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Critical Human Rights-Based Approach to Applied Psychology: Context and power

Nimisha Patel

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Introduction

The operations of power saturate human rights and psychological theories and practice, and any clarion call for psychologists to adopt a human rights-based approach requires an understanding of the importance of context and power, both structural and material power (Smail, 2005) as well as discursive and disciplinary processes of power (Foucault, 1971). The manifestations, processes and impact of power evident in social and legal policies, in State practice, and in social inequalities, marginalisation, discrimination, oppression and structural violence towards some people, beg the question 'and so what?' – what exactly can be done as psychologists, with what and how. This chapter proposes that human rights offer a tool, flawed but useful to applied psychologists, and it presents a Critical Human Rights-Based Approach (CHRBA) to applied psychology, and relevant competencies for applied psychologists. Here, applied psychology refers to the application of psychological concepts, theories and methods to working with individuals, families, communities, systems, teams and organisations, in a range of health-related settings and with a range of populations, across the lifespan.

Human rights-based approach in healthcare

Using the overarching legal discourse of human rights, at the structural level of State responsibilities and obligations, a human rights-based approach (HRBA) entails the respect, protection and application of human rights norms (for example, on protecting life, privacy, health, family life, freedom from torture), in accordance to the expectations of the international community. It requires that breaches of human rights should be investigated, prosecuted, redressed; repetition of such breaches should be prevented; and that there should be reparations for victims/survivors of human rights violations.

A HRBA to health which encompasses all human rights norms is important, since they are together relevant to health, although Hunt (2016) argues that the right to health (the right to "the enjoyment of the highest attainable standard of physical and mental health", Article 12 of the International Covenant on Economic, Social and Cultural Rights) should be placed at the centre of a rights-based approach to health. The World Health Organisation advocates a HRBA to health as enabling strategies, by States, to "address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes" (WHO, 2015), thereby offering a route to examining the structural determinants and inequalities which lead to suffering. A State-enforced HRBA is nevertheless problematic, particularly when the State's own policies and practices may have led to those very injustices and suffering.

Where practising psychologists and other healthcare professionals may be duty-bearers (e.g. in State services), the application of a HRBA is most meaningful when integrating the principles of human rights in daily clinical practice and services. To this end, Curtice and Exworthy (2010) offer the 'FREDA' principles (fairness, respect, equality, dignity and autonomy), whilst others emphasise the principles of participation, non-discrimination and prioritisation of vulnerable groups (Dyer, 2015). Twelve human rights principles, amongst the many others, are highlighted as particularly relevant to healthcare and applied psychology (e.g. principles of ensuring safety and integrity, fairness, respect, equality, non-discrimination and attention to vulnerable groups, dignity, autonomy, participation and inclusivity, gender and cultural appropriateness, proportionality and monitoring by disaggregation) (see Patel, 2019a). In different countries and settings, HRBA may be interpreted and applied differently, and other principles valued. Nonetheless, human rights offer an ethical framework consistent with psychological practice, alongside a legal framework to ensure accountability and prevention of the causes of poor psychological health. However, an unquestioning use of human rights as an acontextual tool to analyse and address what are defined, within the legal discourse of human rights, as human rights violations, is problematic for two reasons. Firstly, because as Farmer (1999) argues, a purely legal view of human rights violations tends to obscure the dynamics which lead to those violations – local and global inequalities, globalisation, social inequalities, discrimination etc.; and secondly, because human rights are themselves contested, as subsequently illustrated.

A Critical Human Rights-Based Approach (CHRBA) to applied psychology

With respect to healthcare, including applied psychology, a HRBA can be understood as "the adoption of human rights as a conceptual framework for all aspects of healthcare, from policy, research, practice and monitoring; an approach which places physical, psychological and social health firmly within the context of security, social justice, equality and non-discrimination. Hence, a HRBA frames health not just as needs but as rights to safety, various protections and freedoms, whereby every individual and community can enjoy health and well-being" (Patel, 2019a, p.120).

A *critical* human rights-based approach (CHRBA) to applied psychology elaborates upon this definition and foregrounds the need for a commitment to acknowledging, naming, deconstructing and addressing, wherever possible, the operations, maintenance and reproduction of power and oppressive functions of our theories, research, activities and practice, by using the tools of critical thinking, human rights and psychology, to improve health and well-being. A CHRBA to applied psychology acknowledges both traditional, Western psychology and human rights as socially constructed, context-bound yet universalising, hegemonic discourses and inevitably flawed (Patel, 2011). A CHRBA also requires an examination of how power operates in what we choose to value as human rights. For example, which human rights are privileged by who (is the right to private life and family devalued for those with learning disabilities, and why); which human rights principles are ignored, for who and when (is the right to dignity in healthcare seen as less important for older people); and whose notion of health, safety and freedom is considered more important in psychological services (professionals' views or those who use psychological services)?

As with applied psychology, power permeates human rights, in their construction, application and in the normative architecture of legalised human rights - the national, regional and international human rights bodies, institutions and mechanisms. The political process by which human rights were conceived, developed and used has led some to argue that human

rights are in reality moralised politics, or politicised morality (Hoover and Iniguez de Heredia, 2011) and others have criticised human rights as Eurocentric, ideological and political tools (e.g., An-Nai'im, 2016; Panniker, 1982) which perpetuate colonialist othering and racist practices (Mutua, 2002; Rana, 2007), at the service of hegemonic global powers in legitimating particular ideologies and a particular international order. Human rights are also criticised for traditionally privileging Whiteness and patriarchy in the conceptualisation of 'human' (MacCormack, 2009), subjugating the racialised 'other' and women, and therefore to whom human rights pertain, when and how. The structures of human rights to enforce dominant human rights embody and perpetuate power, for example, by seeking improvements in ensuring justice and redress, without necessarily addressing the structures and causes of human rights violations (Bhasker, 1991; Chinkin, 1998). The practice of human rights (in monitoring, data collection, evaluating, reporting, human rights education etc.) meanwhile operate as surveillance systems (Evans, 2005), continuously normalizing and legitimising dominant discourses of human rights. The position in this chapter, in keeping with a critical perspective, is therefore that the mere adoption and unquestioning use of human rights language and principles in psychology is insufficient and problematic, in that it serves to reproduce dominant discourses of rights without questioning their interpretation, value and legitimacy in different contexts.

Similarly, the use of psychological models, methods and research without examining context and power is also problematic. Psychology's neglect, denial, dismissal or justifications of power are evident in many ways. For example, traditionally, applied psychologists have ignored or diminished the importance of history and the influences of slavery and European colonialism in our theories, including the theory, research and application of eugenics (see Pilgrim, 2008), which influenced British health and social policy; and the architect of apartheid, the South African psychologist Hendrik Verwoerd, and apartheid policies where psychologists were 'servants of apartheid' (Webster, 1986); the German eugenic health policy (Weindling, 1989); and discussions on involuntary euthanasia (Joseph, 2005), as examples. Psychologists have also neglected the role of the social, political, economic and cultural contexts and structural inequalities in the development, construction and understanding of psychological difficulties, distress and suffering, and in the professional responses to them, thereby reinforcing inequalities (Patel, 2003) and leading to persistent 'epistemologies of ignorance' (Mills, 2007) - ways in which psychologists have learnt to decontextualize human suffering and distress, ignoring the realities of racism, poverty and other inequalities and discrimination in daily life.

As practitioners, psychologists typically focus on symptoms as manifestations of distress – a reductionist, acontextual and incomplete acknowledgement of the effects, without formulating the multiple causes and the various complex, interacting dynamics and mechanisms by which structural inequalities and social factors may lead to distress and poor psychological health, for different people, in different contexts. Similarly, applied psychology has neglected the operations of power in psychological theorising (ongoing process of theory-making) and knowledge-production, research methods, outputs and misuses of research, psychological practice and in psychological services and the professional and regulatory institutions of applied psychology. Eurocentric psychology is criticised for its racism (Howitt & Owusu-Bempah, 1994) and for continuing to promote the interests of the global privileged minority, specifically, those from WEIRD settings (Western, Educated, Industrial, Rich, Democratic settings) (Henrich, Heine and Norenzayan, 2010). According to Arnett (2008) the majority (99%) of psychology journals are edited and articles are written by those from Western backgrounds, who use Western, White participants in research – evidence then applied to the

'neglected 95%', the global majority. Thus, Whiteness is reproduced in knowledge-production and advocated as universally applicable, whilst the norms of Whiteness, for example, in concepts of 'self', health, family, appropriate behaviour or expression of distress etc., remain the yardstick against which deviance or 'abnormality' is judged.

Historically, psychology has also neglected its patriarchal biases, for example, in the assumptions of women's biological inferiority; misrepresented women in research and in theories (Eagly et al., 2012); neglected androcentrism and the marginalisation of women within psychological theories and within clinical psychology (Ussher and Nicolson, 1992) and subjected women to sexist use of psychoanalytic concepts and psychiatric diagnoses and to sexual misconduct in therapy. At the extreme end, applied psychology's perverse intimacy with power is also highlighted by psychologists' historical involvement in developing, researching and refining methods of torture (see Patel, 2007a; Pope, 2019).

The imperative to address power in a CHRBA to applied psychology is clear when we consider the consequences of neglecting, avoiding or minimising the existence or impact of power. First, neglecting power obscures the social, economic and cultural context, the structural determinants of health, and State policies and structures which give rise to and maintain inequalities– elevating the potential for harm and obscuring or obstructing opportunities for redress. Second, neglecting power inevitably individualises suffering by locating psychological problems within the psyche, genes, behaviours and cognitive 'dysfunctions' of individuals, thereby again, neglecting their causes (e.g. discrimination, inequalities, oppression) and the meanings of the suffering for individuals, families and communities, and reinforcing those very abuses and inequalities. Third, the adoption of the neutrality ideal (scientific and therapeutic neutrality) and ignoring researcher/therapist subjectivity and values, or constructing these as evidence of bias and professional incompetence, can be used to defend against examining power, privilege and the professional and economic interests of the psy-professions. Fourth, a neglect of the operations of power in psychological theorising, practice, and professional education, serves to reproduce and reinforce social injustices, perpetuate 'othering' and consequent epistemic violence (Fricker, 2007), and human rights abuses in our daily practices. Even when psychologists work with survivors of injustices and abuses, traditional psychological approaches have adopted an individualist, acontextual, depoliticised and universalising (though Eurocentric) approach (see Patel, 2003; 2011), perpetuating injustices and the oppressive gaze which normalises patriarchy, racism and oppression as invisible givens.

The notion of 'critical' is important to address, since critical thinking is integral to all education and professional training of applied psychologists. However, adopting a critical approach (CHRBA), as advocated here, demands scrutiny of context and vigilance to the operations of power; it requires acknowledgement and recognition of the manifestations and processes of power, the deconstruction of dominant knowledges often presented as uncontested 'truth' and 'facts', and a questioning of the unexamined assumptions underpinning what we take as theory, law, research, evidence etc. A critical approach invites students, trainee, trainers/teachers and practising psychologists to embark on a process of learning which demands a continuous and a two-way scrutiny of power – of what we are learning/teaching, and of what we each and collectively bring to this process – our own historical legacies, identities and experiences of intersectional discrimination and disadvantage – and privilege (e.g. patriarchal privilege, White privilege, economic privilege and so forth), our biases, assumptions, values and beliefs. Thus, in summary, a CHRBA requires psychology trainers, teachers, students, trainees and practitioners to consider power and context in human rights and in psychology, in terms of (a) the nature and the social,

cultural, political and economic conditions which give rise to distress and difficulties which people experience, and the social context (e.g. of discrimination, oppression, deprivation) which maintains distress; the background, social identities, privileges, and experiences of disadvantage, discrimination and oppression of (b) the trainer/teacher; (c) the students/trainee psychologists; and (d) the individuals, families and communities with whom we work.

For applied psychologists, the aims of CHRBA coalesce around change: how to improve the lives of all, enable changes in macro systems and structures, changes in institutions and practices, changes in individuals, families and communities, changes in social discourses and practices – changes to what creates, contributes to and maintains individual and social distress and suffering. A CHRBA warrants the question what can psychologists do to address distress and suffering related to social inequalities, discrimination and human rights violations; and how can we contribute to the protection of health and the prevention of the causes of suffering and distress? It also requires us to be aware, that context and power have historically shaped *both* Western psychology and human rights – the tools of change, our concepts, theories and methods need themselves to be scrutinised for their cultural, gendered, class and other biases, and for how they have harmed, or their potential to discriminate and harm, and to be changed.

The power of human rights

Importantly, a critical stance necessitates the questioning and critique of the validity and operations of power and interest in human rights - not as a churlish, rhetorical undermining of human rights, but engaging in critique as a form of action. A critical stance can then create spaces to reflect on alternatives, whilst at the same time, acknowledge and not sanitise the role of human rights in reproducing power and domination at the local, regional and global levels. The adoption and expansion of human rights has also enabled resistance movements to pragmatically achieve particular changes (e.g. ensuring rights of women, workers, indigenous communities, sexual minorities, justice and reparation etc); and to support radical movements for anti-slavery, women, decolonisation, civil rights etc.). Indeed, Ignatieff (2001) argues for a focus on what can human rights *do*, perhaps to use human rights for action to 'do good'. The pragmatic and/or strategic use of human rights, however, does not sidestep the issue of power, rather, it illustrates how power and competing interests are navigated, one consequence of which is the maintenance of power, legitimising the legal discourse of human rights as *the* (only) discourse of human rights. Paradoxically, human rights offers both a discourse of domination, and of freedom (Evans, 2005), and can be used in different ways strategically, to disrupt and challenge the social order (Hoover and Iniguez de Heredia, 2011). Psychology too offers both discourses of oppression and of the alleviation of distress and suffering; and applied psychology can be used to defend the 'human-ness' and inclusivity of all, and their desires for safety, security, peace and a 'good life'.

Both human rights and psychology can guide political and social action – for change, and this requires acceptance that, in seeking particular changes (whether towards a particular social and political order or a particular version of a 'good life' and good 'health outcomes'), neither psychology nor human rights are neutral, interest-free, value-free, acontextual, ahistorical, apolitical and or free of the operations of power. For psychologists, adopting a pragmatic epistemological stance to human rights, not as a crude form of utilitarianism, or a blind acceptance of human rights as fixed and universally accepted, involves acknowledging structural and discursive power, and the Eurocentric, gendered, ideological, ethical, political

and constructed nature of human rights (Patel, 2019a). Such a stance accepts the evolving and pluralist approach to human rights as providing tools to achieve particular ends: essentially, to ensure improvements in the lives of all human beings, their families and communities.

A CHRBA to teaching, professional training of psychologists and pedagogy

A CHRBA to applied psychology requires educational institutions and professional psychology regulatory bodies to embed human rights principles and framework in their aims, curricula, teaching and assessment methods and in continuing professional development activities. A CHRBA to applied psychology requires a minimal set of competencies which applied psychologists should develop during their psychological education and professional training (Box 1) – competencies which trainers/teachers themselves would need to develop in order to facilitate learning of their students/trainees. The process of teaching CHRBA to psychology, and which competencies are prioritised by teachers/trainers, may vary in different settings, educational institutions and courses. Ultimately, teaching CHRBA demands a commitment to continual critical thinking and reflexivity – an examination of our own biases as trainers/teachers. It requires a critique of the social, political, cultural and philosophical context and foundations of what we consider to be 'knowledge'; the operations of power within knowledge-production, in educational institutions and teaching practices and in how we construct 'human needs', 'psychology', 'indigenous psychology/approaches', and the role of psychologists.

Box 1. Competencies for Critical Human Rights-Based Approach to applied psychology

Critical awareness, knowledge and understanding of:

Human rights

1. The underpinning philosophical basis, ethics and values of human rights and psychology; and differences across contexts.
2. Human rights principles, norms and their context; and the human rights framework relevant to applied psychology and healthcare.
3. The role of domestic, regional and international courts, United Nations mechanisms and other procedures in enforcing human rights legal norms.
4. Key limitations, critiques and the potential of the human rights framework for psychologists.

Context

5. The influence of the wider social, cultural, economic, political, legal and historical contexts on:
    - Intersectional oppression;
    - What those from historically marginalised, discriminated against and persecuted groups feel able to ask for by way of safety, security, opportunities and services; and what they can access/ or are denied;
    - The homogenisation, othering and labelling of marginalised groups and the pathologisation, negative stereotyping, dehumanisation and degradation they

are repeatedly subjected to within society, public institutions and psychological services.

Power

6. The discursive operations of power and related ideologies in
   - Knowledge production;
   - Psychological assessments, formulations, therapy and practice;
   - Constructions and use of psychological measures and tools;
   - The conceptualisation, design (including inclusion/exclusion criteria) and delivery of psychological services;
7. Structural power, its systems (e.g. patriarchy, Whiteness, neo-liberalism), its mechanisms in maintaining structural inequalities and oppressive practices.

Inequalities

8. The role of structural inequalities in individual and collective suffering and well-being.
9. The differing patterns in the adverse psychological health impacts of inequalities and individual and institutional/structural discrimination on:
   - Individuals, families, communities;
   - Marginalised communities, including those marginalised on the basis of intersectional identities (e.g. disability-gender-race).

Psychological theories and models

10. How (or if) different psychological theories and therapy models:
    - conceptualise the role of context, power and social inequalities;
    - reproduce a view of the subject as an individual; and psychological distress, health and well-being as universal and acontextual.

Research

11. How psychological research practices:
    - Attend to/perpetuates inequalities and reproduce power in their models, methods and interpretations of findings; in what is seen as science/ devalued as biased and unscientific; in what is published, where, by whom and funded by who/which funding body.

Impact on people

12. How those we work with, within psychological practice, make sense of context, social inequalities and power and their impacts on them.

Settings and organisations

13. How the settings in which psychologists work (schools, organisations, health and social care services, prisons, care settings etc.) acknowledge the influence of context; reflect social inequalities in society (e.g. in staffing, management, policies, salaries); and how they reproduce dominant discourses and subjugation of certain people/groups of people.

Skills in:

Assessment and formulation

14. Integrating in psychological assessments and formulations the role of context, power, social inequalities and human rights abuses.

15. Integrating relevant human rights principles, specific to the individual, family, community, and the specific client group, setting and organisation in which psychologists work.
16. Identifying which aspects of the domestic and regional human rights framework and mechanisms offer avenues for change.

Interventions

17. Naming, exploring and addressing the role of context, power and social inequalities in the distress, suffering, endurance and survival of individuals, families and communities.
18. Embedding human rights principles in all psychological practice.

Service design, delivery and evaluation

19. Embedding human rights principles in the design, delivery and evaluation of psychological services.

Research

20. Embedding human rights principles in the research process, from conceptualising research questions, research design, conduct, evaluation, publication and dissemination.

Prevention

21. Developing, engaging in and evaluating a range of prevention activities, which embed human rights principles, at different primary, secondary and tertiary levels to prevent psychological distress and its causes.

Ethical and professional conduct of psychologists

22. Embedding human rights principles in all activities and conduct of psychologists.
23. Critiquing the role of psychologists in perpetrating, condoning or perpetuating human rights violations.

Personal-professional development

24. Exploring and reflecting on our own identities, values, assumptions, biases and world views – and the contexts which have shaped us.
25. Reflecting on our own personal and collective histories and experiences of power, powerlessness, social disadvantage, privilege, discrimination and harm.
26. Addressing the ways in which our own experiences, backgrounds, privileges and disadvantages influence and manifest in our work as psychologists.

There are a number of ways in which teachers/trainers can facilitate the development of competencies, and this depends on the audience and context. A combination of lectures, interactive learning, discussions may be supplemented for trainee/practising applied psychologists with specific role play, discussions of scenarios and vignettes (of situations, individuals, communities, settings), and field placements/internships to develop skills in applying a CHRBA to psychological practice.

Some discussions points, related to key aspects of a CHRBA, are suggested for teaching purposes (Box 2).

Box 2. Discussion questions

1. Which social inequalities are prevalent in your society? How are these inequalities perpetuated in your academic teaching, your workplace and in psychological services? How do they impact on the health and well-being of people from different social groups?
2. What are the historical legacies relevant in your context (e.g. slavery, colonialism, dictatorships and political oppression)? How do these historical legacies manifest in psychological practice? How are they denied, minimised or simply not talked about – and why?
3. What does power look like in psychological theories, therapy models, practice and psychological services?
4. Which social policies (e.g. on education, health and social care, employment, housing), or the absence of State policies (e.g. criminalising domestic violence) have adverse psychological and health consequences for individuals, families and communities?

The application of a CHRBA approach to psychology is illustrated in Box 3, by focussing on the example of sexual violence and torture.

Box 3: Application of a CHRBA to psychological practice

Example: Sexual violence and torture

Many torture survivors, including those who are forced to seek asylum, have experienced multiple injustices, persecution, marginalisation and discrimination. Torture is a systematic abuse and function of power, a political tool of State oppression to destroy the identity of the person, to silence and subjugate them. Many women torture survivors experience other forms of historical oppression, patriarchal subjugation, misogynistic practices and gender-based discrimination and violence (including financial or sexual exploitation, harassment, sexual insults, sexual abuse, domestic violence, rape). The psychological impact can reach the individual woman, her family, children, couple relationship and community. The structures of patriarchy and sexism which pervade education, health, politics, law etc. can also be prevalent in psychological practices and services, as well as in asylum decision-making processes and justice mechanisms. The persistence of impunity, ongoing persecution, intimidation and threats of harm against the person and their family; and the inability to access justice mechanisms or rehabilitation services can mean that survivors live in isolation, continued fear and suffering.

Applying a CHRBA

A CHRBA approach to working with women survivors of torture and other sexual violence, explicitly applies a human rights framework to therapy, and to the understanding of suffering not as an individual, internal pathology, but as an understandable, human response to a gross human rights violation (a structural pathology). A human rights framework is then the antithesis to the psychologisation of torture (Patel, 2011) and the decontextualization and depoliticisation of gender-based violence. In a CHRBA, psychological therapy is seen as one component of holistic and multidisciplinary rehabilitation as a form of reparation for gross human rights violations (Sveaass, 2013, Patel 2019b), not as a psychological 'treatment' for an assumed internal pathology, disease, disorder or illness.

Psychologists applying a CHRBA to working with torture survivors can:

1. Critique the ways in which ***psychological language, concepts, models and their methods*** reproduce power, by:
    - not acknowledging or obscuring power, including in the therapeutic process;
    - obscuring systematic gender-based inequalities in their role in sexual violence against women and perpetuating dominant patriarchal discourses which position women as passive victims, blame survivors, demean and pathologize women survivors (as psychologically 'inherently' vulnerable by virtue of being women, 'emotionally unstable', 'manipulative', 'hysterical', 'personality disordered' etc.);
    - psychologising torture and sexual violence;

2. Critique ***psychological research*** for its:
    - historical gender biases and the privatising and psychiatrisation of sexual violence (e.g. in the sole language of psychiatric diagnoses);
    - historical role in developing and refining torture methods;
    - complicity with State abuses of power.

3. In ***therapeutic work*** with torture survivors:
    - Scrutinise assessment and therapy practices for how they neglect/address the economic, social and political contexts of sexual violence and torture.
    - Contextualise and address distress and suffering.
    - Avoid locating the problem (e.g. by using reductionist labels, language of individual pathology) within the survivor.
    - Adopt an explicit stance of non-neutrality – taking a position against gender-based violence and torture.
    - Explore intersectional discrimination in the sexual violence and torture a woman is subjected to.
    - Notice power, and how gender dynamics and inequalities manifest and are perpetuated in the therapeutic relationship.
    - Name power– in what happened to the person (dehumanisation, marginalisation, persecution, torture) and in its ongoing manifestations (e.g. feeling silenced, diminished, blamed, not having a choice or control, being and/or feeling discriminated against and punished).

- Notice, talk about and challenge social discourses which continue to stigmatise and dehumanise women and other marginalised people.
- Explore how patriarchal power, sexism and other forms of intersectional discrimination within society, within the criminal justice system, health services and other public institutions can silence women and normalise, excuse, tolerate violence and torture, and maintain impunity for the perpetrators.
- Enable survivors and their families to exercise choice wherever possible, seeking and supporting their participation, respecting their dignity and treating them as human beings.
- Identify and address the ongoing abuses and economic, sexual or other forms of exploitation; risks of further harm; any threats of harm and reprisals against them or family members; and any ongoing discrimination – to ensure their safety and welfare.

4. Monitor and examine how ***services*** where torture survivors are seen:
   - reflect social inequalities (e.g. within staff make-up and positions, service policies, practices and decision-making);
   - reproduce power in discriminatory practices and in how they talk about survivors, women, sexual violence and perpetrators.

5. Identify which ***human rights principles*** are relevant in services and psychological practices with survivors.

6. Identify the key ***human rights*** which are engaged (e.g. rights to be free from torture and cruel, inhuman or degrading treatment or punishment, to private and family life, liberty, life, health and rehabilitation as a form of reparation).

7. Identify the ***national legal context and the international human rights framework*** which
   - Protect against torture and sexual violence; or
   - Fail to protect women (e.g. where marital rape is not recognised as rape, where abortion is illegal even if a woman was raped);
   - Recognise that sexual violence can amount to an international crime, torture, part of genocide and a crime against humanity.
   - Offer avenues for redress and reparation;
   - Enable survivors to access justice and other reparation measures; and as psychologists support them through this process if they want.

8. Engage in ***prevention activities*** at different levels (e.g. Caplan, 1964) adopting a stance of practitioner-activist (Patel, 2019a) to prevent psychological distress related to torture (see Patel, 2007b) and sexual violence.

   P*rimary prevention*:
   - Contribute to public health strategies targeting populations not yet affected by health problems; and to the development of macro-level policies (national social, economic and legal policies); and strategies to address the social determinants of health –strategies which require social change (Albee, 1995).
   - Challenge/influence those policies which adversely impact on psychological health and well-being.

- Raise public awareness of torture, its impact and the importance of justice and reparation.
- Provide human rights education to psychology students and training professionals.

Secondary prevention

- Identify national policies (e.g. asylum and immigration policy) and practices (e.g. lack of protection against domestic violence and other harm) which perpetuate social injustices and human rights abuses and worsen existing psychological health problems;
- Provide expert witness reports to challenge impunity for crimes of sexual violence and torture; to protect against return to a place where survivors may face torture again; and to ensure access to appropriate healthcare.

Tertiary prevention

- Prevent the further deterioration and chronicity of the psychological and social impacts of social inequalities and human rights abuses on individuals, families and communities. For example, by providing psychological care, as part of a multidisciplinary, holistic service, within a human rights framework, to survivors, their families and communities affected by sexual violence and torture.

Conclusions

Applying a critical human rights-based approach to psychology explicitly constructs the role of applied psychologists as practitioner-activists. Broadly, this (a) involves the critical unpacking of the foundations, contexts and biases of psychological theories, research and practices as well as of human rights doctrine; (b) addressing discursive and structural power; (c) embedding human rights principles in psychological practice, research and services; and (d) engaging in change processes, collective activism and prevention to address the causes of harm and psychological distress and suffering. As a stance against oppression and oppressive practices, structural inequalities and human rights abuses, a CHRBA invites critical reflection of ourselves, our roles as psychologists and the ways in which we may reinforce inequalities and human rights abuses, and, importantly, the ways in which we may challenge and help transform policies and practices which harm people.

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