and often in the implicit or explicit protest of dissent, in fearful, painful, and manipulative ways to force compliance of desired behaviors.

4. *Psychologists advance equal access to the benefits of psychological science and practice*.

   The implicit bias here is a blatant Hobson's choice: Those seeking care have access to the science and practice of forced treatment. Moreover, it mitigates against an informed choice by limiting the plurality of sciences (i.e., natural science and human science) and the plurality of practices (i.e., from a variety of practices of care). Furthermore, access is left uncoupled from discernment and decision; that one has access does not mean that one has freedom to reject such science and practice. The further implicit bias is that psychological science and practice is beneficial, but for whose sake? Given the financial burden of in-depth and more meaningful forms of assistance to people in distress, those of lower economic means, which highly correlates to people of color and other marginalized groups, do not have equal access to the benefits of psychological science. Thus, they are more likely to be subjected to involuntary, coercive, and repressive forms of treatment. Psychologists should offer a plurality of sciences and practices of care for the informed decision of what would be beneficial to the one receiving services, towards his, her, or their desired purposes.

5. *Psychologists advocate for human rights*.

   The implicit bias in this statement isn't very implicit; it is explicit: As a profession, psychologists have not advocated for human rights. If psychologists collude with involuntary forced treatment, then psychologists are violating human rights. Psychologists should aim to advocate for human rights, including a commitment to no involuntary, forced treatment and as an informed and ongoing consent to and for care as possible.

We conclude with the general reiteration that a basic human right is the right to informed choice of treatment and the freedom to accept or refuse such treatment, from our own hands! Without the ownership of how the profession of psychology has violated its very hypocritical position of advocating for human rights, it is operating in bad faith and lying to, not protecting, the public. The violation of human rights in psychology by involuntary forced treatment is predicated on a medical model of false analogy of physical medicine applied to mental suffering (any actual organic disease excluded), and the conflation of the brain with the mind, both ignoring plasticity. This link must be renounced as it is false. In doing so we can enhance our care for human rights and also enhance our care for non-human rights as animals then would not have to suffer randomized controlled trials for our sake—yet another implicit and forgotten bias, and next omission to address, in our virtue signaling.