

BOARD OF DIRECTORS

May 21, 2024

APPROVED MINUTES

Board Members Present: Cynthia de las Fuentes, PhD; Debra M. Kawahara, PhD; Thema S. Bryant, PhD; Michael L. Hendricks, PhD, ABPP; Kathleen S. Brown, PhD; Arthur C. Evans Jr., PhD; Luz Maria Garcini, PhD, MPH; Quincy Guinadi, PsyD; Elizabeth Louis, PhD; Tamara S. Lyn, PhD, ABPP; Mary Ann McCabe, PhD, ABPP; Arlene Noriega, PhD; Lindsay Patterson, CIA, CPA; Hideko Sera, PsyD; Talee Vang, PsyD

Board Members Absent: Noelle Lefforge, PhD, ABPP

- A. The Board voted to accept the 2023 Division Annual Reports.
- B. The Board voted to 1) determine that the *Clinical Practice Guideline for the Nonpharmacological Treatment of Chronic Musculoskeletal Pain in Adults* poses no undue risk to the Association and 2) refer the item to the Council Leadership Team for a content review and to make a recommendation to Council.
- C. The Board discussed the upcoming launch of APA Community, an online platform that will allow members to connect with peers, share content, and collaborate on projects.
- D. The Board had a conversation with Guillermo Corea, APA's Chief Business Innovation & Growth Officer, regarding some initial reflections on opportunities for innovation and revenue growth.

BOARD OF DIRECTORS

June 7 & 8, 2024

APPROVED MINUTES

Board Members Present: Cynthia de las Fuentes, PhD; Debra M. Kawahara, PhD; Thema S. Bryant, PhD; Michael L. Hendricks, PhD, ABPP; Kathleen S. Brown, PhD; Arthur C. Evans Jr., PhD; Luz Maria Garcini, PhD, MPH; Quincy Guinadi, PsyD; Noelle Lefforge, PhD, ABPP; Elizabeth Louis, PhD; Tamara S. Lyn, PhD, ABPP; Mary Ann McCabe, PhD, ABPP; Arlene Noriega, PhD; Lindsay Patterson, CIA, CPA; Hideko Sera, PsyD; Talee Vang, PsyD

Board Members Absent: None.

I. MINUTES OF MEETING

A.(1) The Board voted to approve the minutes of its February 22, 2024, meeting; its following 2024 calls: March 5, March 19, April 2, April 16, May 7; and votes taken by unanimous written consent from February 23 through May 6, 2024.

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) The Board voted to recommend that Council approve the following amendments to the Association Rules (bracketed/strikethrough material to be deleted; underlined material to be added):

110-14. RULES GOVERNING SIMULTANEOUS SERVICE

110-14.1 It is the goal of this section that members not serve simultaneously on the Board of Directors at the same time as another elected or appointed APA position, and also that members not serve for more than one advisory group except as ex-officio, non-voting, and/or with certain other minor exceptions noted. To that end, sections 110-14.2, 110-14.3 and 110-14.5 identify specific groups as to which simultaneous service is prohibited and set forth qualifications for participation in election or appointment to the Board of Directors and advisory groups when a member is currently serving or has been elected or appointed to serve on another advisory group.

110-4.2 Members of the Board of Directors shall serve simultaneously on the Board of Directors of the American Psychological Association Services, Inc., but not serve simultaneously on APA advisory groups, other than as ex-officio or liaison; in any elected positions in any Divisions or state/provincial/territorial psychological associations; or on governing bodies of other advocacy or political action organizations for psychologists or psychology that are national in scope.

110-14.3 Members shall not serve simultaneously on any of the following advisory groups, except as ex-officio and/or non-voting members or if other exceptions are provided below.

Boards

Advancement of Psychology in the Public Interest
Convention Affairs
Educational Affairs
Membership
Policy and Planning
Publications and Communications
Professional Affairs (except that one member is also a member of the Committee on Professional Practice and Standards)
Scientific Affairs

Committees

Advancement of General Applied Psychology
Aging
American Psychological Association of Graduate Students
Animal Research and Ethics
Associate and Baccalaureate Education
Children, Youth and Families
Continuing Education
Council Leadership Team
Disability Issues in Psychology
Division/APA Relations
Early Career Psychologists
Ethics
Ethnic Minority Affairs
Fellows
Finance
Global Psychology
Health Equity (ad hoc)
Human Research
Needs Assessment, Slating and Campaigns
Professional Practice and Standards (except that one member is also a member of the Board of Professional Affairs)
Rural Health
Sexual Orientation and Gender Diversity
Socioeconomic Status
Psychological Tests and Assessment
Teachers of Psychology in Secondary Schools
Women in Psychology

Commissions

Commission for the Recognition of Specialties and Subspecialties in Professional Psychology
Commission on Accreditation

110-14.4 Members shall not run for election in the same calendar year for more than one of the following positions: President-Elect, Recording Secretary, Treasurer, member-at-large of the Board of Directors, Council Leadership Team Chair-Elect, Early Career Representative of the Council Leadership Team, member-at-large of the Council Leadership Team.

110-14.5 Members shall not 1) simultaneously run for election (i.e., appear on an election ballot that is open for voting) for the Board of Directors and for any of the following advisory groups ; 2) run for election for one of the following advisory groups if the term of service will begin prior to the end of a term the member is currently serving or has been elected or appointed to serve on one of the advisory groups listed in Association Rule 110-14.3.; 3) be appointed to one of the advisory groups listed in Association Rule 110-4.3 if service will begin prior to the end of a term the member is currently or has been elected or appointed to serve on one of these groups.

Boards

Advancement of Psychology in the Public Interest
Convention Affairs
Educational Affairs
Membership
Policy and Planning
Publications and Communications
Professional Affairs
Scientific Affairs

Committees

Advancement of General Applied Psychology
American Psychological Association of Graduate Students
Council Leadership Team
Ethics
Finance
Global Psychology
Rural Health

Commissions

Commission for the Recognition of Specialties and Subs specialties in Professional Psychology

- B. The Board participated in a discussion regarding Member Engagement.
- C. In executive session, the Board voted to recommend that Council elect the members listed to Fellow status, on the nomination of the indicated divisions and on the recommendation of the Fellows Committee and the Board of Directors.
- D. In executive session, the Board voted to approve Jennifer F. Kelly, PhD, as the recipient of the 2024 Raymond D. Fowler Award for Outstanding Contributions – Member.
- E. In executive session, the Board reviewed and recommended no changes to the Board member-at-large slates recommended by the Needs Assessment, Slating and Campaigns Committee.

VI. ORGANIZATION OF THE APA

A.(3) The Board voted to recommend that Council extend the expiration date for 1) the *Guidelines for Clinical Supervision in Health Service Psychology* to December 31, 2025, and 2) the *Guidelines for the Psychological Practice with Transgender and Gender Nonconforming People* to December 31, 2026.

B. In executive session, the Board discussed report outs from the February 2024 Council and March 2024 Consolidated meetings regarding Artificial Intelligence and the development of a statement on Artificial Intelligence and the Field of Psychology for adoption as APA policy by the Council in August 2024.

C. In executive session, the Board had a strategic conversation regarding advancing Population Health.

IX. EDUCATIONAL AFFAIRS

A. In executive session, the Board discussed the update on the Unified Competency Framework for Doctoral and Master's Degrees in Health Service Psychology.

X. PROFESSIONAL AFFAIRS

A.(5) The Board received an update on the work of the Advisory Steering Committee for Development of Clinical Practice Guidelines and APA Guideline Panels and plans for 2024.

XI. SCIENTIFIC AFFAIRS

A.(4) The Board voted to (1) determine that the *Guidelines for Behavioral Projects with Nonhuman Animals in Schools (K – 12)* poses no undue risk to the Association and (2) refer the item to the Council Leadership Team for a content review and to make a recommendation to Council.

XII. PUBLIC INTEREST

A. The Board discussed the update on the Racial Equity Action Plan.

B. In executive session, the Board discussed the update on Council New Business Item #11B/FEB 2024, Association of Jewish Psychologists' Affiliation with APA and Seat on Council as an Ethnic Psychological Association.

XIV. INTERNATIONAL AFFAIRS

A. The Board discussed the Immigration Task Force Report and Policy Statement.

XV. FINANCIAL AFFAIRS

A. In executive session, the Board received a report from the Finance Committee.

B. In executive session, the Board voted to approve that the membership dues allocation for FY2025 remain at APASI 60% and APA 40%.

C. In executive session, on recommendation of the Finance Committee, the Board voted to approve that the August Council of Representatives meetings become an in-person only event, without a hybrid participation option, beginning with the August 2025 Council meeting.

BOARD OF DIRECTORS

June 18, 2024

APPROVED MINUTES

Board Members Present: Cynthia de las Fuentes, PhD; Debra M. Kawahara, PhD; Thema S. Bryant, PhD; Michael L. Hendricks, PhD, ABPP; Kathleen S. Brown, PhD; Arthur C. Evans Jr., PhD; Luz Maria Garcini, PhD, MPH; Quincy Guinadi, PsyD; Noelle Lefforge, PhD, ABPP; Tamara S. Lyn, PhD, ABPP; Mary Ann McCabe, PhD, ABPP; Arlene Noriega, PhD; Lindsay Patterson, CIA, CPA; Hideko Sera, PsyD; Talee Vang, PsyD

Board Members Absent: Elizabeth Louis, PhD

A. The Board voted to recommend that Council archive the following association policies contained in the Council Policy Manual:

APA position statement on managed care (MC) and utilization review (UR)

WHEREAS Government officialdom, representatives of industry and employer groups, and representatives of managed care (MC) and utilization review (UR) companies are increasingly and aggressively promoting managed care as a solution to the nation's health care delivery problem;

AND WHEREAS objective data as to the efficacy of MC and UR approaches to the nation's health problems when adequate quantity and high quality of care are held constant is not extant;

AND WHEREAS degradation in the quantity and quality of care occasions rising concern;

AND WHEREAS the media and the courts (see New Republic, "Managed Care: A Sick Joke"; American Psychiatric News, December 20, 1992; New York Times, "Do They Want My Wife to Die?," April 15, 1992) have documented flagrant abuses by some MC and UR companies;

AND WHEREAS both administration and congressional proposals for health care reform, almost without exception, mandate the establishment of national MC and UR programs exempt from all state mandates as to benefit structure and regulation of service provisions and state controls as to the standards of care;

THEREFORE BE IT RESOLVED The American Psychological Association calls upon the Congress and/or the President to develop objective data demonstrating that managed care and utilization review can effect economic savings while maintaining acceptable levels of quantity and quality care BEFORE committing to such programs as a solution to current problems in health care delivery.

The American Psychological Association believes that the exemption of any MC or UR program from state-mandated benefits and/or state-mandated controls is demonstrably contrary to the public interest unless such mandates and/or controls are replaced by federal controls and mandates offering the same or greater protection.

The American Psychological Association believes that all managed care and utilization review programs should be held to the same high standards of performance required of credentialed providers in the states in which MC and UR services are offered; and the APA urges its state affiliates to become involved in a legislative process designed to procure such regulation. In legislation of this type, professionals' responsibility to protect the public interest demands the involvement of all health disciplines. The Council of Representatives of the American Psychological Association requests that the affiliated state psychological associations:

1. take a leadership role in developing the legislative process and content; and
2. also take a leadership role in developing effective coalitions of health disciplines to address the increasingly serious problems in order to protect the public interest.

The American Psychological Association further asks the Congress and the Administration to develop minimum standards for federally sponsored national MC and UR programs as the most efficacious way to avoid the numerous problems currently affecting the quantity and quality of care that have developed under Medicare. Hopefully, such action at a federal level will also help diminish the spate of litigation which we believe MC and UR programs have already begun to engender.

Appropriate Therapeutic Responses to Sexual Orientation

Adopted by the APA Council of Representatives on August 14, 1997

Whereas societal ignorance and prejudice about same gender sexual orientation put some gay, lesbian, bisexual and questioning individuals at risk for presenting for "conversion" treatment due to family or social coercion and/or lack of information (Haldeman, 1994);

Whereas children and youth experience significant pressure to conform with sexual norms, particularly from their peers;

Whereas children and youth often lack adequate legal protection from coercive treatment;

Whereas some mental health professionals advocate treatments of lesbian, gay, and bisexual people based on the premise that homosexuality is a mental disorder (e.g., Socarides et al, 1997);

Whereas the ethics, efficacy, benefits, and potential for harm of therapies that seek to reduce or eliminate same-gender sexual orientation are under extensive debate in the professional literature and the popular media (Davison, 1991; Haldeman, 1994; Wall Street Journal, 1997);

Therefore, be it resolved that APA affirms the following principles with regard to treatments to alter sexual orientation:

Therefore, be it resolved that homosexuality is not a mental disorder (American Psychiatric Association, 1973); and

Therefore, be it resolved that psychologists “do not knowingly participate in or condone unfair discriminatory practices” (American Psychological Association, 1992); and

Therefore, be it resolved that “in their work-related activities, psychologists do not engage in unfair discrimination based on ... sexual orientation” (American Psychological Association, 1992); and

Therefore, be it resolved that “in their work-related activities, psychologists respect the rights of others to hold values, attitudes, and opinions that differ from their own.” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists ... respect the rights of individuals to privacy, confidentiality, self-determination and autonomy” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists are aware of cultural, individual and role differences, including those due to ... sexual orientation” and “try to eliminate the effect on their work of biases based on [such] factors” (American Psychological Association, 1992); and

Therefore, be it resolved that “where differences of ... sexual orientation ... significantly affect psychologist's work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists do not make false or deceptive statements concerning ... the scientific or clinical basis for ... their services,” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists attempt to identify situations in which particular interventions ... may not be applicable ... because of factors such as ... sexual orientation” (American Psychological Association, 1992); and

Therefore, be it resolved that “psychologists obtain appropriate informed consent to therapy or related procedures” [which] “generally implies that the [client or patient] (1) has the capacity to consent, (2) has been informed of significant information concerning the procedure, (3) has freely and without undue influence expressed consent, and (4) consent has been appropriately documented” (American Psychological Association, 1992); and

Therefore, be it resolved that “when persons are legally incapable of giving informed consent, psychologists obtain informed permission from a legally authorized person, if such substitute consent is permitted by law” (American Psychological Association, 1992);.

Therefore, be it resolved that “psychologists (1) inform those persons who are legally incapable of giving informed consent about the proposed interventions in a manner commensurate with the persons' psychological capacities, (2) seek their assent to those interventions, and (3) consider such persons' preferences and best interests” (American Psychological Association, 1992); and

Therefore, be it resolved that the American Psychological Association “urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientation” (Conger, 1975, p. 633); and

Therefore, be it further resolved that the American Psychological Association opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation.

References

American Psychiatric Association. (1973). Position Statement on Homosexuality and Civil Rights. *American Journal of Psychiatry*, 131 (4), 497.

American Psychological Association. (1992). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist*, 47, 1597-1611.

Conger, J.J. (1975). Proceedings of the American Psychological Association, Incorporated, for the year 1974: Minutes of the Annual Meeting of the Council of Representatives. *American Psychologist*, 30, 620-651.

Haldeman, D.C. (1994). The Practice and Ethics of Sexual Orientation Conversion Therapy. *Journal of Consulting and Clinical Psychology*, 62 (2), 221-227.

Letters to the Editor. (1997, January 23). *Wall Street Journal*, p. A17.

Socarides, C., Kaufman, B., Nicolosi, J., Satinover, J., & Fitzgibbons, R. (1997, January 9). Don't forsake homosexuals who want help. *Wall Street Journal*, p. A12.

Please cite this policy statement as:

DeLeon, P. H. (1998). Proceedings of the American Psychological Association, Incorporated, for the legislative year 1997: Minutes of the Annual Meeting of the Council of Representatives, August 14 and 17, Chicago, Illinois; and June, August and December 1997 meetings of the Board of Directors.

American Psychologist, 53, 882-939.

Changing U.S. health care system

WHEREAS the health care system in this country has been dramatically transformed in the last decade from a patient-focused system with an emphasis on the provision of adequate services to a market-driven system increasingly concerned about the cost of providing care to the nation's citizenry;

WHEREAS this transformation has been extremely far-reaching in its influence on all aspects of the health care delivery system and on all communities of interest, including health care professionals and purchasers and consumers of health care services;

WHEREAS all aspects of the profession of psychology are being affected by the changing health care system, including its practices, the education and training of psychologists, related research directions and psychology's objective of promoting human welfare;

THEREFORE BE IT RESOLVED That APA declares the changing health care system's impact on psychology and the public, with all its resulting challenges and opportunities, to be a matter of the highest priority and concern for the entirety of the Association.

Collection of information about the representation of women, ethnic minorities, gay men, lesbians and bisexuals, transgender individuals, and individuals with disabilities in APA governance

Collection of Information about the Representation of Women, Ethnic Minorities, Gay Men, Lesbians and Bisexuals, Transgender Individuals and Individuals with Disabilities in APA Governance: That staff is directed to 1) annually collect and disseminate information on the number of women, ethnic minorities, gay men, lesbians, bisexuals, transgender individuals and individuals with disabilities serving on Council and boards and committees; 2) at least every five years, collect and disseminate information on the number of women, ethnic minorities, gay men, lesbians, bisexuals, transgender individuals and individuals with disabilities who have been nominated to boards and committees and/or put on a board/committee election slate and to nominees on the Council of Representatives election ballot. The information will be collected by mailing a survey requesting voluntary self disclosure regarding gender, ethnicity, sexual orientation, and disability status from board/committee members and Council members (annually) and board/committee nominees and members running for Council (at least every five years). The results of the survey will be disseminated to APA governance groups and will be used in determining whether further action to increase diversity is warranted based on the results and, if so, at what point in the nomination/election process diversity issues may need to be most vigorously addressed.

Council requested that the APA Research Office be involved in the development of the survey and analyzation of the data

Disaster response network

Council voted to approve designating the Committee for the Advancement of Professional Practice as the appropriate governance entity with responsibility for the Disaster Response Network administered by the Practice Directorate.

Duties of Council and trial delegation of specific duties to the Board

Adopted by APA Council of Representatives in February 2017

WHEREAS, in 2013, the American Psychological Association embarked on a project of good governance (the "Good Governance Project" or "GGP") in order to enhance and improve the efficiency, nimbleness and effectiveness of APA's governance infrastructure;

WHEREAS the Good Governance Project Team brought forth to Council the Good Governance Project Report detailing ways that the governance infrastructure of APA can be more effective, more nimble and more efficient;

WHEREAS the GGP Report was received by Council at its July/August 2013 meeting;

WHEREAS the GGP Team brought forward for a vote to Council in July/August 2013 eight (8) motions relating to the implementation of the GGP Report including:

Technology
Leadership Development Triage

Council Purpose Fiduciary Roles Board Composition Council Structure Implementation

WHEREAS among these motions, Council adopted the following motion at its July 31 & August 2, 2013: Motion #5 Fiduciary Roles (108/50/1)

Council supports delegating the authority for the following areas of fiduciary responsibility to the Board of Directors on a trial basis for a three-year period following implementation:

Financial/budget matters

Hiring, evaluation and support for the Chief Executive Officer Assuring alignment of the budget with the APA strategic plan Internally focused policy development

In addition, Council will receive regular reports from the Board on the delegated areas during the trial period and retains its responsibility as set forth in the Bylaws. In the interest of transparency, such reports to Council will also be made available to the entire membership.

WHEREAS Council has determined that it is in the best interests of the Association, and will facilitate APA fulfilling its mission, to allow Council to focus its work more fully on developing and adopting policy and ensuring APA policies are aligned with APA's plans.

WHEREAS Council has determined that it can best meet its fiduciary duty to the Association as a whole, and in particular in the areas of financial and budget matters, alignment of the budget with the strategic plan, management of Chief Executive Officer, and internally focused policy development, by delegating evaluation, oversight, management and decision making authority for these areas to the Board of Directors.

WHEREAS pursuant to Motion #5 noted above, in order to allow Council to fulfill its fiduciary responsibility more fully so that it may focus its work on policy issues and alignment of policy with APA's mission and strategic plan, the Council of Representatives voted to evaluate on a trial basis the effectiveness of delegating authority for that part of its fiduciary responsibility to certain financial and administrative tasks to the Board to discharge for a trial period of three years beginning on March 1, 2014;

WHEREAS in the intervening three years since Council adopted Motion #5, for the reasons stated in the December 2016 Finance Committee's extensive analysis of the trial delegation, Council has not been able to fully develop its policymaking role and the Board has not been fully able to regularize its process for its delegated responsibilities;

WHEREAS the Board of Directors, Council Leadership Team and Finance Committee have all recommended a three-year extension of trial delegation and allocation of duties through Council's first meeting in 2020;

WHEREAS in light of the issues encountered during the current three-year delegation period, Council now wishes to extend the trial period for the delegation of authority and allocation of duties between the Board and Council for an additional trial period of three years beginning on March 1, 2017;

THEREFORE BE IT RESOLVED pursuant to its authority as set forth in Article IV, Sections 1 and 7 of the Bylaws, and pursuant to a suspension of Association Rules to the extent necessary, the Council of Representatives hereby delegates to the Board of Directors, for a period of three years ending following Council's first meeting in 2020, authority for the following areas:

Financial and budget matters,
Hiring , evaluation and support of the CEO,
Assuring alignment of the budget with the APA Strategic Plan, and Internally focused policy development

The Board shall prepare and provide to Council semi-annual reports on these delegated areas during this period, which shall also be available to the membership.

During the three year period:

1) Council will rely on the Board of Directors to carry out its responsibilities in these four areas, subject to Council's overall power and authority as set forth in the Bylaws, while Council will focus on development of policy for the discipline of psychology, and;

2) Those portions of the Association Rules requiring a vote of approval by Council for action in these four areas shall be suspended until further action by Council, such as:

Rule 110-10 through 110-12 (Chief Staff Officer confirmation, evaluation and reconfirmation);
Rule 210-2.3/210-4 (approval by Council of long term goals for investing recommended by the APA Finance Committee); Rule 210-2.5 (approval by Council of Presidential Discretionary Fund);
Rule 210-5 (approval of dues) ;
Rule 10-12 (Life Membership Status dues exemption);
Rule 50-3 (approve new ad hoc group if new funding is needed); Rule 210-2.2 (approval of budget by Council)

3) For the evaluation process:

The Chief Financial Officer, on behalf of the Board of Directors, Finance Committee and APA staff, will provide a semi-annual report to Council. This report will provide Council detail on how APA is meeting the organizational financial goals as set forth in the Association Rules.

The President, on behalf of the Board of Directors, will provide a semi-annual report to Council on the state of the Association. This report will provide Council detail as to how APA is meeting the organizational governance goals set forth in the Association Rules, on hiring, evaluation and support of the CEO, and on any new internally focused policy developments.

The Council Leadership Team will name a subgroup of Council to evaluate how Council is fulfilling its role to develop policy for the discipline of psychology, and also provide an annual report to Council.

Two evaluations related to financial and budget matters will be conducted under the direction of the Finance Committee which will solicit input from Council, Board of Directors, Finance Committee and appropriate APA staff.

The first evaluation will be conducted in the spring of 2018. The Treasurer will report the findings of the evaluation to Council at its August 2018 meeting. Data collected will be used to modify the on-going trial.

The second evaluation will be conducted in the spring of 2019. The Treasurer will report the findings of the evaluation to Council at its August 2019 meeting. Data provided will be used to improve the on-going trial period.

At the end of the trial period during its first meeting in 2020, Council will decide how to proceed.

Suggested Citation

American Psychological Association. (2017). Duties of Council and Trial Delegation of Specific Duties to the Board. Retrieved from: <http://www.apa.org/about/policy/duties-council-board>

Impact of selective reduction of support for "social research"

While the American Psychological Association recognizes the appropriate and legitimate role of the political process in determining priorities for research on problems that require the expenditure of public funds, we object to policies that a priori favor one theoretical approach over another, or that selectively suppress certain scientific approaches that happen to be at odds with the prior opinions or ideology of political officials.

The selective reduction of support for "social research" by the current Administration appears to be a case in which ideological considerations are inappropriately influencing the scientific process. Current policies of the Administration (e.g., in the mental health area) presume that certain research approaches are more valuable than others. There is no evidence to support such a premise. In fact, scientific evidence suggests that many mental health and other social problems are best understood and dealt with by looking at the joint impact of biological, behavioral, and social processes. Clearly, policies such as these are inimical both to productive scientific inquiry and to the ultimate solution of many critical social problems in our nation. We strongly oppose such policies that include selective reductions that bias the development of scientific research in all areas including social research.

Managed care accessibility and reimbursement criteria

APA commends those managed care organizations (MCOs) which publish the criteria they use to determine accessibility to, and reimbursement of psychological and neuropsychological services. APA recognizes these MCOs for their responsibility and commitment to publicize their critical decision- making rules.

Correspondingly, APA strongly objects to the practice of any organization that makes healthcare accessibility or reimbursement decisions without publishing the criteria upon which these decisions are based. It is the position of APA that such decision-making criteria should be made accessible so that these critical variables may be subjected to scientific, professional and public review and scrutiny.

Furthermore, it is the position of APA that all MCOs should publish not only their decision-making criteria, but also the process by which these criteria have been developed and applied. To implement the above policy Council requests that the Practice Directorate, on behalf of APA, solicit the MCOs for the release of their criteria and decision-making process.

Managed healthcare programs

WHEREAS, many mental health problems are reflective of profound problems of living, substantial intra-psychic disorganization or serve physical and psychological disruption; and

WHEREAS, some psychological services are specifically focused on the alleviation of the personal distress attendant thereto; and

WHEREAS, managed care or other health care delivery systems should not unduly discriminate against those consumers who need intensive care, against those who need specialty care, and

should not systematically endorse short-term or biomedical intervention as the treatment of choice for all patients at the expense of individual needs; and

WHEREAS, managed care delivery programs, by their very nature, frequently impose artificial and/or economic barriers to consumer access to health care services and, as such, are as subject to mismanagement as are traditional funding and delivery systems; and

WHEREAS, many managed health care programs may unfairly exclude those with the greatest need from adequate care and/or otherwise put both consumer and participating professional at substantial economic/psychological risk; and

WHEREAS, it is important that mental health care delivery programs provide appropriate and equally high quality services to all persons in diverse client and underserved populations; and

WHEREAS, providers and patients should be informed of the limitations and restrictions to types and access of psychological services prior to subscribing to a plan (i.e., truth in advertising or explicit statements regarding any financial disincentives to treat and refer patients in need of psychological services),

THEREFORE, BE IT RESOLVED that the American Psychological Association urges consumers, subscribers and psychologists to review carefully the mechanisms, procedures, practices and policies of managed care programs before deciding to participate. Although such programs may offer the potential to expand access to appropriate mental health care, they may also restrict availability of necessary psychological services.

It is further recommended that providers may wish to require as a condition of their participation that such managed health care delivery systems adequately and concretely demonstrate provisions to serve the consumer's interest with sufficient quantity and highest quality of health care based on the available scientific evidence of efficacy.

It is further recommended that consumers, subscribers and psychologists, as a condition of their participation, require that these programs practice truth in advertising regarding the range and duration of psychological services available through the plan and that these programs provide patients access to a diversity of psychological health care competencies based on the available scientific evidence of efficacy.

It is also recommended that providers require that such systems operate in accordance with prevailing standards of care and prevailing scientific knowledge, applicable ethical principles, and that the systems have sufficient economic resources to cover the delivery system's liabilities.

Finally, individual members, state psychological associations and divisions are strongly urged to monitor and inform themselves of the legal and regulatory requirements imposed on managed health care systems and to advocate that such requirements meet the principles enumerated herein.

Motor vehicle trauma

Whereas motor vehicle trauma causes damage to every system of the human body and every psychological and social system involving the victims of motor vehicle trauma; and

Whereas the great majority of these deaths, traumatic injuries, psychosocial, and financial losses could be prevented or significantly reduced through the application of available or potentially available but neglected countermeasures; and

Whereas we as behavioral scientists and practitioners have special expertise that can be applied to the prevention of motor vehicle trauma and its sequelae; and

Whereas the American Psychological Association herein declares that motor vehicle trauma prevention is rightfully a major concern of behavioral scientists and practitioners;

Therefore be it resolved that the American Psychological Association supports the American Academy of Pediatrics in its "The First Ride" project to see that all newborn babies ride properly protected in infant car safety seats, and in its general program to prevent/reduce infant and childhood motor vehicle trauma; and

Be it further resolved the APA will continue to work with the American Academy of Pediatrics and other groups to promote the prevention/reduction of motor vehicle trauma and its sequelae for Americans of all ages (Fox, 1987).

Policy on scheduling dates of the annual convention

Council approved having the dates for the annual convention remain as presently defined by the Board of Convention Affairs from the second Thursday in August to the following Sunday.

Policy on seating/space at Council meetings

Staff was instructed whenever possible to make available at all future Council meetings seating and work tables of no less than three linear feet (one meter) per person.

Policy regarding council representatives seeking positions on APA boards and committees

That Council members be encouraged to seek nomination to boards and committees. The nomination process would be one of the topics covered at the Committee on Structure and Function of Council sponsored orientation for new Council members. Shortly after their election, Council representatives will be sent a letter encouraging them to participate in the nomination process for boards and committees along with information on the election process for boards and committees.

Psychological treatment as part of the professional preparation of a psychologist

Where psychotherapy, psychoanalysis, or other forms of psychological treatment or behavior modification are undertaken as a required or credited part of the professional preparation of a psychologist, the cost of such training should not be charged against a health plan by either the trainee or a psychologist

/therapist, but where a psychologist or trainee may have a recognized mental disorder and seek professional assistance, the therapy should not be claimed as professional training and should be a reimbursable expense within the limits of the individual's health plan.

Required endorsement dropped from the student application process

Council approved dropping the requirement for endorsements from Association members for applicants for associate member or member status and amended requirements for documentation on application forms and for procedures to ensure an applicant's qualifications for membership in the Association.

Required endorsements dropped from membership application process

Council approved dropping the requirement for endorsements from Association members for applicants for associate member or member status and amended requirements for documentation on application forms and for procedures to ensure an applicant's qualifications for membership in the Association.

Resolution concerning "Mental health consumer protection acts"

WHEREAS a major purpose of the American Psychological Association is to advance psychology as a science and profession as a means of promoting human welfare; and

WHEREAS for almost 50 years the ethical standards of the American Psychological Association have provided extensive safeguards for consumers of mental health services; and

WHEREAS those same standards have been incorporated into state law and regulation to provide additional statutory protection for the consumer; and

WHEREAS these same standards require psychologists to practice only within the boundaries of their competence as determined by demonstrable education, training, and experience; and

WHEREAS there are current efforts to introduce bills in the form of "mental health consumer protection acts" such as those currently being considered by the New Hampshire and Illinois legislatures which purport to protect consumers but on closer inspection contain many provisions that will actually harm consumers and curtail availability of quality services;

NOW THEREFORE the American Psychological Association is opposed to the enactment of legislation that, while seeming to protect the consumer, actually creates a bureaucracy and unnecessary barriers that interfere with consumer access to mental health services and fails to protect consumers.

Resolution on appropriate affirmative responses to sexual orientation distress and change efforts

Whereas the American Psychological Association expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (American Psychological Association, 1998, 2000, 2002, 2003, 2005, 2006, 2008b);

Whereas the American Psychological Association takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008b);

Whereas psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or non-religious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b);

Whereas psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008b);

Whereas those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008b);

Whereas the American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008b);

Whereas societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkowicz, 2001);

Whereas some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968);

Whereas sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997), who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciotto & Cahill, 2006; Ryan & Futterman, 1997); and

Whereas research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Herschberger & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

Therefore be it resolved that the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

Be it further resolved that the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

Be it further resolved that the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

Be it further resolved that the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

Be it further resolved that the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

Be it further resolved that the American Psychological Association concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren & Prince, 2004; Ryan & Futterman, 1997; Norcross, 2002);

Be it further resolved that the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

Be it further resolved that the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (American Psychological Association, 1998), in particular the following standards and principles: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity;

Be it further resolved that the American Psychological Association encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma, and contribute to variations in sexual orientation identity development, expression, and experience;

Be it further resolved that the American Psychological Association opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

Be it further resolved that the American Psychological Association supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation; and

Be it further resolved that the American Psychological Association encourages advocacy groups, elected officials, mental health professionals, policy makers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the wellbeing of sexual minorities.

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Resolution on handgun control

Whereas, the American Psychological Association deplores the increase in violence in the United States; and

Whereas, the ready availability of handguns contributes to this problem; and
Whereas, the psychological research on factors which contribute to human aggression indicates that exposure to guns can result in an increased likelihood of aggression;

Resolved, that the American Psychological Association affirm the need for legislation at every social level (local, state, and federal) controlling the availability of handguns.

Resolution on licensing for psychoanalysts

On the recommendation of the Board of Directors and the Board of Professional Affairs, Council voted to approve the following resolution on licensing for psychoanalysts:

APA has long endorsed the principle of generic education and training for psychology, further recognizing that within any profession there are identifiable and demonstrable specialties.

Thus, from the standpoint of these principles, psychoanalysis is viewed as a set of theories and techniques. In addition, psychoanalysis is viewed as an advanced specialization of a number of professions rather than as an independent profession. Therefore, APA does not recognize psychoanalysis as an independent or licensable profession.

[The text of the second paragraph of the resolution reflects amendments approved by Council in February 1992.]

Resolution on Marriage Equality for Same-Sex Couples

Adopted by the APA Council of Representatives on August 3-5, 2011.

Whereas people benefit by sharing their lives with and receiving support from their family, friends, and other people who are important to them (Cohen & Wills, 1985);

Whereas a person's sexual orientation defines the universe of persons with whom he or she is likely to find the satisfying and fulfilling romantic and intimate relationships that, for many individuals, comprise an essential component of personal identity (D'Augelli, 2000; Gonsiorek & Weinrich, 1991; Herek, 2001, 2006; Peplau & Garnets, 2000);

Whereas homosexuality is a normal expression of human sexual orientation that poses no inherent obstacle to leading a happy, healthy, and productive life, including the capacity to form healthy and mutually satisfying intimate relationships with another person of the same sex and to raise healthy and well-adjusted children, as documented by several professional organizations (American Psychiatric Association, 1974; American Psychological Association, 2004a, 2004b; Conger, 1975, National Association of Social Workers, 2003);

Whereas many gay men and lesbians, like their heterosexual counterparts, desire to form stable, long-lasting, and committed intimate relationships and are successful in doing so (Gates, 2006; Henry J. Kaiser Family Foundation, 2001; Herek, Norton, Allen, & Sims 2010; Peplau & Fingerhut, 2007; Simmons & O'Connell, 2003);

Whereas the consideration of policies to provide or deny same-sex couples full access to civil marriage and other legal forms of family formation in all branches of both the federal and state

governments in the United States has frequently subjected the human rights of lesbian, gay, and bisexual people to public debate and resulted in wide variation among jurisdictions in access to these rights (Gates, Badgett, & Ho, 2008; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Herek, 2006; National Gay and Lesbian Task Force, 2010; Rostosky, Riggle, & Horne 2009; Russell, 2000);

Whereas emerging evidence suggests that statewide campaigns to deny same-sex couples legal access to civil marriage are a significant source of stress to the lesbian, gay, and bisexual residents of those states and may have negative effects on their psychological well-being (Hatzenbuehler et al., 2010; Rostosky et al., 2009);

Whereas the denial of civil marriage, including the creation of legal statuses such as civil unions and domestic partnerships, stigmatizes same-sex relationships, perpetuates the stigma historically attached to homosexuality, and reinforces prejudice against lesbian, gay, and bisexual people (Badgett, 2009; Herek, 2006; Hull, 2006);

Whereas many gay, lesbian, and bisexual adults who are in a committed same-sex relationship have taken advantage of the right to marriage, either in their home jurisdictions or in other jurisdictions, even though many jurisdictions that do not permit marriage of same-sex couples do not recognize these valid marriages (Badgett, 2009; Gates et al., 2008; Herel, Marech, & Lelchuk, 2004; Marech, 2004);

Whereas many other adults who are in a committed same-sex relationship wish to marry, but are prevented by state law from being married in their home jurisdiction or from receiving recognition of their marriages performed elsewhere (Herek et al., 2010);

Whereas empirical research demonstrates that the psychological and social aspects of committed relationships between same-sex partners closely resemble those of heterosexual partnerships, and an emerging research literature suggests that legally recognized same-sex relationships may also be similar to heterosexual marriages in these psychological and social aspects (Balsam, Beauchaine, Rothblum, & Solomon, 2008; Kurdek, 2004, 2005; Peplau & Fingerhut, 2007);

Whereas married individuals generally receive social, economic, health, and psychological benefits from their marital status, including numerous rights and benefits provided by private employers and by state and federal governments (Badgett, 2001; Brown, 2000; Chauncey 2005; Gove, Hughes, & Style, 1983; Gove, Style, & Hughes, 1990; Kiecolt-Glaser, 2001; Murray, 2000; Ross, Mirowsky, Goldsteen, 1990; Stack & Eshleman, 1998; Williams, 2003;

Whereas all people can be adversely affected by high levels of stress and the link between experiencing stress and manifesting symptoms of psychological or physical illness is well established in human beings and other species (Cohen, Doyle, & Skoner, 1999; Dohrenwend, 2000); Kiecolt- Glaser, McGuire, Robles, & Glaser, 2002);

Whereas individuals with a homosexual or bisexual orientation are often subjected to minority stress, that is, additional stress beyond what is normally experienced by the heterosexual population, as a consequence of stigma, discrimination, and violence (Badgett, 2001; Berrill, 1992; Herek, 2009; Herek, Gillis, Cogan, 1999; Mays & Cochran, 2001; Meyer, 1995; 2003; Meyer, Schwartz, & Frost, 2008);

Whereas the experience of minority stress may create somewhat higher levels of illness or psychological distress in the sexual minority population, compared to the heterosexual population (Herek & Garnets, 2007; Mays & Cochran, 2001; Meyer, 1995; 2003);

Whereas minority stress is common to all minority groups that experience stressors due to prejudice and discrimination based on their minority status (Meyer, 2003);

Whereas lesbian, gay, and bisexuals with multiple minority statuses (e.g., people of color, persons with disabilities) often experience a dual minority stress that may negatively impact their mental health (Crawford, Allison, Zamboni, & Soto, 2002; Green, 1994; Harley, Nowak, Gassaway, & Savag, 2002).

Whereas policies supportive of lesbian, gay, and bisexual people's human rights may have positive effects on their psychological well-being (Blake, Ledskey, Lehman, Goodenow, Sawyer, Hack, 2001; Goodenow, Szalacha, & Westheimer, 2006; Hatzenbuehler, Keyes, Hasin, 2009);

Therefore be it resolved that the American Psychological Association supports full marriage equality for same-sex couples;

Be it further resolved that the American Psychological Association reiterates its opposition to ballot measures, statutes, constitutional amendments, and other forms of discriminatory policy aimed at limiting lesbian, gay, and bisexual people's access to legal protections for their human rights, including such measures as those that deny same-sex couples the right to marry (Conger, 1975, APA 2007);

Be it further resolved that the American Psychological Association calls on state governments to repeal all measures that deny same-sex couples the right to civil marriage and to enact laws to provide full marriage equality to same-sex couples;

Be it further resolved that the American Psychological Association calls on the federal government to extend full recognition to legally married same-sex couples, and to accord them all of the rights, benefits, and responsibilities that it provides to legally married different-sex couples;

Be it further resolved that the American Psychological Association encourages psychologists and other behavioral scientists to conduct quality research that extends our understanding of the lesbian, gay, and bisexual population, including the role of close relationships and family formation on the health and well-being of lesbian, gay, and bisexual adults and youths;

Be it further resolved that the American Psychological Association encourages psychologists and other professionals with appropriate knowledge to take the lead in developing interventions and in educating the public to reduce prejudice and discrimination and to help ameliorate the negative effects of stigma;

Be it further resolved that the American Psychological Association will work with government and private funding agencies to promote such research and interventions to improve the health and well-being of lesbian, gay, and bisexual people.

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THE SEVILLE STATEMENT

On behalf of the twenty who APPROVED and signed the Seville Statement of Violence and the many people who are disseminating it throughout the world, I wish to call the Statement to the attention of your readers. We hope that your readers can use it in service of peace! By publishing the Statement, you will take part in a process that extends worldwide. The text of the Statement is being published in scientific and popular journals from Australia to the USSR. It is being formally endorsed and disseminated by professional scientific organizations. It is being adopted in teaching curriculums at the secondary school and university level. It is being discussed and circulated by the peace movements of various countries. We hope that it will eventually be adopted by UNSECO for dissemination and we would appreciate the help of your readers to ask their National UNESCO Commissions to support the process. As indicated in the Statement, there is much more that can be said. We have not said the last word but taken a first step. We hope that your readers will agree and will carry the process forward. Yours in the struggle for Peace, David Adams Professor of Psychology Wesleyan University Middletown Connecticut Psychological Laboratory USA

March- April 1987 Vol 12 N9 Statement on Violence

Believing that it is our responsibility to address from our particular disciplines the most dangerous and destructive activities of our species, violence and war; recognizing that science is a human cultural product which cannot be definitive or all-encompassing; and gratefully acknowledging the support of the authorities of Seville and representatives of the Spanish UNESCO we, the undersigned scholars from around the world and from relevant sciences have met and arrived at the following statement on Violence. In it, we challenge a number of alleged biological findings that have been used, even by some in our disciplines, to justify violence and war. Because the alleged findings have contributed to an atmosphere of pessimism in our time, we submit that the open, considered rejection of these misstatements can contribute significantly to the International Year of Peace. Misuse of scientific theories and data to justify violence and war is not new but has been made since the advent of modern science. For example, the theory of evolution has been used to justify not only war, but also genocide, colonialism, and suppression of the weak. We state our position in the form of five propositions. We are aware that there are many other issues about violence and war that could be fruitfully addressed from the standpoint of our disciplines, but we restrict ourselves here to what we consider a most important first step.

IT IS SCIENTIFICALLY INCORRECT to say that we have inherited a tendency to make war from our animal ancestors. Although fighting occurs widely throughout animal species, only a few cases of destructive intra-species fighting between organized groups have ever been reported among naturally living species, and none of these involve the use of tools designed to be weapons. Normal predatory feeding upon other species cannot be equated with intra-species violence. Warfare is a peculiarly human phenomenon and does not occur in other animals.

The fact that warfare has changed so radically overtime indicates that it is a product of culture. Its biological connection is primarily through language which makes possible the co-ordination of groups, the transmission of technology, and the use of tools. War is biologically possible, but it is not inevitable, as evidenced by its variation in occurrence and nature over time and space. There are cultures which have not engaged in war for centuries, and there are cultures which have engaged in war frequently at some times and not at others.

IT IS SCIENTIFICALLY INCORRECT to say that war or any other violent behaviour is genetically programmed into our human nature. While genes are involved at all levels of nervous system function, they provide a developmental potential that can be actualized only in conjunction with the ecological and social environment. While individuals vary in their predispositions to be affected by their experience, it is the interaction between their genetic endowment and conditions of nurturance that determines their personalities. Except for rare pathologies, the genes do not produce individuals necessarily predisposed to violence. Neither do they determine the opposite. While genes are co-involved in establishing our behavioural capacities, they do not by themselves specify the outcome.

IT IS SCIENTIFICALLY INCORRECT to say that in the course of human evolution there has been a selection for aggressive behaviour more than for other kinds of behaviour. In all well-studied species, status within the group is achieved by the ability to co-operate and to fulfil social functions relevant to the structure of that group. 'Dominance' involves social bindings and affiliations; it is not simply a matter of the possession and use of superior physical power, although it does involve aggressive behaviours. Where genetic selection for aggressive behaviour has been artificially instituted in animals, it has rapidly succeeded in producing hyper-aggressive individuals; this indicates that aggression was not maximally selected under natural conditions. When such experimentally-created hyper-aggressive animals are present in a social group, they either disrupt its social structure or are driven out. Violence is neither in our evolutionary legacy nor in our genes.

IT IS SCIENTIFICALLY INCORRECT to say that humans have a 'violent brain'. While we do have the neural apparatus to act violently, it is not automatically activated by internal or external stimuli. Like higher primates and unlike other animals, our higher neural processes filter such stimuli before they can be acted upon. How we act is shaped by how we have been conditioned and socialized. There is nothing in our neurophysiology that compels us to react violently.

IT IS SCIENTIFICALLY INCORRECT to say that war is caused by 'instinct' or any single motivation. The emergence of modern warfare has been a journey from the primacy of emotional and motivational factors, sometimes called 'instincts', to the primacy of cognitive factors. Modern war involves institutional use of personal characteristics such as obedience, suggestibility, and idealism, social skills such as language, and rational considerations such as cost-calculation, planning, and information processing. The technology of modern war has exaggerated traits associated with violence both in the training of actual combatants and in the preparation of support for war in the general population. As a result of this exaggeration, such traits are often mistaken to be the causes rather than the consequences of the process.

We conclude that biology does not condemn humanity to war, and that humanity can be freed from the bondage of biological pessimism and empowered with confidence to undertake the transformative tasks needed in this International Year of Peace and in the years to come. Although these tasks are mainly institutional and collective, they also rest upon the consciousness of individual participants for whom pessimism and optimism are crucial factors. Just as 'wars begin in the minds of men', peace also begins in our minds. The same species who invented war is capable of inventing peace. The responsibility lies with each of us.

Seville, 16 May 1986

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Policy Statement on Social Practices that Induce Violence

Violence is a public health problem of major proportions. The United States ranks first among industrialized developed nations in personal violence, and, whether homicide, suicide, or accidents, violence is the leading cause of death among America's youth. Violence, fear of violence, and the aftermaths of violence have eroded the quality of life in both urban and rural areas, with far-ranging dangerous effects (Violence & Youth: Psychology's Response, 1993).

There is extensive literature pertaining to the various aspects of violence, including the violent manifestations and outcomes of practices institutionalized into the country's current social order (Eron, Gentry, & Schlegel, 1995). Although emphasis has been understandably placed on the perpetrators and victims of violence, it is also necessary to focus on publicly accepted practices that are themselves violent and precipitators of violence.

Some overlooked essential aspects of this complex problem are the social practices of violence and malignant neglect that have been institutionalized into our society in the course of daily life for many Americans, but which may be destructive, even life threatening, or condone or stimulate violence. Societal attitudes may implicitly sanction some manifestations of violence. Community context may shape how a victim of violence labels or responds to his or her experience (Sorenson & Bowie, 1995). Entertainment media may characterize violence as a normative response when desires are thwarted or frustrated (Hill, Soriano, Chen, & LaFromboise, 1995).

A developmental perspective can support the assumption that people who are victimized in daily life may be less likely to perceive alternatives and options than those who have a history of more positive, healthy, violence-free life experiences (Sorenson & Bowie, 1995).

Whereas graphic depictions of acts of violence have become viewed in many quarters as attractive, commercially necessary content for amusement for all ages in films, television, toys and games, music, and general media resulting in multiple daily exposures to violent content (Donnerstein, Slaby & Eron, 1995; Hill, Soriano, Chen, & LaFromboise, 1995; Prothrow-Stith, 1991);

Whereas some aspects of society are becoming more openly polarized along racial, ethnic, cultural, economic, age, gender, sexual orientation, immigration status, religious belief, disability, health status, and power differences, increasingly expressed by psychological abuse, verbal and physical violence (Brown, Hamilton, Hoffman, & Mavaddat, 1995; Holmes, 1996; McClosky, Fernandez-Esquer, Southwick, & Locke, 1995; Seigelman, Bledsoe, Welch, & Combs, 1996);

Whereas the widespread socially sanctioned availability of firearms has escalated youth violence to an accelerating rate of lethal outcomes (Verhovek, 1995);

Whereas the conditions of unemployment and underemployment are relegating more persons and families into generations of entrenched poverty with its well-known pathological sequelae (Mead, 1989), with 21 percent of all children, 39 percent of Hispanic children, and 46 percent of African-American children included among the poor (Thompson & Hupp, 1992);

Whereas many urban and rural poor, and also ethnic/racial minority, populations are housed in areas that are disproportionately subject to life-threatening conditions of malignant neglect such as fires, lead poisoning, crime, and hazardous toxic dumping (Violence & Youth: Psychology's Response, 1993);

Whereas many schools for the urban and rural poor are neither safe nor successful in educating or even retaining their youth, thereby depriving them of hope and chances to compete for "the American dream" (Carta, 1992);

Whereas basic health care, prevention and treatment programs are too often not readily accessible to neglected population groups, resulting in otherwise avoidable infant mortality, illness, disability, shortened life span, or continued addictions (Baquet & Fritsch, 1995; Pear, 1993);

Whereas court and penal systems' inappropriate handling of youth victims and persons apprehended for even minor offenses can brutalize both the innocent and those convicted (Radelet, 1989).

Whereas state-sanctioned taking of lives through capital punishment has accumulated over 2,000 people in death rows, a disproportionate number of whom are ethnic minorities, and 31 of whom were sentenced for crimes committed when they were juveniles (Radelet, 1989);

Therefore, be it resolved, That any serious effort to understand and ameliorate the public health menace of violence must include attention to the practices that are often accepted as a normal way of organizing life for some people that constitute or promote violence. These interactive effects are within the expertise of psychology, thus

Be it also resolved, That efforts by APA to stimulate research and to provide leadership concerning reduction and management of violence include a focus on socially endorsed and institutionalized expressions of violence, and that social policy initiatives of the APA include that focus as well (DeLeon, 1996).

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Association.

Special Education and Related Services for Children with Conduct Disorders

WHEREAS Congress has mandated that public schools provide special education services to all handicapped children, including those who are seriously emotionally disturbed;

WHEREAS Congress has defined serious emotional disturbance to include unsatisfactory relationships and inappropriate behavior that Interfere with educational performance over a long period of time and to a marked degree;

WHEREAS such characteristics are commonly associated with conduct disorders;

WHEREAS children with diagnoses manifested primarily by troubling behavior, such as conduct disorders and attention deficit disorders, constitute a large proportion of seriously emotionally disturbed children;

WHEREAS special education and related services, Including psychological services, are often critical to seriously emotionally disturbed children's educational progress;

WHEREAS schools are Important components In the child mental health system; and

WHEREAS psychologists provide services to seriously emotionally disturbed children both within and outside school settings;

THEREFORE BE IT RESOLVED that the American Psychological Association opposes efforts by some states to exclude conduct disordered children from special education and related services;

BE IF FURTHER RESOLVED that the Association calls upon the Congress a the United States Department of Education to take action to ensure that states do not further deprive seriously emotionally disturbed children of special education and related services, including psychological services, that are Important to their educational achievement and psychological development."

Membership Board Charge

The Membership Board's charge was extended to include recruitment and retention activities Council approved having the Membership Board oversee Association membership retention and recruitment activities and make annual reports on these activities to Council.

The universality of science

WHEREAS the federal government has the authority to classify information shown to be essential to national security; BE IT THEREFORE RESOLVED that the American Psychological Association

ASSERTS its conviction that all unclassified scientific information should be disseminated freely, and
DECLARES its profound opposition to all attempts to interfere with the free exchange of unclassified scientific information at meetings of scientific societies and in scientific journals.

Three-year trial of having four ethnic minority associations as observers to council

1993

Ethnic minority education

WHEREAS the general population of the United States is projected to change within the next generation and become a pluralistic society;

WHEREAS there is a current and projected under-representation of ethnic minority students, faculty, practitioners, and researchers in the field of psychology;

Whereas the educational pipeline requires recruitment and retention efforts across the spectrum of education from pre-college to entry into the field of psychology;

WHEREAS psychologists in education will need to become increasingly conversant on issues relevant to an increasingly diverse student population and pluralistic society; and

WHEREAS the lack of ethnic minority representation and focus impacts the relevance of psychology to prepare students to function in a diversified society and to provide appropriate services;

THEREFORE BE IT RESOLVED that APA places a high priority on issues related to the education of ethnic minorities. These issues include planning appropriately diverse curricula, promoting psychology as a course of study and career option as well as recruitment, retention, advising, and mentoring of minority students at all levels of education.

Substance abuse by pregnant women (PDF, 52KB)

That Board vote to recommend that Council amend the following association policies contained in the Council Policy Manual (bracketed/strikethrough material to be deleted; underlined material to be added):

A candidate for initial fellow status should select one nominating division

A person may be nominated for initial Fellow status by only one division. If additional division Fellow nominations are submitted at the same time as the initial nomination, Fellow status may take place for these additional divisions upon initial Fellowship election by the Council of Representatives. If the individual is nominated by more than one division, the nominee will select the division which best represents his/her/their work and contributions to psychology. The selected division will become the “nominating division.” The nominee will inform the nominating division of any other divisions which have also expressed interest in his/her/their nomination for Fellow.

Advertising in APA journals (1984)

Advertising of ~~[doctoral]~~ educational programs in APA publications will be restricted to those schools or other institutions fully accredited by regional or other institutional accrediting associations recognized by the US Department of Education.

APA principles for health care reform

1. Everyone should have coverage that provides affordable health care for all basic services.

1. Basic health care services eliminate the artificial distinction between “mental” and “physical” health, recognize the inseparable relationship between mental and physical well-being, and offer access to treatment for “mental health conditions” equivalent in all respects to access for “physical health conditions”.

1. Basic health care services include the provision of psychological services and treatment ~~[of physical conditions in order]~~ to maximize rehabilitation, functioning and quality of life.

1. Basic health care services include appropriate prevention services that address the role that behavior plays in ~~[seven out of the ten]~~ the leading causes of mortality and morbidity.

APA RESOLUTION on Ending Homelessness

WHEREAS safe, stable, affordable, accessible, and permanent housing is a human right, and its absence negatively impacts typical development; physical and mental health functioning; nutrition; social and emotional wellbeing; education, employment, and training opportunities; academic success; family and social cohesion; and the ability to exercise individual rights and responsibilities (e.g., American Psychological Association, 2021a; Report of Special Rapporteur on Adequate Housing A/HRC/31/54, 2015; Tars, 2017; United Nations, 1948; United Nations Human Rights, Office of the High Commissioner, 1966);

WHEREAS certain activities associated with individuals who lack a home or shelter or are in unstable living conditions, such as sleeping outdoors, in cars, or in abandoned buildings, doubled up, congregating in specific settings, violating curfews, or sharing food have been criminalized or sanctioned under specific state and local civil ordinances, and can result in encounters with law enforcement officers and legal systems causing stigmatization, increased hardship, and a further curtailment of legal rights and liberties, including incarceration, loss of the ability to vote, financial penalties and costs, forfeiture of possessions and property, employment loss, ineligibility for public housing and other benefits, and in some instances separation from children and loss of legal custody (Bailey, 2016, Batko et al., 2020; MacDonald et al., 2015; Muentner et al., 2019; National Coalition for the Homeless, 2014; National Law Center on Homelessness and Poverty, 2014);

WHEREAS at least 1.5 million Americans yearly live without homes, and many more unaccounted-for persons live doubled up and in crowded and unsafe settings as a result of insufficient supplies of adequate affordable housing and in combination with other factors, and where health and homelessness are inextricably linked insofar as poor health often contributes to homelessness and living without homes can cause or exacerbate health conditions, housing instability and homelessness are matters of significant public health concern. Homelessness and housing instability have a deleterious impact across the life span on physical and emotional health and wellbeing, and the societal costs associated with unstable housing are staggering. From infancy through childhood, adulthood, and old age, persons living without homes, when compared with the general population, are disproportionately at risk for the neuro-psychological, developmental, cognitive, social, emotional, and health consequences of toxic

exposures, infectious diseases and chronic illnesses, unclean water, faulty plumbing, unsafe wiring, inadequate food, unhealthy living spaces and crowded conditions, air pollution, and environmental injustice; are more likely to be displaced by natural disasters, pandemics, and the outcomes of climate change; and tend to die on average twelve years sooner than persons who are housed. Additionally, whereas persons living without homes have been particularly impacted by higher than average rates of severe acute respiratory syndrome— coronavirus disease 2019 (SARS— COVID-19) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS; Ahmed et al., 2016; Briggs et al., 2013; Chun et al., 2020, Cutili et al., 2016; Donovan & Shineski, 2013; Elder & King, 2019; Grant et al., 2013; Haskett et al., 2015; Karb et al., 2020; Milloy et al., 2012; Montgomery et al., 2016; National Alliance to End Homelessness, 2020; National Center for Homeless Education, 2020; National Health Care for the Homeless Council, 2019; Sandel et al., 2018; United States Conference of Mayors, 2016);

WHEREAS populations who have historically been marginalized and discriminated against are disproportionately impacted by the lack of affordable, accessible, safe, and stable housing and are evicted from existing housing at significantly higher rates, and whereas these same populations are least likely to benefit from neighborhood revitalization and economic recovery. Such oppressed groups include those living in poverty or of low socioeconomic status; persons of color including Black, Indigenous, and other ~~[people of color]~~ communities of color and other minorities; immigrants and refugees; persons with disabilities ~~[along with cognitive, physical, behavioral, and/or mental health challenges]~~; single parents or caregivers with children; older adults; unaccompanied youth including those who hold sexual orientation and/or gender diverse identities (e.g., gay, lesbian, bisexual, queer, transgender, and nonbinary gender); emerging adults transitioning from foster care, juvenile justice, or child welfare settings; victims of interpersonal violence; veterans; and persons who have been incarcerated, arrested, paroled, on probation, or otherwise court involved; (e.g., Crane & Joly, 2014; Desmond, 2016; Dworsky et al., 2013; McCann & Brown, 2019; Muentner et al., 2019; Shinn & Khadduri, 2020; Stone et al., 2018; Wiltz, 2019);

WHEREAS oppressed groups, persons of low socioeconomic status, and all individuals living in poverty are disproportionately impacted by housing loss related to destruction following natural disasters; illness, loss of income, and eviction during pandemics; inequitable wages based on gender, race, or immigration status; wage theft and underpayment; insufficient income and savings; higher rates of unemployment and under-employment; gentrification and dislocation; job loss owing to plant shutdowns and job relocations; financial scams; predatory lending and subprime loans; discriminatory leasing practices; and inaccessible or unaffordable public transportation, all of which contribute to housing instability and homelessness (Boustan et al., 2017; Byrne et al., 2020; Desmond, 2020; Duffy et al., 2016; Shinn & Khadduri, 2020);

WHEREAS in times of economic downturn, pandemics, job loss, and periods of high rates of under-employment and unemployment, persons of low socioeconomic status and those living in poverty in urban, suburban, and rural locations are at significantly heightened risk of losing stable housing resulting in homelessness (e.g., Blustein et al., 2019; Desmond, 2016; Kopf, 2017; Shinn & Khadduri, 2020; United States Conference of Mayors, 2020);

WHEREAS homelessness results from structural racism, anti-LGBTQ+ discrimination, systemic barriers, and embedded social injustices including the lack of safe and affordable housing; discriminatory gaps in wages based on gender, race, ethnicity, and immigration status; high costs of food, childcare, transportation, and utilities; health disparities and unequal access to health care treatment; insufficient supportive community services, including those targeted to

treat mental health and substance disorders; under-funded schools ill equipped to prepare students for academic or vocational success; scarce job training programs; limited early childcare and after school programs to support working families; inadequate and unfair wages; job layoffs and under-employment (e.g., Barile et al., 2018; Byrne et al., 2020; Desmond, 2016; Duffield, 2020; Ecker et al., 2019; Grant et al., 2013; Institute of Medicine and National Research Council, 2012; National Alliance to End Homelessness, 2020; Shelton & Bond, 2018; Shinn & Khadduri, 2020);

WHEREAS psychosocial stressors that impact physical, social emotional, and behavioral health functioning are often associated with entrance into and exit from homelessness, and where rapid and supportive housing as well as expanded access to culturally competent health and mental health care; community-based prevention, intervention, and treatment services; and job training opportunities along with structural changes and the creation of affordable housing contributes to the remediation of homelessness (e.g. Armstrong et al., 2014; Desmond, 2016; Duffy et al., 2016; Garrett-Akinsanya, 2014; Guarino, 2014; Haskett & Armstrong, 2019; Kerman et al., 2018; Morton et al., 2018; Navarro-Lashayas & Elroa-Orosa, 2017; Stone, 2019; Thurston et al., 2013; van den Berk-Clark & McGuire, 2013; Warren & Font, 2015; Yu et al., 2020);

WHEREAS the field of psychology is uniquely poised to contribute to the amelioration of homelessness through culturally competent scientific research, program design, and evaluation; empirically supported, culturally competent, trauma-sensitive interventions for those experiencing homelessness or at risk of housing instability; culturally competent education and job training for persons wishing to work at the programmatic or individual levels with persons experiencing homelessness or at risk of housing loss; and culturally competent assessment and treatment of persons across the life span who are without homes or are at risk of homelessness and advocacy around issues and policies associated with racial and socioeconomic injustice; increased access to safe and affordable housing; mandatory fair wages, the decriminalization of homelessness, and the abolishment of cash bail; structural and race-based barriers to health care; and climate justice (e.g., American Psychological Association, 2010; Cutuli & Herbers, 2014; Duffield, 2020; Guarino, 2014; Rogers et al., 2012);

AND, WHEREAS psychologists aspire to promote the human rights and dignity of all persons, through the creation of equal opportunities for work, education, and physical, emotional, and behavioral wellbeing, including equal access to culturally competent treatment and care, especially for those who are most vulnerable owing to systemic racism and classism, structural inequity, or bias based on the intersectionality of marginalized identities (American Psychological Association, 2021a, 2021b);

THEREFORE, BE IT RESOLVED that the Council of Representatives of the American Psychological Association reaffirms its commitment to advance psychology's contributions to ending homelessness and supports the following:

Research efforts directed towards the prevention of homelessness among marginalized and vulnerable populations, evidence-based intervention plans for those currently experiencing homelessness or at imminent risk of homelessness, applied research on service use among populations at risk for homelessness, and the evaluation and assessment of programs that support rapid and permanent housing.

Investigation of methods and interventions to promote resilience in different populations at risk for homelessness, including those within rural, suburban, or urban areas; single female or male heads of household with children; unaccompanied youth (including lesbian, gay, bisexual,

transgender, and gender nonbinary youth); emerging adults (e.g., youth aging out of foster care system and leaving the juvenile justice system); ~~[people of color]~~ communities of color; refugees and immigrants; adults reentering communities following incarceration; older adults; persons with disabilities ~~[(including physical, cognitive, and mental health conditions)]~~; and veterans.

Recognition that success based on scientific findings may require a change of policy as well as program rules and procedures.

Focus on training and educational practices that enhance the cultural competency and trauma sensitivity of psychologists to effectively work with populations currently, or at risk of, experiencing homelessness. Such practices include: expansion of graduate school curricula focused on the ways in which harmful stereotypes and individualistic attributions are culturally constructed and hold the potential to influence service provisions; enhancing training to include diverse and underserved populations; creating internships and continuing education opportunities that encourage psychologists to work with populations experiencing homelessness; enlisting psychologists to offer appropriate mental health education programs focused on the remediation of homelessness to service providers, community-based organizations, community volunteers, and the public.

Recognition that psychologists should promote vocational training, decent work, and fair and equitable remuneration for all people.

Encouragement of psychologists to provide strength-based clinical assessment services to populations who are currently, or are at risk of, experiencing homelessness. Culturally competent services address a continuum of needs, focus on serving people in the communities in which they and their families live, and take into consideration how specific structural/systemic issues intersect and interact in different combinations and in discrete ways for specific populations. Psychologists are encouraged to establish meaningful collaborations with physicians, nurses, social workers, attorneys, educators, service providers, community organizations, outreach services, and advocates committed to addressing the multifaceted needs of persons who are experiencing homelessness or at risk of losing their homes.

Promotion and advocacy for policies and legislation that support the rapid reentry of persons into stable, safe, affordable, and permanent housing, including:

- Comprehensive services, as well as safe, stable, affordable, less restrictive, and accessible housing in urban, suburban, and rural areas;
- Targeted comprehensive services, such as education and job training opportunities for youth in foster care, and for transitional services for those returning to home placement and/or communities;
- Education, job training, and affordable day care to support families, including but not limited to low-income families;
- Health care coverage for those without homes and at risk of losing stable housing;
- Increased programs and services in mental health, substance abuse, and alcohol dependency prevention and treatment;
- Public funds to support emergency responses to homelessness and implement preventative programs to reduce the incidence and prevalence of persons and families experiencing homelessness;

- Stricter regulations governing financial institutions, predatory lending, credit, and mortgage practices and support for living wages;
- Dissemination of accurate information about homelessness to psychologists, policymakers, and the public in an effort to call attention to the structural/systemic issues that exacerbate homelessness. Both psychological (e.g., clinical) and structural/systemic interventions are needed for those experiencing the consequences of poverty and homelessness.

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APA Resolution on Gender Identity Change Efforts

The foundational professional guideline for working with gender diverse persons acknowledges that, “Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person’s gender identity may not align with sex assigned at birth[.]” (APA, 2015, p. 834). Gender identity refers to “a person’s deep felt, ~~[inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; [or another]]~~ internal, intrinsic sense of their own gender” (Coleman et al., 2022, p. S252 [APA, 2015, p. 862]). While gender refers to the trait characteristics and behaviors socio-culturally associated with one’s sex assigned at birth[;], in some cases, gender may be distinct from the physical markers of biological sex (e.g., genitals, chromosomes). Gender identity is also distinct from gender expression, which refers to “the presentation of an individual including physical appearance, clothing choice and accessories, and behaviors” ~~[that express aspects of gender identity]~~ (APA, 2015, p. 861) and may not necessarily align with socio-cultural expectation of person’s gender identity (Coleman et al., 2022). Cisgender refers to “a person whose gender identity aligns with sex assigned at birth” (e.g., an individual assigned female at birth who identifies as a woman/ girl; APA, 2015, p. 861). Transgender is “an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex

assigned at birth” (APA, 2015, p. 863). For the purpose of this resolution, we are using a broad definition of transgender to include transgender women /girls, transgender men/boys, nonbinary individuals (i.e., people who may identify as a gender other than a woman/girl or a man/boy), and any individual who articulates a gender identity different from societal expectations based on their sex assigned at birth.

Some transgender and gender ~~[nonbinary]~~ diverse individuals seek gender-affirming medical care (e.g., hormone therapy, surgery) while others do not. Similarly, some transgender and gender ~~[nonbinary]~~ diverse individuals seek to change their gender marker and/or their name on legal documents, while others do not. In this resolution, we strive to be inclusive of all gender diversity regardless of a person’s pursuance of social, medical, or legal transition.

The fields of psychiatry and psychology have a long history of pathologizing transgender and gender diverse individuals and those who question their gender identity (Barkai, 2017; Benson, 2013; Bouman et al, 2014; Burke, 2011; Drescher, 2010; Nadal et al., 2010; Riggs et al. 2019). This history is informed by, and parallels, the larger Western and United States-based, medical-model, narratives that 1) define gender as binary and conflate it with physical markers, 2) define masculinity, and characteristics historically attributed to men/ boys, as superior to femininity and characteristics historically attributed to women/girls, 3) create systems that confer privilege to cisgender people and label cisgender identities and expressions as normative, 4) discriminate against transgender and gender ~~[nonbinary]~~ diverse individuals (Stryker, 2017).

Gender identity change efforts (GICE) refer to a range of techniques used by mental health professionals and nonprofessionals with the goal of changing gender identity, gender expression, or associated components of these to be in alignment with gender role behaviors that are stereotypically associated with sex assigned at birth^{1,2} (Ashley, 2022; Hill et al., 2010; SAMHSA, 2015). In addition to explicit attempts to change individuals’ gender according to cisnormative pressures, GICE has also been a component of sexual orientation change efforts (SOCE). As intense focus on cisnormative conformity is a frequent characteristic of SOCE it is possible that authors in the literature describing sexual orientation change efforts misgendered their participants (Hipp et al., 2019). Moreover, “ex-gay” literature and discourse conceptualize gender diversity as a sin, a mental illness, and harmful, perpetuating cisgenderism and transmisogyny (Robinson & Spivey, 2019). Finally, Hipp et al. (2019) identified forms of GICE that are often not discussed in the psychological literature but that appear to disproportionately affect Black transgender and gender diverse ~~[nonbinary]~~ individuals including violence, “church hurt” (i.e., religious or faith-based trauma), and gatekeeping from gender affirming care. These efforts may be referred to as “conversion therapies”, “corrective” treatments, or “normalizing” therapies (Hill et al., 2010). However, to consider these techniques as therapies or treatments is inaccurate and inappropriate because, the incongruence between sex and gender in and of itself is not a mental disorder (World Health Organization, n.d.) so, any behavioral health or GICE technique or treatment that seeks to change an individual’s gender identity or expression is not indicated; thus, any behavioral health or GICE effort that attempt to change an individual’s gender identity or expression is inappropriate (Fish & Russell, 2020; Hill et al. 2010; SAMHSA, 2015).

With roots in this history, GICE are founded on the notion that any gender identity that is not concordant with sex assigned at birth is disordered, and that a cisgender identity is healthier, preferable, and superior to a transgender or gender nonbinary identity (Ansara & Hegarty, 2011; Hill et al., 2010; Robinson & Spivey, 2019).

GICE cause harm by reinforcing anti-transgender and anti-gender nonbinary stigma and discrimination (Turban et al., 2020); and by creating social pressure on an individual to conform to an identity and/or presentation that may not be consistent with their sense of self (e.g., Bockting et al., 2013; Egan & Perry, 2001; Meyer, 2003; Nadal et al., 2012; Russell et al., 2012; Toomey et al., 2010; Sandfort et al., 2007). Furthermore, GICE are not supported by empirical evidence as effective practices for changing gender identity and are associated with psychological and social harm (Brinkman et al., 2014; Carr, 1998; Gagné & Tewksbury, 1998; Green et al., 2020; Horn, 2007; Price et al., 2019; Smith & Leaper, 2006). The ~~[American Psychological Association (]APA[)]~~, as well as other healthcare organizations, (e.g., American Counseling Association (ACA), The Endocrine Society, World Professional Association for Transgender Health) have established empirically-supported practice guidelines that encourage clinicians to use gender-affirming practices when addressing gender identity issues (ACA, 2010; APA, 2015; Colemen et al., 2022; Coleman et al., 2012; Hembree et al., 2017). Additionally, a number of national and international professional healthcare organizations have publicly warned against the harmful effects of GICE and SOCE (Sexual Orientation Change Efforts) by endorsing the United States Joint Statement Against Conversion Efforts (USJS, n.d.), including the American Academy of Family Physicians, American Academy of Nursing, American Association of Sexual Educators, Counselors and Therapists, American Counseling Association, American Medical Association, American Medical Student Association, American Psychoanalytic Association, The Association of LGBTQ Psychiatrists, Society for Affectional, Intersex, and Gender Expansive Identities, Clinical Social Work Association, GLMA: Health Professionals Advancing LGBTQ Equality, The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies, and the World Professional Association for Transgender Health. A growing number of states and municipalities have enacted laws that prohibit licensed mental health professionals from engaging in sexual orientation and gender identity change efforts with minors (Movement Advancement Project, n.d.)

GENDER DIVERSITY, STIGMA, AND DISCRIMINATION

WHEREAS diversity in gender identity and expression is part of the human experience and transgender and gender ~~[nonbinary]~~ diverse identities and expressions are healthy, incongruence between one's sex and gender is neither pathological nor a mental health disorder (APA, 2009, 2015; SAMHSA, 2015);

WHEREAS gender diverse individuals experience cissexist discrimination and prejudice throughout the lifespan and life domains (APA, 2009) including significant discrimination in healthcare settings (Burnes et al., 2016; Fredriksen-Goldsen et al., 2014; Grant et al., 2011; James et al., 2016; Johns et al., 2019; Lambda Legal, 2010; Macapagal et al., 2016; Reisner et al., 2015; White Hughto et al., 2015);

WHEREAS the practice of GICE reinforces stigma and discrimination against transgender and gender diverse people (Turban et al., 2020);

WHEREAS gender-related bias, victimization, discrimination, criminalization, and forced-gender conformity experienced by transgender and gender ~~[nonbinary]~~ diverse people are associated with poor psychosocial outcomes, such as heightened psychological distress, compromised overall wellbeing, and disparities across various contexts (e.g., healthcare, schools/education, workplace, law) (Bockting et al., 2013; dickey et al., 2016; Egan & Perry, 2001; Meyer, 2003; Nadal et al., 2012; Russell et al., 2012; Hendricks & Testa, 2012; Toomey et al., 2010; Sandfort et al., 2007);

WHEREAS invalidation and rejection of transgender and gender ~~[nonbinary]~~ diverse identities and ~~[diverse gender]~~ expressions by others (e.g., families, therapists, school personnel) are forms of discrimination, stigma, and victimization, which result in psychological distress (Bockting et al., 2013; D'Augelli et al., 2006; Egan & Perry, 2001; Hendricks & Testa, 2012; Hidalgo et al., 2015; Landolt et al., 2004; Meyer, 2003; Nadal et al., 2012; Price, et al., 2019; Roberts et al., 2012; Sandfort et al., 2007; Stotzer, 2012; Russell et al., 2012; Toomey et al., 2010; Truong et al., 2020a, 2020b; Zongrone et al., 2020);

GICE AND RISKS OF HARM

WHEREAS individuals who have experienced pressure or coercion to conform to their sex assigned at birth or therapy that was biased toward conformity to one's assigned sex at birth have reported harm resulting from these experience such as emotional distress, loss of relationships, and low self-worth (Brinkman et al., 2014; Carr, 1998; Gagné & Tewksbury, 1998; Horn, 2007; Price et al., 2019; Smith & Leaper, 2006);

WHEREAS in one study of a large online sample of LGBTQ young people, those who reported experiencing change efforts were more than twice as likely to report having attempted suicide and having multiple suicide attempts as those who did not experience change efforts, (Green et al., 2020);

WHEREAS GICE have not been shown to alleviate or resolve gender dysphoria (Bradley & Zucker, 1997; Cohen-Kettenis & Kuiper, 1984; Gelder & Marks, 1969; Greenson, 1964; Pauly, 1965, SAMHSA, 2015); WHEREAS GICE can cause undue stress and suffering and interfere with healthy sexual and gender identity development (Hiestand & Levitt, 2005; SAMHSA, 2015);

WHEREAS GICE can reduce one's willingness to pursue future mental health treatment (Craig et al., 2017);

WHEREAS GICE often involves the promotion of stereotyped gender behaviors consistent with cultural expectations (Coleman et al., 2022; Coleman et al., 2012; Hill et al., 2010);

WHEREAS GICE are associated with harmful social and emotional effects for many individuals, including but not limited to, the onset or increase of depression, anxiety, suicidality, loss of sexual feeling, impotence, deteriorated family relationships, a range of post-traumatic responses, and substance abuse (c.f. Burnes et al., 2016; Green et al., 2020; SAMHSA 2015 for a review; Turban et al., 2019);

WHEREAS ~~[diverse gender expressions and]~~ transgender and gender ~~,[nonbinary]~~ diverse identities and expression are not mental disorders (American Psychiatric Association, ~~[2013]~~ 2018) and many transgender and gender ~~[nonbinary]~~ diverse individuals lead satisfying lives and have healthy relationships (APA, 2015; SAMHSA, 2015);

GENDER AFFIRMING PRACTICES

WHEREAS transgender and gender ~~[nonbinary]~~ diverse people whose gender has been affirmed report increased quality of life (Ainsworth & Spiegel, 2010; APA, 2015; Gerhardstein & Anderson, 2010; Kraemer et al., 2008; Newfield et al., 2006);

WHEREAS self-determination in defining one's gender identity is a source of resilience for transgender and gender ~~[nonbinary]~~ diverse people and associated with improvements in wellbeing and reductions in psychological distress (Menvielle & Tuerk, 2002; Pickstone-Taylor, 2003; Rosenberg, 2002; Singh et al., 2011; Singh et al., 2014);

WHEREAS individuals who have experienced gender affirming psychological and medical practices report improved psychological functioning, quality of life, treatment retention and engagement, and reductions in psychological distress, gender dysphoria, and maladaptive coping mechanisms (Austin & Craig, 2015; de Vries et al., 2014; Haas et al., 2011; Sevelius, 2013; White Hughto & Reisner, 2016);

WHEREAS professional consensus recommends affirming therapeutic interventions for transgender and gender ~~[nonbinary]~~ diverse adults who request that a therapist engage in GICE, and for transgender and gender diverse youth whose parents/guardians or other custodians (e.g., state, foster care) request that a therapist engage in GICE (~~[American Counseling Association]~~ ACA, 2009; APA, 2012; 2015; American Psychiatric Association, 2018; Byne et al., 2012; Edwards-Leeper et al., 2016);

WHEREAS affirming therapeutic practices and guidelines recommend that the therapist should remain objective and nonjudgmental to the outcome, focusing on empowering the client to be active in exploring, discovering, and understanding their own identity (American Counseling Association, 2009; APA, 2012; 2015; American Psychiatric Association, 2018; Byne et al., 2012; Edwards-Leeper et al., 2016);

APA POLICY

WHEREAS APA opposes discrimination on the basis of gender identity, gender expression, and transgender and gender nonbinary identities, and actively opposes the adoption of discriminatory legislation (APA, 2008);

WHEREAS APA supports the passage of laws and policies protecting the legal rights and freedoms of transgender and gender nonbinary people, regardless of gender identity or expression (APA, 2008);

WHEREAS Psychologists' work is based upon established scientific and professional knowledge of the discipline. (APA, 2017b, p. 5);

WHEREAS APA recognizes that psychologists work is based upon Respect for People's Rights and Dignity (Principle E), Avoiding Harm (3.04), and Unfair Discrimination (3.01; APA, 2017b);

WHEREAS gender affirming psychotherapy is founded in clinical practice guidelines, and harm has not been identified for any of these gender-affirming treatment practices (APA, 2015, 2017b; Byne et al., 2012);

WHEREAS the APA policy and practice guidelines (e.g., Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality; Guidelines for Psychological Practice with Transgender and Gender Nonconforming People) affirm that psychologists do not engage in discriminatory or biased practices and urge psychologists to take a leadership role in preventing discrimination towards transgender and gender diverse people (APA, 2009, 2015, 2017a);

WHEREAS APA's 2005 Policy Statement on Evidence-Based Practice in Psychology defines evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA, 2005);

BE IT THEREFORE RESOLVED that consistent with the APA's definition of evidence-based practice (APA, 2005), the APA affirms that scientific evidence and clinical experience indicate that GICE put individuals at significant risk of harm;

BE IT FURTHER RESOLVED that the APA opposes GICE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals, and organizations to avoid GICE;

BE IT FURTHER RESOLVED that APA opposes the idea that incongruence between sex and gender is a mental disorder (Hill et al., 2010; SAMHSA, 2015; WHO)[-];

BE IT FURTHER RESOLVED that after reviewing scientific evidence on GICE harm, affirmative treatments, and professional practice guidelines, the APA affirms GICE are associated with reported harm[-];

BE IT FURTHER RESOLVED that the APA opposes GICE because of their association with harm[-];

BE IT FURTHER RESOLVED that [T]ransgender and gender nonbinary identities, as well as other gender identities that transcend culturally prescriptive binary notions of gender, represent normal variations in human expression of gender[-];

BE IT FURTHER RESOLVED that neither transgender or gender ~~[nonbinary]~~ diverse identities nor the pursuit of gender-affirming medical care constitutes evidence of a mental disorder[-];

BE IT FURTHER RESOLVED that APA opposes portrayals of transgender and gender ~~[nonbinary]~~ diverse people as mentally ill because of their gender identities and expressions[-];

BE IT FURTHER RESOLVED that evidence supports psychologists in their professional roles to use affirming and culturally relevant approaches with individuals of diverse gender expressions and identities[-];

BE IT FURTHER RESOLVED that APA is committed to promoting accurate scientific data regarding gender identity and expression in its own policy, public advocacy, judicial proceedings, media, and public opinion;

BE IT FURTHER RESOLVED that APA encourages collaboration between and among individuals and organizations to promote the wellbeing of transgender and gender ~~[nonbinary]~~ diverse people;

BE IT FURTHER RESOLVED that the APA encourages psychologists to be aware of multiple and intersecting factors in identity, such as sex assigned at birth, gender expression, gender identity, age, race, ethnicity, religion, spirituality, socioeconomic status, disability, national origin, and sexual orientation in conceptualization, treatment, research, and teaching about transgender and gender ~~[nonbinary]~~ diverse people;

BE IT FURTHER RESOLVED that the APA opposes the dissemination of inaccurate information about gender identity, gender expression, and the

efficacy of GICE, including the claim that gender identity can be changed through treatment, the characterization of transgender or gender ~~[nonbinary]~~ diverse identities ~~[identity]~~ as a mental disorder and the promotion of treatments that prescribe gender identity or expression consistent with one's birth- assigned sex as effective for clients with gender dysphoria;

BE IT FURTHER RESOLVED that APA encourages the development and dissemination of evidence-based, multiculturally-informed, and gender affirmative educational resources that inform psychologists, the community and education and mental health institutions about the harms of

GICE; BE IT FURTHER RESOLVED that APA re-affirms that APA (2015) encourages psychologists to:

- Acknowledge the diversity and complexity of identities and experiences and recognize transgender and gender ~~[nonbinary]~~ diverse identities as healthy expressions of gender
- Recognize that descriptions of any gender identity or expression as unnatural, abhorrent, or unhealthy perpetuate stigma for sexual and gender minorities, and have negative mental health and social consequences
- Assist clients in a developmentally appropriate manner to explore and understand the cultural and familial influence on gender roles and expression. Psychologists are urged to help clients in a developmentally appropriate manner understand the societal contexts of sexism, heterosexism, transphobia, racism and other forms of social oppression, and to use a developmental multicultural- and gender affirmative framework in research, teaching, training, and supervision;

BE IT FURTHER RESOLVED that the American Psychological Association opposes GICE because there is evidence of former participants reporting harm resulting from their experiences of GICE and the contribution that such efforts make to social stigma, injustice, and prejudice directed at gender diverse individuals, consistent with other major professional mental health associations, including the American Psychiatric Association (2018); ~~{American Counseling Association}~~ ACA (2017), SAMHSA (2015), American Academy of Child & Adolescent Psychiatry (2018), World Health Organization (n.d.) and World Psychiatric Association (2016);

BE IT FURTHER RESOLVED that the APA, because of evidence of harm and lack of evidence of efficacy, supports public policies and legislation that prohibit, or aim to reduce GICE, cissexism, and anti-transgender and anti-gender nonbinary bias and that increase support for gender diversity;

BE IT FURTHER RESOLVED that the APA supports collaboration and partnerships with global, national and state and local partners to achieve the aims of this resolution;

BE IT FURTHER RESOLVED that the APA promotes professional training in gender-affirming practices and opposes professional training in GICE in any stage of the education of psychologists, including graduate training, continuing education, and professional development.

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APA Resolution on Sexual Orientation Change Efforts

Sexual orientation is a multidimensional aspect of human experience, comprised of gendered patterns in attraction and behavior, identity related to these patterns, and associated experiences, such as fantasy (Katz-Wise & Hyde, 2014; Klein, 1993; Rosario & Schrimshaw, 2014). "Attraction" is conceptualized as both romantic and sexual (e.g., Rosario & Schrimshaw, 2014) and as focusing on biological characteristics of sex as well as aspects of gender identity and expression (van Anders, 2015). Individuals with same-gender and multiple gender attractions and behaviors have been stigmatized. Heterosexism and monosexism are social stigmas and societal inequalities that denigrate, discredit, and disadvantage those with same- and multiple-gender attractions, behaviors, and associated identities (American Psychological Association [APA], 2021 [2012]; Herek, 2007; Roberts, et al., [Horne, & Hoyt,] 2015). Because of the social stigma they experience, individuals with same- and multiple-gender attractions and behaviors may be referred to collectively as sexual minorities (Herek, 2007; SavinWilliams, 2001; van Anders, 2015).

Sexual orientation change efforts (SOCE) include a range of techniques used by a variety of mental health professionals and non-professionals with the goal of changing sexual orientation (APA, 2009) or any of its parts. SOCE was a term developed by the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) to describe these efforts that have been known by several names and may take a variety of forms. The term SOCE avoids the use of the term therapy and thus the implication that there is some disorder to be treated. Some mental health professionals who have utilized or promoted SOCE have used the term "therapy" to describe their practices and/or to support the idea that sexual minority youths and adults are mentally ill due to their sexual orientation. In fact, mainstream mental health professions have rejected this idea since the 1970s.

SOCE refer to a wide variety of efforts. SOCE have taken a variety of forms such as one-on-one meetings, drop-in groups, residential programs, conferences, and online groups. Rationales for SOCE have included assertions that same-gender attractions are caused by bad parenting, peer abuse, sexual trauma, gender "inferiority," and/or unmet emotional needs. SOCE have included interventions such as recommending dating someone of a different sex; developing nonsexual intimacy and belonging with heterosexual same-gender peers; experiencing same-gender non-erotic touch; using religious practices such as prayer, scripture study, exorcism, and confessing same-gender attractions; implementing aversive conditioning; practicing traditional gender expression and gender role behavior; and suppressing gender nonconforming behaviors (APA, 2009; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Hipp, Gore, Toumayan, Anderson, & Thurston, 2019; Flentje, Heck, & Cochran, 2013; Rix, n.d.). The wide variety of SOCE are not consistently reflected in SOCE literature and popular culture. As the latter examples of interventions indicate, SOCE have not only targeted sexual and romantic behavior but also gender expressions that do not conform to stereotypes.

In this way, gender identity change efforts have also been a component of SOCE. A focus on White cisgender individuals and sexual orientation may also make less visible the impacts of SOCE on communities of color. For example, in Black Memphis communities, SOCE might not be readily identified as such but appear as violence and “church hurt” (Hipp et al., 2019). SOCE may appear differently in different social contexts.

SOCE HAVE INCLUDED ONE OR MORE OF THE FOLLOWING:

- nonscientific explanations of sexual orientation diversity that stigmatize and frame same-gender and multiple gender orientations as unhealthy (Fjelstrom, 2013; Flentje et al., 2013; Hipp et al., 2019; Shidlo & Gonsiorek, 2017),
- claims that sexual attraction can be changed through psychotherapeutic treatment (e.g., Dehlin et al., 2015; Fjelstrom, 2013; Shidlo & Shroeder, 2002; Super & Jacobson, 2011; Weiss et al., 2010; Wood & Conley, 2014),
- pre-determined or prescribed outcomes for sexual orientation, gender-expression, or sexual identity (e.g., Bradshaw et al., 2015; Fjelstrom, 2013;
- Flentje et al., 2013; Ryan, Toomey, Diaz, & Russell, 2018), and
- dissemination of inaccurate information about the effects of SOCE or about sexual orientation, such as the discredited idea that same-gender orientations are caused by negative childhood events or family dysfunction (Flentje et al., 2013; Shidlo & Gonsiorek, 2017).

CONTEXTS WITH MULTIPLE STIGMAS AND VULNERABILITIES

Given the pervasive cis-heteronormativity, cis-heterosexism and monosexism in society, it is no surprise that some sexual minority individuals seek to change their sexual orientation through SOCE and some parents, guardians, and custodians (e.g., foster care) seek SOCE for their sexual and/or gender minority children. Participants in studies of people who have experienced SOCE typically have less family or community support for lesbian, gay, bisexual, transgender, queer and other marginalized sexual and gender identities (LGBTQ+), more religiously orthodox backgrounds, and greater likelihood of residing in rural areas (APA, 2009; Dehlin et al., 2015). They may also experience additional inequalities such as racism and anti-immigrant stigma (Hipp et al., 2019; Ryan et al., 2018), identify as Hispanic/Latinx, identify as transgender or nonbinary, come from families with lower incomes, and have parents who use religion to say negative things about being LGBTQ+ (Green, Price-Feeney, Dorison, & Pick, 2020). Many of these associations place LGBTQ+ individuals at risk of the downstream consequences of multiple stigmas and inequalities.

Participants in studies of people who have experienced SOCE have also explained their SOCE involvement. Reasons reported for seeking SOCE have included the following: fear of rejection from family, faith community, or God/Divinity; the belief that expressions of same-gender attractions are sinful or against religious teachings; fear of an unfamiliar LGBTQ+ community; or belief in a variety of stereotypes about life as sexual minorities (e.g., beliefs that it would be impossible to have children, that sexual minorities are destined to have life-threatening illnesses, that sexual minorities can never have fulfilling relationships; APA, 2009; Haldeman, 2018). The foregoing reasons reflect the intersectional contexts of social stigma and systemic inequalities in which SOCE are embedded (APA, 2017a; Crenshaw, 1989). Some SOCE proponents reinforce these messages to their consumers (Hipp et al., 2019; Jacobsen & Wright, 2014; Schroeder & Shidlo, 2001). The connection between stigma and SOCE has long been clear. As one scholar historically stated, “The very existence of sexual orientation

conversion therapy is a significant causal element in the social forces causing some people to attempt changing their sexual orientation in the first place” (Davison, 1976).

APA is particularly concerned about the significant risk of harm to minors from SOCE. LGBTQ+ individuals are exposed to individual, social, and institutional levels of stigma, which negatively affect multiple health domains (Hatzenbuehler & Pachankis, 2016; Robinson, 2017). Moreover, LGBTQ+ youth are also overrepresented in foster care, child welfare, and juvenile justice systems (Conron & Wilson, 2019; Detlaff, et al., [Washburn, Carr, & Vogel,] 2018) where they face significant exposures to adverse childhood experiences. SOCE may be understood as an adverse childhood experience or trauma (Fish & Russell, 2020) that place youth at even greater risk of harm. Thus, youth and their families and custodians may be particularly vulnerable to misinformation about sexual orientation and SOCE and to the dangers of SOCE involvement.

As of [December 2020] June 2023, at least 20 states, D.C, and more than 70 municipalities in the United States (U.S.) have adopted laws or statewide regulations prohibiting licensed mental health practitioners from using SOCE with minors (Movement Advancement Project, n.d.). However, one study estimated that in the U.S., licensed health professionals will use SOCE on 16,000 adolescents by the time those adolescents are age 18 (Mallory, [Brown, & Conron,] et al., 2019). Thus, notwithstanding the change in mainstream professional opinion and the increasing prohibition of SOCE, there is significant concern that SOCE is still a problem. Based on expert consensus, the Substance Abuse and Mental Health Service Administration (SAMHSA), an agency within the US Department of Health and Human Services, concluded that “conversion therapy” should be ended with minors as they are not supported by evidence and could seriously harm youth (SAMHSA, 2015).

In recent years, U.S. SOCE proponents have attempted to further export and legitimize SOCE outside the U.S. In some cases, these efforts have resulted in dire consequences to local LGBTQ+ communities and advocates such as life imprisonment and other criminal penalties for “homosexuality” (Bailey et al., 2016; Dicklitch, [Yost, & Dougan,] et al., 2012; Global Philanthropy Project, 2018; Horne & McGinley, in press). SOCE adds to harm in parts of the world where sexual and gender minorities have few legal protections, or where attitudes towards them are extremely negative even if legal protections exist (e.g., Horne & McGinley, in press; Zahn et al., 2016). Scientifically and culturally accurate knowledge about sexual minorities is often limited or distorted in such regions and SOCE, including medical techniques such as hormone treatments (Horne & McGinley, in press) and aversive techniques such as electroshock treatment (Jahangir & Abdullatif, 2016; Lewin & Meyer, 2002), are employed to “cure” sexual minorities. The instigation of SOCE by professionals serves to justify and reify stigma and discrimination directed against sexual minorities, making them more vulnerable to negative consequences, including human rights abuses (Horne & McGinley, in press; Lewin & Meyer, 2002; Winskell et al., 2017).

Given the transnational consequences of SOCE, SOCE are opposed by a number of health organizations, such as the British Psychological Society (Memorandum of Understanding on Conversion Therapy in the UK, 2017), and a number of national psychological associations endorsed a statement rejecting SOCE as stigmatizing and often harmful and supporting instead affirmative therapeutic interventions for sexual and gender minorities (International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues, 2018). Furthermore, countries as different as Brazil, Ecuador, Germany, Malta, and Taiwan as well as regions of Australia, Canada, and Spain have enacted laws to protect individuals from “conversion therapy” (Chaudhry, 2018; Gstalter, 2020). In 2013, the United Nations Human Rights Council’s (UNHRC) Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment

stated some SOCE do rise to the level of human rights violations, labeling SOCE “abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment” (UNHRC, 2013). After a wide-ranging international exploration, the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity characterized the many efforts under the term “conversion therapy” as “relying on the medically false pathologization of sexual orientation and gender identity, manifested through interventions that inflict severe pain and suffering and result in psychological and physical damage” (UNHRC, 2020, p. 5). The report denies an ethical and evidentiary basis for conversion and calls for measures to prevent conversion efforts, which it defines as “degrading, inhuman and cruel” (UNHRC, 2020, p. 21).

SCIENCE AND SOCE

SOCE lack sufficient bases in scientific principles. A variety of methodological and statistical issues have rendered many SOCE reports invalid (APA, 2009; Glassgold, 2022; Glassgold & Haldeman, 2023; Panozzo, 2013; Retraction notice, 2019; Spitzer, 2012). In addition to problems with their specific study designs, SOCE proponents’ claims distort others’ valid research. SOCE proponents’ claims about the possibility of environmental influences on sexual orientation are inconsistent and lack connectivity with the ways scientific theories meaningfully integrate multiple biological and cultural factors contributing to sexual orientation (Bailey, Vasey, Diamond, Breedlove, Vilain, & Epprecht, 2016; Diamond & Rosky, 2016; Shidlo & Gonsiorek, 2017; see Tolman & Diamond, 2014, for scientific theories on sexual orientation). Failing to correct refuted claims, some SOCE proponents have referenced discredited factors in sexual orientation etiology, such as “defective” gender identity, and made inaccurate claims using psychoanalytic concepts, such as referring to sexual minorities as inherently developmentally arrested due to parent-child relationships (Isay, 1989; Shidlo & Gonsiorek, 2017). Literature on SOCE has also inaccurately applied evidence of sexual fluidity across the lifespan by distorting sexual fluidity as a justification for SOCE (Diamond & Rosky, 2016). Rather than willful shifts in sexual orientation, fluidity describes changes in awareness, attractions, behaviors, and identities that unfold over time (Diamond, 2008). However, that sexual orientation can evolve and change for some does not mean that it can be altered through intervention or that it is advisable to try.

ETHICAL CONCERNS

Application of ethical considerations about SOCE have long included concerns about their associations with stigma and their potential to be used coercively (e.g., APA, 1998). The charge to “do no harm” has historically been a foundational principle of practice for healthcare professionals. Aspirational principles such as “Respect for People’s Rights and Dignity” (Principle E, APA Ethics Code), which includes respecting the rights of individuals to self-determination, are held in dynamic tension with other principles, including “Beneficence and Nonmaleficence” (Principle A, APA Ethics Code). Shidlo and Gonsiorek (2017) argued that self-determination is not intended to be used as the only or more important ethical principle in clinical decision-making. There are a number of patient requests a psychologist would decline (e.g., a request for a behavioral weight loss program from a patient with anorexia nervosa) in the interest of the patient’s health and well-being. Ethics Code Standard 2.04 also states “Psychologists’ work is based upon established scientific and professional knowledge of the discipline” (APA, 2017b, p. 5). Moreover, Standard 3.04(a) of the APA Ethics Code requires that “psychologists take reasonable steps to avoid harming their clients/patients and to minimize harm where it is foreseeable and unavoidable” (APA, 2017b, p. 6). Self-determination does not necessitate or justify dispensing with other ethical obligations regarding patient care.

CURRENT CONTEXTS

Major medical and mental health care organizations in the U.S. have long raised concerns about risks of harm from SOCE. In addition to APA (1998, 2009), advisory policies against SOCE have been adopted by the American Academy of Child and Adolescent Psychiatry (2012), the American Academy of Pediatrics (1993), the American Association of Sexuality Educators, Counselors, and Therapists (2017), the American College of Physicians (2015), the American Counseling Association (2013), the American Medical Association (2019), the American Psychiatric Association (2000), the American Psychoanalytic Association (2012), the American School Counselor Association (2016), and the National Association of Social Workers (2015). Furthermore, at least ~~18~~ 23 professional associations have signed on to the United States Joint Statement Against Conversion Efforts (n.d.), which aims to end SOCE and gender identity change efforts.

The research on SOCE published since APA's (2009) task force report and resolution has continued to support the conclusions that former participants in SOCE look back on those experiences as harmful to them and that there is no evidence of sexual orientation change. The consensus panel that APA conducted for SAMHSA likewise found no credible evidence to support SOCE with children and adolescents and called for an end to SOCE (SAMHSA, 2015). Public opinion has shifted markedly since 2009 as well, showing greater acceptance of sexual and gender diversity, including LGBTQ+ individuals (Flores, 2014). Thus, an updated policy statement on SOCE from APA supports those who are struggling with the belief that they must or can change their sexual orientation or that parents, guardians, or custodians must or can change their children's sexual orientation to fit with their societal, familial, and institutional membership, and assists the public to understand the conflicts experienced by sexual minority individuals and their families.

An updated policy will also provide more current information to legislators and advocates and dispel the distortions and inaccuracies favored by SOCE proponents (Haldeman, 2018). In nearly half of states (Miller, 2018) and on the federal level (e.g., Therapeutic Fraud Prevention Act, 2017) legislation has been adopted or proposed to prohibit SOCE with minors, to warn consumers that SOCE can be fraudulent, and/or to advise professionals that SOCE are not ethical. SOCE have also been increasingly scrutinized in U.S. legal cases. A New Jersey trial court case (Ferguson v. JONAH, 2015) identified a program of SOCE as a form of consumer fraud. Decisions in cases that have challenged ordinances prohibiting licensed mental health professionals from providing SOCE to minors (Otto v. Boca Raton, 2019; Pickup v. Brown, 2013; Welch v. Brown, 2013) have upheld the authority of professional oversight bodies to regulate professional mental health care interactions and to prohibit SOCE by mental health professionals. Persecution of LGBTQ+ people worldwide is an international humanitarian issue, including systematic abuse, imprisonment, and torture. The U.S. field of psychology is influential around the world, and an updated APA policy has the potential to support the rights and safety of LGBTQ+ persons worldwide.

SEXUAL ORIENTATION DIVERSITY IS NORMAL AND HEALTHY WHEREAS diversity in sexual orientation represents normal human variation (APA, 2009);

WHEREAS there is no scientific basis for regarding any sexual orientation negatively or as a deficit or deviance or result of trauma or parenting (American Psychiatric Association, 2000; APA, 1975; Drescher, 2015; Shidlo & Gonsiorek, 2017); furthermore, sexual behavior with same, other, and more than one gender occurs across species, time, and culture (Bagemihl, 2000; Tskhay & Rule, 2015) and sexual fluidity is normal (Diamond, 2008);

WHEREAS a large percentage of sexual minorities are bisexual rather than exclusively same-gender attracted individuals (Copen, [Chandra, & Febo-Vazquez,] et al., 2016; Gates, 2011; Pew Research Center, 2013; Savin-Williams, 2017); and SOCE protocols tend to oversimplify, misrepresent, or dismiss bisexuality (Vasey & Rendall, 2003);

WHEREAS stigma related to same-gender attraction, behaviors, and identity (heterosexism) and stigma related to multiple-gender attraction, behaviors, and identity (monosexism) can be internalized by sexual minorities, which can contribute to negative mental health outcomes, such as depression, suicidality, anxiety, and substance use (e.g., American Psychiatric Association, 2000; Barnes & Meyer, 2012; Bostwick, Boyd, Hughes, West, & McCabe, 2014; Herek & McLemore, 2013) as well as negative physical health disparities and outcomes (Fredriksen-Goldsen et al., 2014; Frost, [Lehavot, & Meyer,] et al., 2015);

WHEREAS APA affirms that psychologists do not discriminate (APA, 1998, 2000, 2002, 2003, 2005a, 2006a, 2008b, 2017b), do not misrepresent research (APA, 2009), and strive to prevent bias from their own beliefs from taking precedence over professional practice and standards required by psychological science (APA, 2008b; 2009);

SOCE REINFORCES SOCIETAL STIGMA FOR SEXUAL MINORITIES

WHEREAS the premise of SOCE is that same-gender attractions are a disorder that requires treatment and that such treatments change sexual orientation, which is contrary to scientific evidence and policies by APA and other mental health organizations (APA, 1998, 2000, 2009);

WHEREAS SOCE locate the source of the problem in the individual rather than within the context of a biased society and ignore the societal contributions to feeling negative about same gender attraction (Davison, 1976; Herek & McLemore, 2013; Meyer, 2013);

WHEREAS some forms of SOCE are based on negative religious perspectives on sexual orientation that promote bias and prejudice against sexual minorities and APA both “condemns prejudice and discrimination against individuals or groups based on their religious or spiritual beliefs, practices, adherence, or background” and “condemns prejudice directed against individuals or groups, derived from or based on religious or spiritual beliefs” (APA, 2008a; 2008b);

WHEREAS societal ignorance and prejudice about same-gender and multiple-gender sexual orientations have led to personal, family, moral, and religious conflicts and lack of information, which places some sexual minorities at risk for seeking sexual orientation change (Beckstead & Morrow, 2004; Dehlin et al., 2015; Flentje, Heck, & Cochran, 2014; Haldeman, 1994; Hatzenbuehler, Pachankis, & Wolff, 2012; Mallory, [Brown, & Conron,] et al., 2019; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

WHEREAS SOCE are theoretically associated with stigma; specifically, attempting to change a socially discredited state is theorized as a response to stigma (Goffman, 1963), and seeking SOCE is one component of a valid measure of internalized stigma (Martin & Dean, 1992; Meyer, 2013; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015);

WHEREAS SOCE are empirically associated with stigma; specifically, research evidence supports the relationship between SOCE and constructs associated with stigma, including prejudice (McGeorge, Carlson, & Toomey, 2015), internalized homonegativity (Pachankis et al., 2015; Tozer & Hayes, 2004), and family rejection (Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan et al.,

2018); WHEREAS SOCE often overlap with other forms of stigma; for example, SOCE proponents have held negative views of sexual minorities and advocated for criminalization of sexual minorities, including in developing countries (Shidlo & Gonsiorek, 2017);

WHEREAS SOCE proponents have held negative views of sexual minorities and advocated for criminalization of sexual minorities (Shidlo & Gonsiorek, 2017) and some transnational efforts to do so have placed sexual and gender minorities at risk of psychological, sociopolitical, and physical harm (Waidzun, 2015);

WHEREAS the UN HRC (2013; 2015; 2020) categorizes some practices of SOCE as rising to the level of human rights abuse, and these often occur in nations with other anti-LGBTQ+ laws and norms; WHEREAS youth may be particularly vulnerable because they have been exposed to negative messages about sexual and gender minorities, but they have not developed the resources to cope with these messages (Baams, [Dubas, Russell, Buikema, & van Aken,] et al., 2018; Rimes, [Shivakumar, Ussher, Baker, Rahman, & West,] et al., 2019; SAMHSA, 2015);

WHEREAS psychologists are called to oppose stigma and discrimination (APA, 2006a, Conger, 1975), and the PanAmerican Health Organization (2012) recommends professional associations “disseminate documents and resolutions...that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation”;

WHEREAS APA opposes discrimination against sexual minorities and the adoption of discriminatory legislation and supports the passage of laws and policies protecting the legal rights and freedoms of people of all sexual orientations (APA, 2008a);

SOCE AND RISKS OF HARM

WHEREAS prejudice and minority stress cause adverse mental health and other negative consequences, and SOCE assumptions and interventions reinforce prejudice and sexual minority stress while neglecting education and exploration of affirming sexual minority options/identities and affiliations (Davison, 1976; Frost et al., 2017; Herek & McLemore, 2013; Meyer, 2013; Ramirez & Galupo, 2019);

WHEREAS sexual minority youth and adults who have undergone SOCE are significantly more likely to experience suicidality and depression than those who have not undergone SOCE (Dehlin, et al., 2015; Ryan et al., 2018); and this elevated risk of suicidality, including multiple suicide attempts, persists when adjusting for other risk factors (Blosnich, et al., 2020; Green, et al., 2020).

WHEREAS research studies using a wide range of designs have found harms associated with SOCE (APA, 2009; Blosnich, Henderson, Coulter, Goldback, & Meyer, 2020; Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015; Green et al., 2020; Ryan et al., 2018), including the following:

- Suicidal behavior and depressive symptoms among youth (Green et al., 2020; Ryan et al., 2018) and adults (Blosnich et al., 2020; Shidlo & Shroeder, 2002); indeed, Green et al. found that SOCE “was the strongest predictor of multiple suicide attempts, even after adjustment for other known risk factors” (p. 1224)
- More mental health problems and lower levels of life satisfaction, social support, educational attainment, and socioeconomic status (Ryan et al., 2018)

- Sexual identity distress (Dehlin et al., 2015)
- Dissociation and emotional numbness, characterized by celibacy, compulsive behaviors, depression, and anxiety (Jacobsen & Wright, 2014; Shidlo & Shroeder, 2002)
- Unprotected anal intercourse with un-tested partners (Shidlo & Shroeder, 2002)
- Substance abuse (Ryan et al., 2018; Shidlo & Shroeder, 2002)
- Disorientation and confusion (Shidlo & Shroeder, 2002; Weiss, Morehouse, Yeager, & Berry, 2010)
- Feelings of inauthenticity in terms of disconnection with parts of themselves (e.g., emotions, thoughts, interests), feeling they would have to choose among parts of themselves, and loss of connection to community (Fjelstrom, 2013)
- Feelings of anger and grief at having lost time and money, and feelings that they were betrayed by mental health professionals (Dehlin et al., 2015; Shidlo & Shroeder, 2002);

WHEREAS for young adults whose parents attempted to change their sexual orientation during adolescence, efforts to send the adolescents to a therapist or religious leader to change their sexual orientation are associated with greater severity of negative outcomes (Ryan et al., 2018);

WHEREAS for many years, professional health associations have deemed SOCE harmful (American Academy of Child and Adolescent Psychiatry, 2018; American Academy of Pediatrics, 1993; American Psychiatric Association, 2000; Australian Psychological Society, 2015; International Society of Psychiatric Mental Health Nurses, 2008; National Association of Social Workers, 2015; Memorandum of Understanding on Conversion Therapy in the UK, 2017; World Psychiatric Association, 2016);

WHEREAS a consensus of an advisory panel of research and practice experts reviewed professional statements, research, and clinical guidelines, and stated SOCE are “coercive, can be harmful, and should not be part of behavioral health treatment” (SAMHSA, 2015, p.1);

WHEREAS when change in sexual orientation has been reported by participants as a result of SOCE, the scope of reported change has been limited, unreliable, later retracted, and/or not assessed by valid, reproducible methods (APA, 2009):

- Change has been reported only by a limited sample of individuals, who are primarily White/Caucasian, cisgender men who are engaged in conservative religious communities and who aim to be celibate or be in a mixed gender marriage (e.g., Byrd, Nicolosi, & Potts, 2008; Dehlin et al., 2014; Flentje et al., 2013; Jones & Yarhouse, 2011)
- In numerous cases reports of change have been reversed or retracted (e.g., Retraction notice, 2019; Spitzer; 2012; Weiss et al., 2010)
- Many people did not report change and, in fact, reported elevated distress about the ineffectiveness of SOCE and blamed themselves and/or were blamed for the SOCE failure, despite being “highly motivated” (e.g., Dehlin et al., 2014; Flentje, Heck, & Cochran, 2014; Maccio, 2011; Shidlo & Shroeder, 2002)
- Rather than decrease same-gender attraction, SOCE have been reported to suppress same-gender sexual/romantic behavior (Dehlin et al., 2015; Fjelstrom, 2013; Flentje et al., 2014; Shidlo & Shroeder, 2002)

- Differences in reported sexual attraction and behavior over time can be explained by extant sexual fluidity or bisexuality rather than changes in sexual orientation as a result of SOCE (e.g., Beckstead, 2012; Haldeman, 1994)
- SOCE places individuals at significant risk of serious harm (e.g., depressive symptoms, suicidality, dissociation, substance abuse; Blosnich et al., 2020; Bradshaw et al., 2015; Dehlin et al., 2015; Green et al., 2020; Ryan et al., 2018; Shidlo & Shroeder, 2002)
- Studies have used flawed methodological and statistical approaches that render their conclusions invalid (e.g., APA, 2009; Panozzo, 2013; Retraction notice, 2019; Spitzer, 2012);

WHEREAS participants in SOCE reported self-blame, guilt, shame, negative self-concept, confusion, anxiety, depression, disconnection from family and religious community, and feelings of abandonment by God when their SOCE did not reduce same gender desire or behavior (Dehlin et al., 2015; Fjelstrom, 2013; Freeman-Coppadge & Horne, 2019; Shidlo & Shroeder, 2002; Super & Jacobson, 2011; Weiss et al., 2010; Wood & Conley, 2014);

WHEREAS a study of a range of methods in which same-gender attracted Latter-day Saints (LDS) church members engaged to help them deal with their sexual orientation found that those who attempted to change their sexual orientation reported all methods to be more harmful and less effective than those who reported other goals, such as understanding or coping with same-gender attraction (Dehlin et al., 2015; cf. APA, 2012 and O'Shaughnessy & Speir, 2018);

WHEREAS reports of harm may be delayed or not reported to SOCE facilitators, even when SOCE participants are experiencing significant harm or distress according to their later reports (Bancroft et al., 2003; Fjelstrom, 2013; Flentje et al., 2013; Shidlo & Schroeder, 2002);

WHEREAS when communicating among themselves, participants who view SOCE as successful ("ex-gays") report similar kinds of harm to that of participants who do not view them as successful ("ex-ex-gays"), such as depression and guilt (Weiss et al., 2010);

WHEREAS many participants report harm from SOCE, including SOCE that draw on otherwise evidence-based practices (e.g., cognitive behavioral therapy) when used to attempt sexual orientation change (Fjelstrom, 2013; Shidlo & Schroeder, 2002);

ETHICAL AND PROFESSIONAL CONCERNS

WHEREAS "psychologists strive to benefit those with whom they work and take care to do no harm" (Principle A, APA, 2017b, p. 3);

WHEREAS "psychologists respect the dignity and worth of all people..." (Principle E, APA, 2017b, p. 4); "psychologists are aware of and respect cultural, individual, and role differences, including those based on... gender, gender identity,... sexual orientation..." and other individual differences (Principle E, APA, 2017b, p. 4).

WHEREAS the APA expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005a, 2006a, 2008b, 2009);

WHEREAS “psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not... engage in fraud, subterfuge, or intentional misrepresentation of fact” (Principle C, APA, 2017b, pp. 3-4); “psychologists do not make false, deceptive, or fraudulent statements concerning... (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; ... or (8) their publications or research findings” (Standard 5.01, APA , 2017a, p. 8);

WHEREAS “psychologists’ work is based upon established scientific and professional knowledge of the discipline” (Standard 2.04, APA, 2017b, p. 5);

WHEREAS psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b); WHEREAS minors who have been subjected to SOCE have reported more suicide attempts than those who have not (Green et al., 2020; Ryan et. al., 2018), and these SOCE have been deemed “degrading, inhuman and cruel” creating “a significant risk of torture” by the UN HRC (2020, p. 21);

WHEREAS sexual minority youth are especially vulnerable populations, and those who encounter additional social stigma and inequality, including youth of color and youth from immigrant families, are exposed to multiple forms of prejudice, discrimination, criminalization, family rejection, and loss of support (e.g., Durso & Gates, 2012; O’Donnell, Meyer, & Schwartz, 2011; Ramirez & Galupo, 2019; Ryan et al., 2018);

WHEREAS sexual minority youth are without consistent legal protection from SOCE, and youth as well as their parents, guardians, and custodians need accurate information to make informed decisions regarding their development and well-being (APA, 2009);

WHEREAS the UN HRC (2015) states that “conversion therapy,” when forced or otherwise involuntary, can breach the prohibition on torture and ill- treatment, and youth lack adequate legal protection and are particularly vulnerable to involuntary or coercive treatment (APA, 2009; Ryan et al., 2018); the APA states “psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04(a)” (APA, 2017a, p. 6);

ALTERNATIVES TO SOCE

WHEREAS the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation recommends LGBTQ+ affirmative therapeutic interventions for sexual minority adults presenting with an intention to change their sexual orientation to include the following (APA, 2009, 2012; Tozer & Hayes, 2004):

Acceptance and support Comprehensive assessment Active coping
Social support
Identity exploration and development Reduction of internalized stigma;

WHEREAS there is a growing evidence-base for LGBTQ+ affirmative approaches (APA, 2009; Pachankis & Safran, 2019), and LGBTQ+ affirmative approaches have not been associated with harm;

WHEREAS LGBTQ+-affirmative interventions are founded in guidelines of professional practice broadly (e.g., APA, 2006b, [~~2012~~] 2017b, 2021; Ritter, 2018);

WHEREAS sexual minority youth have benefitted from interventions that utilize LGBTQ+-affirmative approaches in fostering acceptance in family therapy (Diamond, Diamond, Levy, Closs, Ladipo, Siqueland, 2013);

WHEREAS there are ways of reducing distress related to conflicts between sexual orientation and culture/religion that do not have risks of harm and that have promising efficacy (e.g., Chaudoir, Wang, & Pachankis, 2017).

WHEREAS APA's 2005 Policy Statement on Evidence-Based Practice in Psychology defines evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA, 2005b);

BE IT THEREFORE RESOLVED that consistent with the APA definition of evidence-based practice (APA, 2005b), the APA affirms that scientific evidence and clinical experience indicate that SOCE put individuals at significant risk of harm;

BE IT FURTHER RESOLVED that the APA opposes SOCE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals, and organizations to avoid SOCE;

BE IT FURTHER RESOLVED that after identifying ethical issues (APA, 1998) and empirical problems (APA, 2009) with SOCE, and after reviewing scientific evidence on SOCE published since 2009, the APA affirms SOCE puts individuals at significant risk of harm;

BE IT FURTHER RESOLVED that the APA opposes SOCE because of their association with harm.

BE IT FURTHER RESOLVED that the APA opposes any efforts by mental health professionals that aim at a specific, predetermined sexual orientation or gender-expression outcome or that prescribe a particular sexual orientation or identity;

BE IT FURTHER RESOLVED that, consistent with the APA (2009) Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation and research since that report, the APA urges psychologists to assist patients seeking SOCE to understand the dangers of SOCE, the lack of research showing efficacy, the societal contexts of heterosexism and monosexism, and the internalized stigma that results from these contexts, and to use acceptance, support, comprehensive assessment, active coping, social support, and identity exploration and development, within a culturally responsive [~~competent~~] framework;

BE IT FURTHER RESOLVED that the APA re-affirms that APA (~~[2012]~~ 2021) encourages psychologists to use an affirming, multicultural, and evidence-based approach with individuals of all sexual orientations and identities, and to be aware of multiple and intersecting cultural factors, such as those associated with [~~ability~~] disability, age, class, education, ethnicity, race, and spirituality in conceptualization, treatment, research, and teaching about sexual minorities who are questioning their sexual orientation or experiencing conflict related to sexual orientation;

BE IT FURTHER RESOLVED that the American Psychological Association opposes SOCE because there is abundant evidence of former participants reporting harm resulting from their

experiences of SOCE and the contribution that such efforts make to social stigma and prejudice directed at sexual minorities, consistent with other major professional mental health associations, including the Pan-American Health Organization (2012), American Counseling Association (2017), American Academy of Child and Adolescent Psychiatry (2018), American Psychiatric Association (2000), National Association of Social Workers (2015), and World Psychiatric Association (2016);

BE IT FURTHER RESOLVED that the APA opposes training supporting SOCE in any stage of the education of psychologists and psychology;

BE IT FURTHER RESOLVED that APA affirms that same-gender and multiple-gender attraction, feelings, and behavior are normal variations in human sexuality, being LGBTQ+ is not a mental disorder, and APA opposes portrayals of sexual minorities as mentally ill because of their sexual orientation;

BE IT FURTHER RESOLVED that the APA re-affirms that APA (~~{2012}~~ 2021) urges psychologists to acknowledge the diversity and complexities of identities and experiences and describe same-gender and other-gender attractions, behavior, and identities as normal expressions of human sexuality, and that descriptions that rely on stereotypes or describe any sexual orientation as unnatural or bad for one's health perpetuate stigma for sexual and gender minorities and have deleterious mental health consequences;

BE IT FURTHER RESOLVED that the APA opposes any efforts that use nonscientific explanations that stigmatize sexual orientation diversity and efforts that frame same-gender and multiple-gender orientations as unhealthy;

BE IT FURTHER RESOLVED that the APA opposes making claims that sexual attraction can be changed through SOCE;

BE IT FURTHER RESOLVED that the APA opposes distortions of scientific data regarding sexual orientation in policy, judicial proceedings, media, and public opinion;

BE IT FURTHER RESOLVED that the APA opposes dissemination of inaccurate information about the effects of SOCE, such as information that minimizes the evidence of harm from SOCE or information that misconstrues sexual fluidity as an outcome of SOCE;

BE IT FURTHER RESOLVED that the APA opposes dissemination of inaccurate information about sexual orientation, such as the discredited idea that same-gender orientations are caused by negative childhood events or family dysfunction;

BE IT FURTHER RESOLVED that APA encourages the development and dissemination of evidence-based, multiculturally-informed, and LGBTQ+- affirmative educational resources that inform psychologists and the community, including agencies, organizations, and institutions that provide mental health care, education, or child welfare services, about the harms of SOCE;

BE IT FURTHER RESOLVED that the APA, because of evidence of harm and lack of evidence of efficacy, supports public policies and legislation that oppose, prohibit, or aim to reduce SOCE, heterosexism, and monosexism and that increase support for sexual orientation diversity;

BE IT FURTHER RESOLVED that the APA supports collaboration and partnerships with global, national, and state and local partners to achieve the aims of this resolution.

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APA resolution recommending the retirement of American Indian mascots, symbols, images, and personalities by schools, colleges, universities, athletic teams and organizations

WHEREAS the American Psychological Association has recognized that racism and racial discrimination are attitudes and behavior that are learned and that threaten human development (American Psychological Association, 2008; American Psychological Association, June 2001);

WHEREAS the American Psychological Association has resolved to denounce racism in all its forms and to call upon all psychologists to speak out against racism, and take proactive steps to prevent the occurrence of intolerant or racist acts (American Psychological Association, June 2001);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities undermines the educational experiences of members of all communities-especially those who have had little or no contact with Indigenous peoples (Chaney, Burke, & Burkley, 2011; Connolly, 2000; Fryberg, Markus, Oyserman, & Stone, 2008; Davis-Delano, Gone, & Fryberg, 2020; [U.S. Commission on Civil Rights, 2001]; Society of Indian Psychologists, 1999; U.S. Commission on Civil Rights, 2001; Webster, Loudbear, Corn, & Vigue, 1971);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities establishes an unwelcome and often times hostile learning environment for American Indian students

that affirms negative images/stereotypes that are promoted in mainstream society (Chaney, Burke & Burkley, 2011; Clark & Witko, 2006 [~~in press~~]; Fryberg, 2003; Fryberg & Markus, 2003; Fryberg, 2004a; Munson, 2001; Society of Indian Psychologists, 1999; U.S. Commission on Civil Rights, 2020; Staurowsky, 1999);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities by school systems appears to have a negative impact on the self-esteem of American Indian children

(Chamberlin, 1999; Eagle and Condor Indigenous People's Alliance, 2003; Fryberg, Markus, Oyserman, & Stone, 2008; Fryberg, 2004b; Fryberg & Markus, 2003; Maryland Commission on Indian Affairs, 2001; Society of Indian Psychologists, 1999; The Inter-Tribal Council of the Five Civilized Tribes, 2001; Watt & Roubideaux, 2022; Vanderford, 1996);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities undermines the ability of American Indian Nations to portray accurate and respectful images of their culture, spirituality, and traditions (Clark & Witko, 2006; [~~in press~~]; Davis, 1993; Gone, 2002; Rodriguez, 1998; Witko, 2005);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities presents stereotypical images of American Indian communities, that may be a violation of the civil rights of American Indian people (Davis-Delano, Gone, & Fryberg, 2020; Davis-Delano, Galliher, & Gone, 2022; Dolley, 2003; King, 2001; King & Springwood, 2001; Pewewardy, 1991; Pewewardy, 2004; Springwood & King, 2000; U. S. Commission on Civil Rights, 2001);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities is a form of discrimination against Indigenous Nations that can lead to negative relations between groups (CookLynn, 2001; Coombe, 1999; Davis-Delano, Galliher, & Gone, 2022; U. S. Commission on Civil Rights, 2001; Witko, 2005);

WHEREAS the continued use of American Indian symbols, mascots, images, and personalities is a detrimental manner of illustrating the cultural identity of American Indian people through negative displays and/or interpretations of spiritual and traditional practices (Adams, 1995; Banks, 1993; Dai, Lopez, Brady, Eason, & Fryberg, 2021; Nuessel; 1994; Staurowsky, 1999; Witko, 2005);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities is disrespectful of the spiritual beliefs and values of American Indian nations (Churchill, 1994; Gone, 2002; Sheppard, 2004; Staurowsky, 1998);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities is an offensive and intolerable practice to American Indian Nations that must be eradicated (U.S. Commission on Civil Rights, 2001; Society of Indian Psychologists, 1999);

WHEREAS the continued use of American Indian mascots, symbols, images, and personalities has a negative impact on other communities by allowing for the perpetuation of stereotypes and stigmatization of another cultural group (Davis-Delano, Gone, & Fryberg, 2020; Fryberg,

2004b; Gone, 2002; Staurowsky, 1999; U.S. Commission on Civil Rights, 2001; U.S. Commission on Civil Rights, 2020);

THEREFORE BE IT RESOLVED that the American Psychological Association recognizes the potential negative impact the use of American Indian mascots, symbols, images, and personalities have on the mental health and psychological behavior of American Indian people;

THEREFORE BE IT RESOLVED that the American Psychological Association encourages continued research on the psychological effects American Indian mascots, symbols, images, and personalities have on American Indian communities and others;

THEREFORE BE IT RESOLVED that the American Psychological Association encourages the development of programs for the public, psychologists, and students in psychology to increase awareness of the psychological effects that American Indian mascots, symbols, images, and personalities have on American Indian communities and others;

AND

THEREFORE BE IT RESOLVED that the American Psychological Association supports and recommends the immediate retirement of American Indian mascots, symbols, images, and personalities by schools, colleges, universities, athletic teams, and organizations.

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Application of hypnosis

Be it resolved that the American Psychological Association, in the interest of the public, opposes applications of hypnosis by persons who are not fully trained [~~members~~] clinicians or advanced students of health delivery professions and who lack specific, in-depth training in hypnosis. Therefore, be it also resolved that APA opposes the teaching of hypnotic induction techniques or applications of hypnosis that involve treatment or assessment with patients or clients to persons who are not fully trained [~~members~~] clinicians or advanced students of a health delivery profession.

Applied behavior analysis

The principles of applied behavior analysis (also known as behavior modification and learning theory), developed and researched by psychology and competently applied in the treatment of various disorders based on that research, is clearly within the scope of the discipline of psychology and is an integral part of the discipline of psychology. Across the United States, applied behavior analysis is taught as a core skill in applied and health service psychology programs. As such, the American Psychological Association (APA) affirms that the practice and supervision of applied behavior analysis are well-grounded in psychological science and evidence-based practice. APA also affirms that applied behavior analysis represents the applied form of behavior analysis which is included in the definition of the "Practice of Psychology" section of the APA Model Act for State Licensure of Psychologists. Therefore, APA asserts that the practice and supervision of applied behavior analysis is appropriately established within the scope of the discipline of psychology.

Suggested Citation

American Psychological Association. (2017). APA Policy: Applied Behavior Analysis. Retrieved from: <http://www.apa.org/about/policy/applied-behavior-analysis>

Complimentary Subscriptions

(a) A member of the Publications and Communications Board shall, during the term of office, be entitled to receive the electronic Gold Package, delivered by ~~[PsycNET]~~ PsycNet. P&C Board members retiring from the board after July, 2009 shall receive the electronic Gold Package, delivered by ~~[PsycNET]~~ PsycNet for life.

(b) An editor of an APA journal shall be entitled, during the term office, to receive complimentary electronic Gold Package, delivered by ~~[PsycNET]~~ PsycNet, and shall be entitled to receive for life a complimentary ~~[print subscription and complimentary]~~ electronic access to the journal ~~[he or she]~~ they edited. During their term of office, an editor may opt to receive a complimentary print subscription of the journal they edit.

(c) Associate editors of APA journals shall be entitled, as long as they serve in these capacities, to receive ~~[a]~~ complimentary [print subscription and complimentary] electronic access to the journal which they serve.

(d) Consulting editors of APA journals shall be entitled, as long as ~~[he or she]~~ they serve a specific journal, to receive a complimentary ~~[print subscription]~~ electronic access to that journal.

Employment Rights of ~~[Gay]~~ 2SLGBTQ+ Teachers

Whereas the American Psychological Association deplores all public and private discrimination in such areas as employment, housing, public accommodation, and licensing against those who ~~[engage in or have engaged in homosexual activities]~~ identify as sexual and gender minorities and declares that no burden of proof of such judgement, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other person;

Be it resolved that the American Psychological Association protests personnel actions against any teacher solely because of ~~[sexual orientation or — affectional preference (Abeles, 1981, p. 581)]~~ gender expression or sexual orientation.

Please cite this policy statement as:

Abeles, N. (1981). Proceedings of the American Psychological Association, Incorporated, for the year 1980: Minutes of the Annual Meetings of the Council of representatives. American Psychologist, 36, 552-586

[Ethnic minority education]

Historically Marginalized Communities of Color Education

WHEREAS the general population of the United States is projected to change within the next generation and become an increasingly pluralistic society;

WHEREAS there is a historical, current and projected under-representation of racial/ethnic minority students, faculty, practitioners, and researchers in the field of psychology;

WHEREAS ~~[Whereas]~~ improving equity in the educational access ~~[pipeline]~~ requires recruitment and retention efforts across the spectrum of education from pre-college to entry into the field of psychology;

WHEREAS psychologists in education will need to become increasingly conversant on issues relevant to an increasingly diverse student population and pluralistic society; and

WHEREAS the lack of racial/ethnic minority representation and focus impacts the relevance of psychology to prepare students to function in an increasingly diversified society and to provide a culturally responsive appropriate services;

THEREFORE BE IT RESOLVED that APA places a high priority on issues related to the education of racial/ethnic minorities. These issues include planning appropriately inclusive [~~diverse~~] curricula, promoting psychology as a course of study and career option as well as recruitment, retention, advising, and mentoring of minority students at all levels of education.

~~[Follow-up to the "Principles for the provision of mental health & substance abuse treatment services A bill of rights"]~~

Principles for the Provision of mental health and substance use disorder treatment services: A bill of rights

WHEREAS APA has adopted the Principles for the Provision of Mental Health & Substance [~~Abuse~~] use disorder Treatment Services: A Bill of Rights and it has come to Council's attention that the procedures and policies of some managed care [~~companies~~] entities may violate these rights...

THEREFORE be it resolved that APA is committed to identifying and publicizing any abuses by those managed care [~~companies~~] entities which violate patients' rights as well as policies that uphold these rights and to educate consumers about their rights as patients.

General principles dealing with the APA election process

Council rejects any requirement for a hiatus on one year in service on boards and committees. There should be no formal restriction on a person's sequential service on different boards and committees. Preference should be given to [~~"new blood" rather than "old"~~] newly appointed or incoming members, if other factors are essentially equal, but the primary consideration in all elections or appointments should be, "Who can best serve the needs of APA in this particular assignment or office?"

No member of one standing board or committee or continuing committee shall serve simultaneously on any other continuing or standing board or committee of the Association unless formally authorized by a board or committee, and unless service is on a group that reports to that board or committee. This shall not preclude liaison assignments or consultant relationships, or task forces or commissions, or other ad hoc groupings, and shall not apply to divisions or officers of affiliated organizations.

Individuals serving in the APA Presidency cycle shall not hold offices within the Association other than ex officio positions that accompany the office. A person elected to the APA Presidency shall, during the term of President-elect, President, and Past President, be restricted from holding any other APA office, including divisional offices, that is not an ex officio extension of the Presidential office. [~~Operationally, (a) candidates for the presidency shall be restricted from running for any other elective office, such as division offices, within the Association while they are candidates for the presidency; and (b) a person elected to the APA presidency shall, during the term of president-elect, president, and past president, be restricted from holding any other office in the Association that is not an ex officio extension of the presidential office.~~]

The Council rejects any requirement for providing information on past and current service of candidates for election to boards and committees, endorsing the concept in principle but not adopting it as a hard and fast rule of the Association.

~~[The Council also adopted the following as general principles, but not hard and fast rules: (1) persons will normally be nominated for election to standing — boards or committees only after they have served on an APA continuing committee, task force or commission, or on the Council; and (2) continuing — committee assignments and those to other appointed groups are considered important avenues for introducing members without prior board or committee experience into APA governance activities, but continuing committees should not be restricted from drawing on experienced members as appropriate to the parent group.]~~

Health service psychologists as primary health care providers

APA reaffirms its commitment to the designation of health service psychologists as primary health care providers in relevant federal, state, and local regulations, and in federal funding programs designated for primary care practitioners. APA views this as a long-term goal in pursuit of which a variety of actions have already been undertaken and will continue to be undertaken as strategic openings and opportunities ~~[can be]~~ are made available.

Philosophy for creating new divisions

The policy of the Council with respect to the admission of new divisions shall be a positive one concerned with the spirit and intent of APA to give full recognition to diversity and to growth in the ~~[field]~~ discipline of psychology. The Council shall not be overly restrained by considerations of orderliness, by fears of centralization, or by the problems created by a sheer increase in size. Council shall naturally satisfy itself that divisional status is warranted under the criteria established in the Bylaws. But, beyond the letter of these rules, Council shall establish that a proposed division represents a new, vigorous, and demonstrably viable interest; that it has achieved recognition in the literature of psychology and in institutional form within departments of psychology, industry, and government; and that it numbers among its members both established psychologists and early career psychologists whose professional interest areas are not represented by the current divisions. When such new interests emerge, Council should be prepared to grant divisional status promptly.

Policy to include a demographic report on those ~~list of men, women and minority groups~~ serving as editors in the Council of Editors' annual report

Council requested that the members of the Council of Editors include routinely in their annual reports a summary of the demographics of those ~~[men, women, and minority groups]~~ serving as editors, associate editors, consulting editors, and reviewers. Further, Council requested that the numbers of men, women, and ~~[minority]~~ underrepresented groups who leave any of these positions also be made available.

Quality professional development and continuing education resolution

Whereas it is an ethical obligation for psychologists to "undertake ongoing efforts to develop and maintain their competence" (American Psychological Association ~~[Ethics Code Standard 2.03, APA, 2010]~~ 2017, p.5);

Whereas the Association of State and Provincial Psychology Boards (ASPPB) describes continuing professional development as a "professional and ethical obligation of every psychologist" (Association of State and Provincial Psychology Boards, 2014; p.3);

Whereas the American Psychological Association defines continuing education as "an ongoing process consisting of formal learning activities that 1) are relevant to psychological practice, education, and science; 2) enable psychologists to keep pace with the most current scientific evidence regarding assessment, intervention, and education as well as important legal, statutory, or regulatory issues [emerging issues and technologies]; and 3) allow psychologists to maintain, develop, and increase competencies in order to improve services to the public and enhance contributions to the profession" (APA, 2015; p.2 [2000]);

Whereas continuing professional development represents a variety of professional interactions, activities, roles, and responsibilities that allow for opportunities for psychologists to engage in learning, to become aware of changes in the field of psychological science, and enhance interdisciplinary understanding; formal continuing education is an integral part of continuing professional development (Institute of Medicine, 2010; Minniti, Chappell, Regnier & Travlos, 2019; Neimeyer, Taylor, Wear, & Linder-Crow, 2012);

Whereas the durability of knowledge in professional psychology diminishes over a short amount of time (Neimeyer et al., 2012; Neimeyer et al., 2014);

Whereas the goals of both continuing professional development and continuing education programming share a focus on enhanced learning and consumer protection ([APA, 2000] ASPPB, 2014; Washburn et al., 2019);

~~[Whereas data from the 2012 Education Leadership Conference indicated that psychologists in attendance were overwhelmingly in favor of the development of an American Psychological Association statement regarding Principles of Quality Professional Development (APA, 2012);~~

~~Whereas the American Psychological Association has endorsed the Guidelines for Assessment and Accountability in Higher Education of the New Leadership Alliance for Student Learning and Accountability that describe practices for the gathering, reporting on and using evidence to improve student learning (APA, 2011a; New Leadership Alliance for Student Learning and Accountability, 2012);]~~

Whereas competency-based education and training, as well as the assessment and documentation of maintenance of competence, are expected across interdisciplinary, educational, and healthcare contexts (Belar, 2012; Breytenback, Ham-Baloyi & Jordan, 2017; Institute of Medicine, 2010[; New Leadership Alliance for Student Learning and Accountability, 2012]);

Whereas the American Psychological Association has adopted a resolution to advocate for psychology as a STEM discipline (APA, 2010, 2011[b]), continuing professional development and continuing education need to be consistent with a scientific, evidenced-based approach to facilitating continued learning and integration of new learning into psychologists' performance in their professional workplace;

Whereas the American Psychological Association has defined evidence-based practice in psychology (EBPP) as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2021a; APA Presidential Task Force on Evidence- Based Practice, 2006[5]);

Whereas commitments to accountability and to improvement are cornerstones of an evidence-based approach (Institute[s] of Medicine, 2010; New Leadership Alliance for Student Learning and Accountability, 2012; Wise et al., 2010);

Whereas independent evaluation and verification of continuing professional development and continuing education are vital to enhancing consumer confidence and to demonstrating the link between ongoing professional development and professional competence (Langendyk, 2006; Neimeyer et al., 2012; Roediger & Karpicke, 2006; Wise et al., 2010);

Whereas there exists a well-developed literature in psychological science and education that can inform programs of professional learning and the design of learning environments (Bransford, Brown, & Cocking, 2000; Paas & Kester, 2006; Washburn et al., 2019);

Whereas the American Psychological Association recognizes that psychologists “rarely receive adequate education or training in disability issues” and has established guidelines for assessment and intervention with persons with disabilities (APA, 2022; p.2);

Whereas the American Psychological Association has established race and ethnicity guidelines that aim to address the persistent inequalities among different races, ethnicities, and cultural backgrounds in the US (APA, 2019);

Whereas the American Psychological Association’s Race and Ethnicity Guidelines specifically urge educators to: (1) “develop inclusive curricula, which should be comprehensive, supportive and take a strengths-based approach to the issues facing traditionally marginalized populations,” (2) “promote critical thinking and awareness, including cultural humility, or a commitment to continual learning and examination of one’s own beliefs about culture, race and ethnicity,” and (3) “instill in their students and trainees clinical skills to help them serve diverse populations” (APA, 2019);

Whereas the APA Council of Representatives has adopted a resolution on equity, diversity, inclusion, and accessibility in quality continuing education and professional development and instructed the Board of Educational Affairs to “integrate these principles into all policy regarding the continued professional development and continuing education of psychologists” (APA, 2023; p.2);

Therefore Be it resolved that the APA Council of Representatives adopts as American Psychological Association policy the following principles of quality professional development and continuing education, and instructs the Board of Educational Affairs to integrate these principles into all policy regarding the continued professional development and continuing education of psychologists:

- Quality continuing professional development activities and continuing education programs should be dedicated to an evidence-based approach with content substantiated by the empirical literature (APA, 2015; Taylor, Neimeyer, Bedwell, Leach, Liese, Minniti, Penberthy, Philip, Segura, & Simonian, 2019; Washburn et al., 2019).
- Quality continuing professional development and continuing education activities should be founded on ~~[evidenced]~~ science-based education methods (APA, 2015; Grus & Rozensky, 2019; Institute of Medicine, 2010; [Neimeyer, Taylor, & Cox, 2012;]Stuart, Tondora, & Hoge, 2004; Washburn et al., 2019; Wise et al., 2010).

- Quality continuing professional development and continuing education should serve the purpose of enhancing and improving psychologists' skills especially in term of service to the public, contributions to the profession, and the development of interdisciplinary and interprofessional collaboration and practice (APA, 2015[00]; Wise et al., 2010; Institute of Medicine, 2010).
- Quality continuing professional development and continuing education should be developed with a systematic focus on diversity and diversity related topics, incorporate viewpoints from scholars from diverse backgrounds, be committed to cultural humility, and address ~~[reflect current research on diversity related topics and be committed to a~~ multiculturally competent approach, respecting issues of diversity and addressing] the needs of underrepresented populations ([APA, 2003; APA, 2004; APA, 2011c; APA 2011d]2014, 2015, 2019, 2021b, 2022; Bell, Bern-Klug, Kramer & Saunders, 2010; Kachani, Ross & Irvin, 2020).
- Quality continuing professional development and continuing education includes evaluation of a learning experience in relation to the learner and the instructor, and the assessment of its outcomes, including verification of the completion of the activity (APA, 2015; Langendyk, 2006; Neimeyer et al., 2012; Roediger & Karpicke, 2006; Wise et al., 2010).
- Quality formal continuing education is a central component of continuing professional development for psychologists[,] and is an important mechanism for documenting the continued professional development expected in the evolving health care system (Belar, 2012; Neimeyer, Taylor,& Wear, 2009, 2010; Wise et al., 2010).
- Quality formal continuing education is necessary for the entirety of psychologists' professional career, given the diminishing durability of knowledge in professional psychology (Neimeyer et al., 2012; Neimeyer et al., 2014).
- Quality continuing education programming should build upon a completed doctoral program in psychology[,] and include introductory to advanced course sequencing to meet the needs of psychologists across the lifespan of their careers (APA, 2015; Metcalfe & Kornell, 2005; Van Merriënboer, Jeroen, Paas[s] & Kester, 2006; Wise et al., 2010).
- Quality continuing education programming incorporates presenters with expertise in the program content ([Ainsworth & Loizou, 2003;]Stuart et al., 2004), and should include the direct input of psychologists into all phases of the decision making and program planning process (APA, 2015). Quality continuing education programming includes multiple teaching methods to enhance retention and the translation of new learning into practice or other professional activities (APA, 2015; Bransford[,] et al., 2000; Breytenbach, Ham-Baloyi, & Jordan, 2017; Graesser, Olde, & Klettke, 2002).
- Quality continuing professional development and continuing education should be accessible to all psychologists, including persons ~~[those]~~ with disabilities (APA, 2015).
- Quality continuing education includes a focus on the active engagement of the learner (~~[Ainsworth & Loizou, 2003;]~~Bransford et al. 2000; Graesser et al., 2002; Knapp & Sturm, 2002; Lock, 2015).
- Quality continuing education makes a clear connection between program content and the application of this content within the learner's professional environment (APA, 2015; Craig, Sullins, Witherspoon, & Gholsohn, 2006; Hakel & Halpern, 2005; Institute of Medicine, 2010).

[Approved by the APA Council of Representatives, August 2013]

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Resolution APA, Psychology and Human Rights

The report of the American Psychological Association (APA) Task Force on Human Rights proposes a definition of human rights in relation to psychology; reviews the relationship between human rights and the concepts that have historically guided APA (e.g., human welfare, public interest, and social justice); proposes an analytical Five Connections framework to assess the connections between psychology and human rights and uses that framework to review APA's recent and ongoing human rights activities; and makes recommendations for organizational mechanisms that can ensure APA's ongoing and visible commitment to human rights. The Five Connection framework is as follows:

- Psychologists possess human rights by virtue of being human as well as specific rights essential to their profession and discipline;
- Psychologists apply their knowledge and methods to the greater realization of human rights;
- Psychologists respect human rights and oppose the misuse of psychological science, practice, and applications and their negative impact on human rights;
- Psychologists advance equal access to the benefits of psychological science and practice; and,
- Psychologists advocate for human rights.

The report concludes that APA has demonstrated an implicit recognition of its human rights obligations throughout its history, but has often acted in piecemeal fashion. Without the clarity or commitment that a fully operationalized theoretical framework would provide, APA has been hampered in its ability to consistently and effectively promote and protect human rights. If APA were to adopt a human rights framework, international human rights instruments and principles such as the Universal Declaration of Human Rights would become foundational to strategic planning and would inform all organizational programs and operations. This would enable APA to better support people's ability to participate in civil and political life; protect their freedom from discrimination, repression, and environmental injustice; promote their economic, social, and cultural wellbeing; and work to reduce the suffering caused by individual and systemic violations of human rights. APA would prioritize education, research, and the application of practices to help to achieve these objectives.

WHEREAS APA has for nearly 50 years expressed its strong commitment to human rights, most recently through its 2019 Strategic Plan, which includes the Guiding Principle that APA will "respect and promote human rights" and the Strategic Objective that APA will "foster the advancement of human rights, fairness, diversity, and inclusion" (APA, 2019a);

WHEREAS the 1977 Council of Representatives' Resolution on Human Rights expressed "APA's concern for and dedication to protecting human rights and human dignity in the United States and abroad" (APA, 1977a);

WHEREAS the 1987 Council Resolution on Human Rights declared that "the discipline of psychology, and the academic and professional activities of psychologists, are relevant for securing and maintaining human rights" and that "APA applauds the ongoing efforts of the United Nations (UN) to defend and protect human rights and undertakes to recommend the main UN human rights instruments and documents to the attention of its boards, committees, and membership at large" (APA, 1987);

WHEREAS the Preamble of the 1977 Ethical Principles of Psychologists and Code of Conduct (Ethics Code) asserts that “Psychologists respect the dignity and worth of the individual and honor the preservation and protection of fundamental human rights” (APA, 1977b);

WHEREAS the revised Preamble of the 2016 Ethics Code states that “Psychologists respect and protect civil and human rights” (APA, 2016a) and since 2010, the Ethics Code has stated (with emphasis added in italics): “If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights” (APA, 2010a);

WHEREAS APA is an accredited Non-Governmental Organization (NGO) at the UN, affiliated with the Department of Global Communications since 1999 and accorded Special Consultative Status with the Economic and Social Council since 2000 (APA, n.d.a.), where it undertakes many human rights initiatives (APA, 2018);

WHEREAS APA has adopted Council resolutions and/or conducted related federal advocacy to urge the US government to meet its obligations under international law to respect, protect, and fulfill human rights by ratifying the following UN treaties: the Convention on the Rights of the Child (APA, 2001a), the Convention on the Rights of Persons with Disabilities (APA, 2014a), and the Convention on the Elimination of All Forms of Discrimination against Women (APA, 2015). APA has also engaged in international advocacy supporting the rights of sexual minorities (APA, 2014b), ethnic minority populations (APA, 2017a), and others whose rights are at risk;

WHEREAS APA has further expressed its respect for, and defense of, human rights on many occasions by issuing resolutions relating to the human rights of persons or groups, including those focused on:

- Children (Resolution on Violence Against Children by Governments (APA, 1989); Child and Adolescent Mental and Behavioral Health Resolution (APA 2022b));
- Women (Resolution on the Equal Rights Amendment (APA, 1975); Resolution Affirming and Building on APA's History of Support for Reproductive Rights (APA, 2022a));
- ~~[Ethnic minorities]~~ Racially/ethnically minoritized people (Resolution on Racism and Racial Discrimination: A Policy Statement in Support of the Goals of the 2001 World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance (APA, 2001b); Resolution on Harnessing Psychology to Combat Racism: Adopting a Uniform Definition and Understanding (APA, 2021a); Role of psychology and APA in dismantling systemic racism in U.S. (APA, 2021b); Resolution on Psychology's Role in Addressing the Impact of, and Change Required With, Police Use of Excessive Force Against People of Color and Other Marginalized Communities in the United States (APA, 2022e));
- People with disabilities (Resolution on the Americans with Disabilities Act (APA, 2008a));
- Sexual and gender minorities (Resolution on Opposing Discriminatory Legislation and Initiatives Aimed at Lesbian, Gay, and Bisexual Persons (APA, 2004); Resolution on Transgender and Gender Identity and Gender Expression Non-discrimination (APA, 2008b); Resolution on Sexual Orientation & Marriage (APA, 2010b); Resolution on

Marriage Equality for Same-Sex Couples (APA, 2011); Resolution on Gender and Sexual Orientation Diversity in Children and Adolescent in Schools (APA, 2015); Resolution on Data About Sexual Orientation and Gender Diversity (APA, 2016b); Resolution on Opposing Discriminatory Laws, Policies, and Practices Aimed at LGBTQ+ Persons (APA, 2020a); Resolution on Sexual Orientation, Gender Identity (SOGI), Parents, and their Children (APA, 2020b); Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (APA, 2022Cc);

- Older adults (Resolution on Ageism (APA, 2020c));
- ~~[Low-income people]~~ People of low socioeconomic status (Resolution on Poverty and Socioeconomic Status (APA, 2000, updated in 2022d)); Resolution on Ending Homelessness (APA, 2021c);
- Other marginalized and at-risk groups (Resolution against Genocide (APA, 2008c); Resolution on Human Trafficking in the United States, Especially of Women and Girls (APA, 2017b); Immigration and Refugee Policy Statement (APA, 2019b); Principles for Healthcare Reform (APA, 2007); Advancing Health Equity in Psychology (APA, 2021d); Resolution on the Imposition of Death as a Penalty for Persons Aged 18 Through 20, Also Known as the Late Adolescent Class (APA, 2022f)).

WHEREAS APA has submitted over 150 amicus briefs, approximately one-third of which have been to the US Supreme Court, many of which focus on human rights-related issues, for example, the execution of child offenders and persons with intellectual disabilities, the rights of persons with disabilities, the right to refuse medication, and discrimination on the grounds of sexual orientation (APA, n.d.b.);

WHEREAS APA became a founding member of the American Association for the Advancement of Science's Science and Human Rights Coalition in 2009 and launched a webpage on Psychology and Human Rights in 2012 containing basic overviews of human rights, a variety of materials for educators on integrating the teaching of human rights and psychology, and opportunities for psychologists' advocacy to advance human rights (APA, n.d.c.);

WHEREAS APA created a Task Force on Human Rights in 2016 instructed to make "recommendations for organizational mechanisms that can ensure APA's ongoing and visible commitment to human rights" (APA, 2016[b]c);

WHEREAS the APA Task Force reviewed APA's history of engagement with human rights and issued the following conclusions in its 2020 report:

APA's human rights efforts have often been informed by international standards as defined by the Universal Declaration of Human Rights and related conventions, protocols, and treaties¹;

- Yet APA's failure to define human rights in relation to psychology has led to a lack of clarity about how to enact its commitment to human rights;
- Furthermore, the lack of foundational human rights knowledge within APA undermines its ability to effectively oppose the misuse of psychological science and practice and any harm done to marginalized populations made vulnerable by societal inequalities as a result of the misuse;
- While APA's research, applied initiatives, and federal advocacy efforts have often been resonant with human rights, they have rarely been informed by an explicit human rights framework;
- Likewise, APA's efforts to promote academic freedom, respond to the persecution of psychologists, or ensure that all people receive the benefits of psychological science and

practice have generally been carried out without explicit reference to human rights instruments or principles;

WHEREAS the International Standard on Social Responsibility (International Organization for Standardization, 2010) guides organizations on how to operate in a socially responsible way and identifies human rights as one of the principles of social responsibility;

WHEREAS, while human rights are guaranteed to all in theory, the degree to which they are actualized is dependent upon power and privilege, often denied to those with marginalized identities, such as individuals of diverse age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status;

THEREFORE, BE IT RESOLVED that, in keeping with its strategic plan, APA align its ethics, governance, and programmatic activities with human rights principles and practices as articulated in the Universal Declaration of Human Rights and related conventions, protocols, and treaties, comprising international law protecting civil, political, economic, social, and cultural rights;

THEREFORE, BE IT RESOLVED that APA adopt the “Five Connections Between Psychology and Human Rights,” stipulated in the Task Force report, as a framework to make explicit connections between human rights and psychology when enacting the mission, goals, and objectives in its strategic plan;

FURTHERMORE, based on the Five Connections framework, APA will:

- Protect psychologists’ human right to ethically and responsibly conduct their science and practice;
- Support the development, production, and dissemination of psychological knowledge and methods that can be applied to the greater realization of human rights;
- Oppose the misuse of psychological science, practice, and applications and their negative impact on human rights;
- Advance equal participation in and access to the benefits of psychological science and practice;
- Advocate for human rights and provide the resources and tools necessary for its members to do so as well;

THEREFORE, BE IT RESOLVED that by adopting a human rights framework, APA will integrate its longstanding concerns for human welfare, public interest, and social justice within a broader international consensus-building process, which will provide clearer guidance and structure for organizational decision-making, including accountability, on issues related to societal good;

THEREFORE, BE IT RESOLVED that APA supports the incorporation of foundational human rights knowledge into the education and training of psychologists at all levels, from high school through postdoctoral training, with particular attention to racism and bias against marginalized populations, as well as to global inequalities;

THEREFORE, BE IT RESOLVED that APA encourages the growth and development of human rights research in psychology;

THEREFORE, BE IT RESOLVED that APA encourages psychologists to support and advocate for populations at risk of human rights violations, including marginalized populations both domestically and globally;

THEREFORE, BE IT RESOLVED that APA prioritizes human rights advocacy and the development of a consistent process to inform public policy and legal decision-making for the protection of human rights;

THEREFORE, BE IT RESOLVED that APA demonstrates that respect for human rights is central to psychological ethics;

THEREFORE, BE IT RESOLVED that the APA central office and governance system will ensure centralized coordination to oversee and maintain engagement with human rights at the organizational level;

THEREFORE, BE IT RESOLVED that APA will continually disseminate and publicize this 2021 Resolution on APA, Psychology, and Human Rights both within the Association (to boards, committees, and the membership at large) and to the wider public.

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[Resolution in support of ethnic minority training in psychology]
Training in Psychology for People from Historically Marginalized Communities of Color

WHEREAS research and services training in psychology and the biomedical and behavioral sciences are a fundamental component of the overall Science and professional practice enterprises;

WHEREAS a reduction of funds for research and services training in psychology and the behavioral and biomedical sciences will adversely impact the nation's training ~~[pipeline]~~ pathway and infrastructure for research and professional practice, and thereby reduce the nation's capacity to generate new knowledge and provide needed mental and behavioral health sciences;

WHEREAS ~~[ethnic minorities (i.e., persons of African, Asian, Hispanic/Latino/a, American Indian, Pacific Islander and Native Alaskan descent nations)]~~ currently comprise approximately 33% of the nation's population, with an expected increase to more than 50% by 2060. National Center for Health Statistics, 2004)] Black, Indigenous, Latinx/e, Asian and other non-Black people of Color and people who identify as bi-racial will grow by 200% by 2060. Asian Americans and the Latine/x communities are expected to double within the next 4 decades (Vespa, J., Medina, L., & Armstrong, D., 2020;

WHEREAS it is broadly acknowledged that within the U.S. significant racial/ethnic disparities exist in health status and treatment; and, in response ~~[, the U. S. Congress and Surgeon General]~~ directed the U.S. Department of Health and Human Services ~~[to have all of its institutes develop action plans related to the elimination of such health disparities (Bret & Hays, 2004; Shavers & Shavers, 2006; Smedley, Stith & Nelson, 2003)]~~ has developed plans to address these health disparities (U.S. Department of Health and Human Services, 2020; U.S. Department of Health and Human Services, 2021; U.S. Health and Human Services Department, 2022);

WHEREAS, there is an underrepresentation of Blacks or African Americans, Hispanics or Latines, American Indians or Alaska Natives, Native Hawaiians, and other Pacific Islanders in NIH Funding (<https://diversity.nih.gov/about-us/population-underrepresented>) ~~[ethnic minority researchers such that in 1999 only 14% of all NIH research grant awards and 10% of all NIMH research grant awards went to ethnic minority researchers, and only 23% and 41% respectively of these were awarded to persons of African, Hispanic/Latino, American Indian or Alaskan Native descent;~~

~~there also is a similar — underrepresentation of ethnic minorities among providers of substance abuse and mental health services;]~~

WHEREAS in ~~[1993]~~ 2021, the Association resolved to advance health equity in psychology (APA, 2021) by centering “race/ethnicity and racism as the key driver of health inequities. At the same time, APA recognizes that inequities are experienced through the intersection of multiple elements of identity, particularly those that are associated with limited political, social, and economic power” [declared by resolution that “APA places a high priority on issues related to the education of ethnic minorities...including planning appropriately diverse curricula, promoting psychology as a course of study and career option as well as recruitment, retention, advising and mentoring of minority students at all levels of education”];

THEREFORE, BE IT RESOLVED that the Association affirms its support for training programs in psychology across the educational ~~[pipeline]~~ pathway (i.e., high school, undergraduate, graduate, and postdoctoral studies) that seek to prepare ethnic minorities for behavioral, social sciences, and biomedical research careers and behavioral and mental health services careers that address the needs of the nation’s increasing racial and ethnic diverse populations;

BE IT FURTHER RESOLVED that APA will maintain and strengthen, as resources become available, its advocacy efforts targeted to (a) the U.S. Congress, (b) major federal research agencies, (c) major federal behavioral/mental health services agencies, (d) other federal agencies engaged in support of behavioral/mental health research and services training, and (e) other public and private entities that support behavioral/mental health research and services.

BE IT FURTHER RESOLVED that such advocacy efforts will include but not be limited to the following objectives: (a) to increase public and private investment in training programs, across the educational ~~[pipeline]~~ pathway, that seek to prepare ethnic minorities and others for research and services careers that address the needs of the nation’s Black, Indigenous, Latinx/e, Asian and other communities of Color ~~[racial and ethnic diverse populations]~~; (b) to oppose reductions in the allocations, appropriations or budgets for such training programs; and (c) to ensure, whenever feasible, that psychology is recognized as an eligible discipline for funding applications for such training programs.

BE IT FURTHER RESOLVED that, as resources become available, the Association increase its workforce research and data collection efforts related to both the characteristics and outcomes of Black, Indigenous, Latinx/e, Asian and other communities of Color ~~[ethnic minority]~~ training programs in behavioral/mental health research and services, as well as the changing priorities, activities and funding of program offices of those federal agencies and major foundations that fund such programs.

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Resolution on culture and gender awareness in international psychology

Whereas an estimated 60 percent (or more) of the world's psychologists now live outside the US (Hogan, 1995);

Whereas psychologists outside of the US have generated perspectives, methods and practices that correspond to the needs of the people in their societies and data that are relevant to the development of a more complete psychology of people (Bhopal, 2001; Espin & Gaweleck, 1992; Martin-Baro, 1994; Weiss, Whelan & Gupta, 2000; Winslow, Honein, & Elzubeir, 2002);

Whereas US leadership in world psychology is sometimes perceived as disproportionately influential, partly because of access to research funds, an abundance of U.S. publication outlets and the wide acceptance of the English language (Arnett, 2008; Kagitcibasi in Sunar, 1996; Sloan 2000);

Whereas U.S. psychology needs to more fully consider the ramifications of national and cultural perspectives and indigenous psychologies (Castillo, 2001; Frank & Frank, 1991; Sue & Zane 1987) in its research, practice, advocacy and educational efforts (Best & Williams, 1997; Draguns, 2001; Segall, Lonner, & Berry, 1998);

Whereas U.S. grounded, normed, and structured measures dominate US empirical psychology, while internationally based, qualitative methods such as community action research are less known or valued in the US (Denzin & Lincoln, 2001; Murray & Chamberlain, 1999; Robson, 1993);

Whereas U.S. assessment procedures, tests and normative data have been used extensively in other countries, some times without consideration of cultural differences that affect reliability and validity (Dana, 2000);

Whereas people of other cultures have adopted U.S. methods of clinical diagnosis and intervention and US psychology has also exported these methods based on US norms and values to other cultures (Foa, Keane, & Friedman, 2000; Mezzich, 2002; Nakane and Nakane, 2002; Thorne & Lambers, 1998);

Whereas there is a need to develop and disseminate materials that will facilitate the training of psychologists to conduct culturally-[appropriate]responsive research and practice around the

world as well as within the culturally diverse United States (diMauro, Gilbert, & Parker, 2003; Friedman, 1997; Hays, 2001);

Whereas universities and colleges have called upon faculty and departments to internationalize their courses and curriculum, given the increasing number of international students at North American institutions (Marsella & Pedersen, 2002; Woolf, Hulsizer, & McCarthy, 2002);

Whereas most individuals from the United States, including psychologists, do not speak a second language or read journals or books in another language other than English, and therefore are unlikely to be familiar with firsthand sources of international research in other countries other than English speaking countries;

Whereas research focused on immigration and discrimination against immigrants and undocumented immigrants is sparse (Esses, Dovidio, Jackson & Armstrong, 2001; Evans, 2002; Martin, 1994);

Whereas decades of psychological studies have demonstrated that scientifically sound practice requires taking into account issues of gender and culture at all stages of the research process (Bem, 1993; Brodsky & Hare-Mustin; 1980; Harding, 1987; Schmitz, Stakeman & Sisneros, 1996; Sherif, 1979; Spence, 1987; White; Russo & Travis, 2001);

Whereas psychologists have demonstrated how privilege and oppression affect the lives of women and men across sexual orientations, disabilities, social class, age, ethnic and religious memberships (APA Guidelines for Psychological Practice with Older Adults, 2003; Banks, 2003; Eberhardt & Fiske, 1998; Gershick, 2000; Sidanius, Levin, Federico & Pratto, 2001; Sidanius & Pratto, 1999;

Whereas women world wide experience discrimination in terms of resources and access to food, health care, inheritance, credit, education, vocational training, hiring, fair compensation for paid work, family and public rights, individual mobility and travel and religious education and participation, and they also may face legal, societal, cultural and religious practices which justify and endorse this discrimination (Bianchi, Casper & Peltola, 1999; Goode, 1993; Hauchler & Kennedy, 1994; Smeeding & Ross, 1999; United Nations, 2000; United Nations Population Fund, 2000), and psychology could address these global problems internationally (United Nations, 2000; United Nations Population Fund, 2000);

Whereas, as a result of gender discrimination, women internationally constitute a majority of the poor, and female headed families are the lowest income groups in many countries around the world (Blossfield, 1995; Duncan & Edwards, 1997; Goldberg & Kremen, 1990; McLanahan & Kelly, 1998); moreover, educational achievements and opportunities and literacy rates for women are significantly less than for men (United Nations Department of Public Information, 1995; UNESCO, 2002);

Whereas, as a result of gender discrimination, women experience violations of their body integrity, interpersonal violence and physical abuse (Center for Policy Alternatives, 1998; European Women's Lobby, 2000; Nysten & Heimer, 2000); and under repressive systems, in wars, and in postwar conditions, women are targeted for violence (Comas-Diaz & Jansen, 1995);

Whereas, as a result of gender discrimination individuals with differently gendered identity and gender expression experience violence and discrimination within many societies from both the populace and from those in authority (Dworkin, & Yi, 2003);

Whereas psychologists strive to promote international human rights, peace and understanding and to decrease ethnic and gender violence;

Whereas, in contrast to the United States where professional practices and policies generally are in concert with and support governmental structures, in many other countries, psychologists must advocate for social justice and oppose unjust governmental structures and policies (Fox & Prilleltensky, 2001; Martin-Baro, 1994; Moane, 1999; Moler & Catley, 2000; Nandy, 1987);

Whereas knowledge management, production and dissemination of information are also affected by global politics and economics in ways that maintain social inequality (Capra, 1996; Fox & Prilleltensky, 2001; Giddens, 2000; Harding, 1993; Wallerstein, 1992);

Whereas the field of psychology could benefit significantly from the expansion of its knowledge base through international perspectives, conclusions and practices (Bronstein & Quina, 1988; Gielen & Pagan, 1993; Marsella, 1998); Nandy 1983, Pareek 1990;

Whereas the opportunity for mutual benefit and greater effectiveness in solving global problems is at hand in research partnerships across nations and cultures if psychologists proceed with critical awareness and a commitment to gender, cultural, social, economic and religious justice (Sloan, 1996);

Whereas psychologists have a responsibility to better understand the values, mores, history and social policies of other nations and cultures that affect generalizations and recommendations about best practices (Schmitz, Stakeman & Sisneros, 1996);

Whereas psychologists are committed to culture fair and gender fair competent unbiased practice (APA Guidelines on Cross Cultural Education and Training, Research, Organizational Change and Practice for Psychologists, 2002; ~~[APA Guidelines for Practice with Girls and Women (APPROVED), 2002]~~; APA Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients, 2000; American Psychological Association, A New Model of Disability, 2003; APA Guidelines for Practice with Girls and Women, 2018; APA Guidelines for Assessment and Intervention with Persons with Disabilities, 2022);

Whereas psychologists are ethically guided to "recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology" and to "respect the rights, dignity, and worth of all people" (American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, 2002);

Whereas the International Committee for Women Task Force of Division 52, International Psychology, has developed an important position paper on "Cultural And Gender Awareness in International Psychology" that identifies critical areas of consideration for psychologists to consider in cross-cultural research (Rice and Ballou, 2002);

Therefore let it be resolved that the American Psychological Association will:

1. advocate for more research on the role that cultural ideologies have in the experience of women and men across and within countries on the basis of sex, gender identity, gender expression, ethnicity, social class, age, disabilities, and religion.
2. advocate for more collaborative research partnerships with colleagues from diverse cultures and countries leading to mutually beneficial dialogues and learning opportunities.

3. advocate for critical research that analyzes how cultural, economic, and geopolitical perspectives may be embedded within US psychological research and practice.
4. encourage more attention to a critical examination of international cultural, gender, gender identity, age, and disability perspectives in psychological theory, practice, and research at all levels of psychological education and training curricula.
5. encourage psychologists to gain an understanding of the experiences of individuals in diverse cultures, and their points of view and to value pluralistic world views, ways of knowing, organizing, functioning, and standpoints.
6. encourage psychologists to become aware of and understand how systems of power hierarchies may influence the privileges, advantages, and rewards that usually accrue by virtue of placement and power.
7. encourage psychologists to understand how power hierarchies may influence the production and dissemination of knowledge in psychology internationally and to alter their practices according to the ethical insights that emerge from this understanding.
8. encourage psychologists to appreciate the multiple dilemmas and contradictions inherent in valuing culture and actual cultural practices when they are oppressive to women, but congruent with the practices of diverse ethnic groups.
9. advocate for cross national research that analyzes and supports the elimination of cultural, gender, gender identity, age, and disability discrimination in all arenas—economic, social, educational, and political.
10. support public policy that supports global change toward egalitarian relationships and the elimination of practices and conditions oppressive to women.

Be it further resolved that the American Psychological Association (1) recommend that Boards and Committees consider the impact of the globalization of psychology and the incorporation of international perspectives into their activities, and (2) charge the Committee on International Relations in Psychology, in collaboration appropriate APA Boards and Committees, to implement any directives from the Council of Representatives that result from the adoption of the resolution.

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[APA Resolution on Ethnic Minority Recruitment and Retention]

Resolution on recruitment and retention of historically marginalized students of color

WHEREAS the general population of the United States is projected to change within the next generation and become a pluralistic society;

WHEREAS there is a current and projected under-representation of ~~[ethnic minority]~~ Black, Indigenous, Latine, Asian and other non-White students, faculty, practitioners, and researchers in the field of psychology;

WHEREAS the educational pipeline requires recruitment and retention efforts across the spectrum of education from pre-college to entry into the field of psychology;

WHEREAS psychologist in education will need to become increasingly conversant on issues relevant to ~~[an increasingly diverse student population]~~ communities of Color and pluralistic society; and

WHEREAS the lack of Black, Indigenous, Latine, Asian and other non-White ~~[ethnic minority]~~ representation and focus impacts the relevance of psychology to prepare students to function in a diversified society and to provide appropriate services;

THEREFORE BE IT RESOLVED that APA places a high priority on issues related to the education of communities of Color. ~~[ethnic minorities]~~ These issues include planning appropriately diverse curricula, promoting psychology as a course of study and career option as well as recruitment, retention, advising, and mentoring of Black, Indigenous, Latine, Asian and other non-White ~~[minority]~~ students at all levels of education.

~~[(December 1993)]~~

Resolution on human trafficking in the United States, especially of women and girls

WHEREAS human trafficking is a human rights violation, especially into the sex trade, slavery, and involuntary servitude defined as the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, or abduction, or fraud, of deception, of the abuse of power or of a position of vulnerability or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation (American Psychological Association, 2009; American Psychological Association, 2014; UN, 2000; United Nations Office on Drugs and Crime, 2014); and

WHEREAS globally and in the United States human trafficking, especially sex trafficking, disproportionately affects women and girls and gender nonconforming people. (APA, 2009; APA, 2014; UNODC, 2014; U.S. Department of State, 2022); and

WHEREAS human trafficking also affects other highly vulnerable populations to human trafficking, including but not limited to the economically vulnerable, persons with disabilities, and runaway youth, with disproportionate vulnerability for youth who identify as gay, lesbian, bisexual, and transgender ~~{{(GLBT)}}~~ (LGBTQ+) (Ahrens, Katon, McCarty, Richardson & Courtney, 2012; Gerassi, 2015; Mufti & Finn, 2013; Reid, 2012; Sallman, 2010; Silbert & Pines, 1981; U.S. Department of State, 2014, 2016);

WHEREAS there is a need for the United States to continue to strengthen a domestic and transnational agenda to combat human trafficking (U.S. Department of State, 2015); and

WHEREAS victims of human trafficking in the United States have been identified in multiple legal and illicit industries (APA, 2009; U.S. Department of State, 2015) and practicing psychologists may interact directly (e.g. health care centers, substance abuse recovery programs) or indirectly (e.g. organizational psychologists consulting to businesses that are at high risk for trafficking) with these victims; and

WHEREAS practicing psychologists also may interact with populations identified as being at highest risk for human trafficking in the United States, such as children in the child welfare and juvenile justice systems, and many other hard to detect “hidden” vulnerable populations (Hepburn & Simon, 2010; Herman, 2003; Phillips, 2015; Pierce, 2012; Reid & Piquero, 2014; U.S. Department of State, 2014); and

WHEREAS increasingly, since the passage of the Trafficking Victim's Protection Act (2000), the need to define non-violent forms of psychological coercion exists to support U.S. law enforcement's increasing number of human trafficking investigations and prosecutions (Burke & Zarembka, 2008; Kim, 2007, 2011; U.S. Department of Justice, 2015); and

WHEREAS there is consensus in the United States that existing anti-trafficking laws have only partially protected victims of human trafficking (Polaris Project, 2015; Reiger, 2007; TVPA, 2000; TVPRA 2003, 2005, 2008, 2013); and

WHEREAS in the United States anti-trafficking task forces need resources to increase their ability to work effectively across multiple disciplines (Office for Victims of Crime & Bureau of Justice Assistance, 2011); and

WHEREAS health and social service providers need training and tools to identify and attend to victims effectively (OVC & BJA, 2011); and

WHEREAS public awareness about human trafficking still needs to reach broader communities and communicate more information about the nuances of this crime (Farrell & Pfeffer, 2014; Greenbaum, 2015; Roe-Sepowitz, Hickie, Dahlstedt, & Gallagher, 2014; Cole & Sprang, 2015); and

WHEREAS promising evidence exists that suggests that addressing sex buying in the United States may reduce rates of sex trafficking (Ali, 2009; Shively et al., 2012; Shively et al., 2010); and

WHEREAS there are limited studies in the United States on the profile of traffickers and their unique pattern(s) of perpetration (APA, 2014; Human Rights Center, 2005; Kamazima, Kazaura, Ezekiel, & Fimbo, 2011) and existing studies suggest that traffickers have a broad profile (Denton, 2016; Human Rights Center, 2005; Kamazima et al., 2011; Roe-Sepowitz, Gallagher, Risinger & Hickie, 2015; UNODC, 2014), high levels of psychopathy (Hargreaves- Cormany, Patterson, & Muirhead, 2016), and sometimes use, in addition to physical violence and sexual assault other, non-violent, forms of manipulation and psychological coercion (Burke & Zarembka, 2008; Kim, 2011; Kim, 2007; Mufti & Finn, 2013; Sallman, 2010; U.S. Department of Justice, 2015); and

WHEREAS human trafficking exposes victims to physical, sexual, and psychological abuse that incur in serious and complex health and psychological consequences (Cole, Sprang, Lee, & Cohen, 2016)

WHEREAS in addition to a trafficker's threats of retaliatory violence (Farrel, 2014; Nichols & Heil, 2012), historical criminalization of persons involved in the sex industry (Busch-Armendariz, Nsonwu, Cook Heffron, Garza, & Hernandez, 2009; Cross, 2013; Gerassi, 2015; Lange, 2011; Minnesota Advocates for Human Rights, 2003; Roe-Sepowitz et al., 2014), as well as complex psychological symptoms that can result from trafficking, such as mistrust, may deter victim participation in prosecutions and in health and social services (U. S. Department of State, 2015; Gibbs, Walters, Lutnick, Miller, & Kluckman, 2015; Pierce, 2012; Raphael, Reichert, & Powers, 2010; Reid, 2013; UNODC, 2014; Zimmerman et al., 2003); and

WHEREAS relationally-focused, trauma-sensitive, and culturally-responsive ~~[attuned]~~ approaches delivered within a social ecological framework to treat the complex psychological consequences of human trafficking are needed (APA, 2014; Contreras, Kallivayalil, & Herman, 2016; Gibbs et al., 2015; Reid, 2016); and

WHEREAS prevention programs addressing human trafficking and re-trafficking are needed for those in health care, in schools, and other community venues is required to educate the public (Cecchet & Thoburn, 2014; Reid, 2012; Reid, 2011; Silbert & Pines, 1981; Widum & Kuhns, 1996); and

WHEREAS in the United States there is still a limited research base to understand the multiple factors related to human trafficking, and an urgent need exists to collect data on human trafficking to determine a global estimate of victims, and explore its causes and psychological consequences despite the enormous challenges involved in conducting such research (APA, 2009; APA, 2014; UNODC, 2014; Martin, 2013; Yonas, Burke, & Miller, 2013);

WHEREAS one of the global recommendations on conducting human trafficking research is to support small and methodologically strong studies to identify the more nuanced characteristics of human trafficking (UNODC, 2014)

BE IT THEREFORE RESOLVED that the American Psychological Association: Continues in its commitment to educate the public, promote awareness, and disseminate research findings to the general public, professionals working with at-risk populations, and professionals engaged in research about consumers, traffickers, and trafficked persons;

BE IT FURTHER RESOLVED that APA encourages government and philanthropic organizations to fund research that would address gaps in knowledge related to human trafficking address the following gaps in knowledge related to human trafficking:

The risk and protective factors related to all victims of human trafficking in the United States with special focus on the most vulnerable populations such as women and girls;
The strengthening of transnational collaborations between professionals and organizations participating in global anti-trafficking efforts;
The training of professionals in information about industries where victims of trafficking are commonly found, and populations at highest risk of human trafficking;
The impact of societal biases on providing services to survivors; The psychology of traffickers and trafficked persons;
The impact of psychological trauma as a contributor and consequence of human trafficking; The nature of all forms of human trafficking (e.g. sex trafficking, labor trafficking);
The evaluation of programs and treatments provided to survivors of human trafficking.

BE IT FURTHER RESOLVED that APA encourages the involvement of psychologists to assist in the development of effective cross-disciplinary anti- trafficking task forces; and to contribute to other community, state, and federal efforts in anti-trafficking;

BE IT FURTHER RESOLVED that APA strongly encourages that research initiatives and program development efforts include the participation of persons directly affected by human trafficking and community based organizations with experience serving trafficked persons;

BE IT FURTHER RESOLVED that APA encourages existing legislation and policies include increased focus on protecting the human rights of trafficked persons and non-criminalization of such persons;

BE IT FURTHER RESOLVED that APA strongly endorses the development and implementation of rigorously tested interventions that prevent and address the consequences of human trafficking;

BE IT FURTHER RESOLVED that APA strongly endorses that psychology partner with legal professionals to redefine psychological coercion in cases of human trafficking;

BE IT FURTHER RESOLVED that APA strongly encourages supporting research that can generate accurate estimates of human trafficking and evidence- based health services for survivors of human trafficking; and,

Be IT FURTHER RESOLVED that APA supports and advocates for evidence-based policy and services for survivors of human trafficking.

Suggested Citation

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Resolution on Poverty and Socioeconomic Status

Whereas the income gap in the United States between low and high Socioeconomic Status (SES) has continued to increase, with the average income of the lowest fifth of the population down 25% and the average income of the top fifth up 23% since the 1970s (Duncan et al., 2019) and where rates of poverty have increased to 11.6[4]% in 2021[0] from 11.5[10.5]% in the preceding year; where overall numbers of persons in 2021[0] who live in poverty are in excess of 37.9[2] million (U.S. Census Bureau, 2022[1]a); and where persons with low SES have limited access to acquiring wealth due to low wages, predatory lending and credit practices, and barriers to income generating resources;

Whereas in times of natural disasters, pandemics, and economic downturns associated with job loss and high rates of unemployment and under-employment, persons of low SES and those living in poverty in urban, suburban and rural locations experience more devastating and long-

lasting personal and financial repercussions than those with greater economic advantage (Buheji et al., 2020; Finch & Finch, 2020; McAlpine & Alang, 2021);

Whereas persons at the intersection of low SES and multiple minoritized identities, including persons of color; women; lesbians, gay, bisexual, queer, transgender, and non-binary individuals; persons with mental illnesses; immigrants; refugees; persons with physical and/or intellectual disabilities; and court system-involved persons, have been historically and systemically discriminated against through policies, laws, and ordinances as well as bias and stereotyping that have created a range of barriers to opportunities thus solidifying financial hardship and economic inequality (APA, 2020; Gonzales et al., 2020; Guedel & Colbert, 2016; Iguchi et al., 2005; McGarrity, 2014; Martinchek & Carther, 2021; Massey, 2020; Sakimura, 2020; Torres et al., 2018; Whittle et al., 2017; Wilson et al., 2020; Wright et al., 2014; U.S. Government Accountability Office, 2018);

Whereas compared to 8.2% of White persons who live in poverty, the rates are disproportionately higher among most non-White populations, 26.8% American Indian and Alaska Natives, 19.5% Blacks, 17% non-White Hispanics, 8.1% Asians, who have been systematically excluded from opportunities to gain wealth while also having the potential for intergenerational wealth stolen (Akee, 2021; National Congress of American Indians, 2020; U.S. Census Bureau, 2021a). Diversity within these various groups should also be recognized [e.g., poverty rates for Asian individuals vary by country of origin: 13% Chinese, 7% Filipino, 8% Japanese, 11% Korean, 6% Indian, 12% Vietnamese (Pew Research Center, 2021)]. Notably, when considering population breakdowns by race/ethnicity in the U.S. are considered, poverty rates are disproportionately higher for Asian, Black, and Indigenous individuals but lower than expected for White individuals (U.S. Census Bureau, 2021b); Diversity within these various groups should also be recognized (e.g. poverty rates for Asian individuals vary by country of origin: 13% Chinese, 7% Filipino, 8% Japanese, 11% Korean, 6% Indian, 12% Vietnamese (Pew Research Center, 2021)

Whereas there was an increase in child poverty rates, with the percentage of children and youth below the age of 18 living below the poverty line rising from 14.4% in 2019 to 16.1% in 2020 (U.S. Census Bureau, 2021a). Furthermore, Black, Hispanic, and Indigenous children are overrepresented among children living below the poverty line (Children's Defense Fund, 2018; Thomas & Fry, 2020). More specifically, 35.5% of Black people living in poverty in the U.S. are below the age of 18. Similarly, 40.7% of Hispanic people living below the poverty line in the U.S. are younger than age 18, and 29.1% of American Indian and Native American children lived in poverty in 2018 (Children's Defense Fund, 2018). In contrast, approximately 21% of White people living in poverty in the U.S. are less than 18 years old (Thomas & Fry, 2020);

Whereas compared to the 2020 poverty rate of families with a male head of household (11.4%), families with a female head of household had a poverty rate of 23.4% in 2020, an increase from 22.2% in 2019 (U.S. Census Bureau, 2021a) with a direct impact on increasing numbers of children and other family members;

Whereas racial, ethnic, and gender economic gaps persist in the U.S. with working white men [~~White male workers~~] making significantly more money than their [~~female~~] White, Black, Latinx, Asian, or Native American women counterparts. Compared to every dollar paid to White, non-Hispanic men, Latinx women were paid 55 cents, Native American women were paid 60 cents, Black women were paid 63 cents, White women were paid 79 cents, and Asian women were paid 85 cents (National Partnership for Women & Families, 2021);

Whereas evidence establishes that the income gap between the economically marginalized and the wealthiest in societies continues to be associated with significant inequity in morbidity and life expectancy (APA, 2021a; Bosworth, 2018). Low SES is associated with higher mortality rates and with increased rates of pervasive and untreated mental illnesses, osteoarthritis, hypertension, diabetes, coronary heart disease, AIDS/HIV infection, cervical cancer, and other chronic health conditions in men and women across the life span (Schiller et al., 2012; Stringhini et al., 2017; Tobias, 2017) than those who are more economically advantaged. Where low-income women are more likely to have chronic and other disabilities than their higher-income counterparts, thus limiting their employment options and straining their financial resources (Brault, 2012; Women's Bureau, U.S. Department of Labor, 2015);

Whereas demonstrable inequities associated with low SES begin before birth with greater likelihood of fetal death and infant mortality (Gilman et al., 2017; Larson, 2007) and where many birthing parents [~~mothers~~], particularly communities of color and those living below the poverty line, receive inadequate prenatal and postnatal care resulting in significantly higher rates of maternal prenatal and perinatal complications and death (Gadson et al., 2017; Kaplowitz et al., 2018; Lefmann et al., 2017; Oropesa et al., 2001; Ross et al., 2020; Ross et al., 2019; Taylor et al., 2019). Where poverty has been identified as an adverse childhood experience [~~event~~] (ACEs), and where low-income children have significantly higher rates of exposure to a range of ACEs that are associated with poor physical and mental health outcomes across the life span (Crouch et al., 2020). This divide in morbidity and mortality rates along economic lines has continued to grow (Bosworth, 2018), with higher death rates for low-income infants (as well as adults), thereby decreasing the life expectancy for all members of society. This inequity may be compounded by an interaction with the negative health outcomes associated with U.S. racial constructs (APA, 2021d; APA, 2021f);

Whereas individuals living in economically depressed communities are more likely to experience adverse food and nutrition conditions such as “food deserts” or “food swamps.” These locations are found in urban, rural, and remote areas and are more likely to have limited access to fresh fruits and vegetables thereby impacting their nutrition and well-being, contributing to higher rates of morbidity and mortality (Banner et al., 2020; Fong et al., 2020; Madzia et al., 2020; Phillips & Rodriguez, 2020; Walker et al., 2010);

Whereas poverty is detrimental to psychological well-being, with [~~low-income~~] individuals with low-income being twice as likely to suffer from a diagnosable mental health disorder compared to those in higher-income brackets (Lipman & Boyle, 2008; Sareen et al., 2011; Walker & Druss, 2017) and with poverty being a significant obstacle to accessing needed emotional and behavioral health treatment for adults and children (APA, 2021a; Ralston et al., 2019; Santiago et al., 2013), and experiencing mental illness, especially when untreated, increases the risk of individuals living below the poverty line and remaining economically disadvantaged across the life span (Anakwenze & Zuberi, 2013; Funk et al., 2012; McAlpine & Alang, 2021);

Whereas the impact of poverty on young children is significant and long lasting, thus limiting opportunities to achieve improved SES (Greenfield & Moorman, 2018; Cohen et al., 2010; Assari, 2018), where poverty is associated with substandard housing, hunger, homelessness, inadequate childcare, unsafe neighborhoods, and under-resourced schools (APA, 2021e; Chaudry & Wilmer, 2016; Ralston et al., 2019; Wimer et al., 2016); and low-income children are at greater risk than higher-income children for a range of cognitive, emotional, and health-related problems, including detrimental effects on executive functioning, below average academic achievement, poor social emotional functioning, developmental delays, behavioral problems, asthma, inadequate nutrition, low birth weight, and higher rates of pneumonia (Aber

et al., 2012; Bailey & Dynarski, 2011; Last et al., 2018; Shonkoff et al., 2009; von Stumm & Plomin, 2015);

Whereas living in poverty is associated with differences in structural and functional brain development in children, adolescents, and adults in areas related to cognitive processes that are critical for learning, communication, and academic achievement, including social emotional processing, memory, language, and executive functioning (Chan et al., 2018; Farah, 2017; Hair et al., 2015; Kim et al., 2013; Noble et al., 2015);

Whereas children and families living in poverty often attend under-resourced, overcrowded schools that lack educational opportunities, books, supplies, and appropriate technology due to local funding policies (Edley et al., 2019; Pfeffer, 2018; Schanzenbach, 2014; Spiegelman, 2018). Children living below the poverty line often live in school districts without adequate equal learning experiences for both gifted and special needs students with learning differences and where high school dropout rates are high (Kearney & Levine, 2016; Mason-Williams et al., 2015; Yaluma & Tyner, 2020);

Whereas students living in poverty are less likely to receive vocational training and/or upon high school graduation are significantly less likely to be able to attend college or employment training programs due to insufficient income for tuition, are more likely to accept student loans and default on loans (Hillman, 2014) thus negatively impacting future opportunities to acquire higher wages and stable employment (Koricich et al., 2018; Madaus et al., 2014);

Whereas living in poverty is associated with environmental injustice, including increased exposure to physical and social environmental stressors such as environmental pollution (e.g., lead paint, unclean air, contaminated water), inadequate infrastructure, under-resourced neighborhoods, crowding, excessive noise, substandard housing, infringement upon natural resources on Native reservation lands, inadequate water and sanitation services (Gasteyer et al., 2016; Rollings et al., 2015; Schüle & Bolte, 2015; USCCR, 2018), and diminished ability to evacuate or rebuild after destructive climate events, including hurricanes, earthquakes, and wildfires, and where the events of dislocation and destruction in totality have detrimental effects on mental and physical health in ways that perpetuate and contribute to poverty (Leichenko & Silva, 2014);

Whereas those living in poverty when compared with more advantaged populations are at substantially greater risk of exposure to community violence (Fonagy et al., 2012; Schüle & Bolte, 2015) and where women and children living in poverty are at increased risk of experiencing interpersonal violence (Ahmadabadi et al., 2017; Bunting et al., 2018; Crouch et al., 2020; Goodman et al., 2009; Nurius et al., 2020) and the associated sequelae of housing instability and homelessness, child welfare involvement (Dworsky et al., 2013), under-employment, and unemployment (APA, 2021e; Crowne et al., 2010; Parapouch et al., 2021);

Whereas lack of affordable health insurance that includes preventive services, mental health, and substance abuse coverage impedes health and well-being, with women of lower incomes being about three times more likely than more affluent women to be uninsured (20% versus 7%, respectively) and more likely to have inadequate access to care (U.S. Census Bureau, 2020a), and where the inability to afford high transportation costs affects the accessibility, adequacy, and quality of the health care services provided to individuals with disabilities (Hamilton et al., 2020; Williamson et al., 2017) with unemployment and financial dependence major barriers to utilize health care services for women with disabilities (Matin et al., 2021), and where about 5.5% of children in the U.S. lacked insurance coverage in 2018;

Whereas children born to teenage parents living in single-parent homes are at increased risk of living in poverty across the life span, and where poverty is a significant predictor of teen parenthood (Young et al., 2004) and where adequate birth control and family planning services are not covered by health insurance plans for a significant number of women or are otherwise inaccessible to those seeking them (Lu et al., 2019);

Whereas older adults often live on limited incomes, have few prospects for future earnings, and frequently face overwhelming health care costs, and where 13.9% of older women and 10 [9].2% of all older adults lived on incomes below the poverty level [~~in 2018~~], with the highest rates of poverty for those 80 years of age and older; and 22% of older African American women living alone live in poverty (Li & Dalaker, 2019; U.S. Census Bureau, 2021[0]b)

Whereas older adults of low SES when compared with more advantaged same-aged peers have higher rates of medical and psychological disorders and reduced access to medical care, prescription medications, long-term care, and community-based care (Kaye et al., 2010; Louie & Ward, 2011) and Medicare funds mental health care services at a lower rate than medical care, further limiting access to mental health and substance abuse services for older adults living in poverty. The underfunding of Indian Health Service (IHS) has an even greater negative impact on specific Native populations. Medicare funding is approximately three times higher than IHS funding per capita (Martinchek & Carther, 2021; U.S. Government Accountability Office, 2018);

Whereas migrant families are by the nature of their work and life circumstances poorly served by health and mental health professionals (Martinez et al., 2015) and are more likely to experience economic exploitation (Brennan, 2014; Hennebry, 2017);

Whereas undocumented immigrants often face harsh and unsafe conditions and are vulnerable to legal actions that displace them and further inhibit their access to health and mental health services, compounding issues of poverty and limited English language proficiency (Chen & Vargas-Bustamante, 2011; Hacker et al., 2015);

Whereas research that excludes communities of color and other populations of marginalized identities and/or persons of low SES contributes to prevailing negative stereotypes and reinforces systemic racism and where culturally sensitive research focused on [~~low-income~~] populations of low income including racial and ethnic minorities, immigrants and refugees, persons with disabilities, minimum- and low-wage workers, families receiving public assistance, older women, migrant workers, and people living without homes is limited (APA, 2021c; APA, 2021d; APA, 2021f; APA, 2019; Cancian & Danziger, 2009; Desmond, 2016; Rosen, 2014);

Whereas negative perceptions of persons of low SES, including those who receive public assistance and other benefits, arise in the context of misguided attitudes that poverty is a result of personal failings rather than the intentionally inequitable distribution of resources that benefit those with economic power and privilege; discriminatory policies and practices that perpetuate systemic racism and discriminatory acts; political systems that maintain the status quo for the benefit of persons with affluence and power while ignoring the strengths and competencies of less advantaged individuals and communities (American Enterprise Institute, 2016; APA, 2019; Gustafson, 2012; Howard et al., 2017; Katz, 2013); and where APA has resolved to act to combat racism and its pervasive impacts on minoritized populations (APA, 2021c; APA, 2021d; APA, 2021f);

Whereas safe housing, adequate food, and access to health care are recognized as human rights (APA, 2021b) and many individuals are financially vulnerable and unable to enjoy equal access to safe and affordable housing, food, equitable wages, and living conditions that promote well-being due to under-employment and instability in working hours; and where full employment for low-income workers at the legal minimum wage is often inadequate to cover basic needs for childcare, rent, food, transportation, and other necessities; and where many jobs do not provide paid sick-leave, family leave, health insurance, or other benefits (APA, 2021e; U.S. Bureau of Labor Statistics, 2019);

Whereas working conditions for low-income individuals tend to be worse than those of more advantaged workers including fewer breaks, unpredictable work schedules, and poor physical working conditions (Fletcher et al., 2011); and where the APA supports the protection of human rights of all persons (APA, 2021b);

Whereas safety net programs and legislative and policy initiatives that ensure individuals and families whose incomes are below the federal poverty threshold have their basic needs met are of crucial importance in addressing the impact of poverty and remain underfunded (e.g., food stamps, free breakfast programs, universal health care, universal basic income, free preschool, and the Indian Health Service) (APA, 2021b; APA, 2021e; APA, 2021f; APA, 2019; U.S. Government Accountability Office, 2018);

Whereas psychologists as researchers, clinicians, human service providers, educators, and policy advocates (and for whom many have privileged status in terms of educational, economic status, racial/ethnic background) have a responsibility and obligation to better understand the causes of poverty, structural racism and their impact on health and mental health, to help prevent and reduce the prevalence of poverty and to effectively treat and address the needs of ~~low-income~~ individuals and families with low income by building on the strengths of communities (APA, 2021a; APA, 2021b; APA, 2021c; APA, 2021d; APA, 2021f; APA, 2019; APA, 2017a); As stated in the ethic code, psychologists are ethically guided to "respect the fundamental rights, dignity, and worth of all people" and "psychologists are aware of their professional and scientific responsibilities to the community and the society in which they work and live" (APA, 2017a);

Therefore, be it resolved that the APA:

1. Will advocate for culturally sensitive and inclusive research that examines the causes and impact of poverty across the life span, including structural racism, economic disparities, and related intersectional issues including SES; classism; ageism; ableism; environmental and psychosocial stressors; physical, mental, and behavioral health problems including, but not limited to, depression and substance abuse; partner and interpersonal violence; unintended pregnancy; child maltreatment and exploitation; elder abuse, trauma, and exploitation; and will advocate for the broader dissemination of these research findings via teaching and service (APA, 2021a; APA, 2021c; APA, 2021d; APA, 2021f).
2. Will advocate for more empirically based and culturally sensitive research focused on stereotypes, stigma, and bias associated with poverty, as well as eradicating prejudicial and negative attitudes about poverty and those living at a lower SES and otherwise challenge prevailing beliefs that collectively perpetuate policies and tolerate poverty and social
3. Will advocate for more research on special populations who are lower SES (women, children, immigrants, refugees, undocumented immigrants, migrants, people of color, older people, people with disabilities and other chronic health conditions such as AIDS/HIV infection, and rural and urban populations).

4. Will advocate for exploration and research about the role higher education loans play for students at all SES levels and their intersecting identities. Will advocate for programs that foster deeper awareness for students and their families before they accept student loans, with increased focus on mindful utilization of student loan funds by the institutions that receive
5. Will advocate for research that identifies and learns from indigenous efforts by low-income people to work together to solve personal and shared problems or create organizations that advocate effectively for social justice. This includes supporting policies that specifically recruit those who have had lived experience with poverty into positions of leadership and public policy institutions, research institutions, and learning institutions.
6. Will recommend that where possible and appropriate SES be identified for published reports of social and health sciences
7. Will advocate for incorporating evaluation and assessment tools for both researchers and practitioners, and for encouraging integrative approaches such as the building of public and private community partnerships in programs addressing the issue of poverty and individuals with low-income and economical marginalization, which psychological research has identified as effective strategies for addressing community-level issues and problems.
8. Will advocate for psychological graduate and postgraduate education and training curricula that give more attention to the causes and impact of poverty, to the psychological needs of individuals and families with low incomes, and to the importance of developing cultural humility and sensitivity to diversity around issues of poverty in order to be able to help prevent and reduce the prevalence of poverty and to treat and address the needs of low-income
9. Will advocate for public policies that encourage access to high-quality early childhood education and a high-quality public school education for all children, better equipping individuals for self-sufficiency.
10. Will advocate for public policies that ensure access to secondary and postsecondary education and training that allows working families to earn a living wage to meet their family's
11. Will advocate for public policies and programs that ensure access to sufficient and nutritious food, environments that enhance health, and affordable and safe housing and neighborhoods for all
12. Will advocate for public policies that ensure access to family-friendly jobs offering good quality health insurance, including mental health and substance abuse services, flexible work schedules, and sufficient family and medical leave.
13. Will advocate for public policies that ensure access to comprehensive family planning in private and public health insurance
14. Will advocate for public policies that ensure parity with medical coverage for mental health and substance abuse services under Medicare and Medicaid and ensure for all individuals, regardless of ability to pay, access to health care and mental health and substance abuse treatment that is comprehensive and culturally sensitive, that accommodates the needs of the children of parents seeking treatment, and that addresses the special needs of older adults in poverty, including prescriptions and long-term care.
15. Will advocate for public policies that encourage access for all individuals, regardless of their types and levels of disabilities, to high-quality health
16. Will advocate for public policies that ensure all working families have access to affordable, high-quality childcare, which is available year-round, for the full day, and for all work shifts, as well as before- and after-school care.
17. Will advocate for public policies that provide early intervention and prevention for vulnerable children and families that enhance parenting, education, and community life so children can develop the necessary competencies to move out of
18. Will support public policies that provide early interventions and prevention for vulnerable children and families that are strengths-based, community-based, flexible, sensitive to culture and ethnic values of the family, and have a long-lasting

*The word family should be understood to incorporate the functions of family members rather than their biological sex or sexual orientation, for example, family members responsible for childcaring and providing financial support. It should be highlighted that these functions are not mutually exclusive but include broad functions within the family system.

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Resolution on Promoting Global Perspectives in U.S. Psychology

Adopted as APA Policy by APA Council of Representatives in February 2017

WHEREAS the psychology produced and taught in the United States remains largely U.S.-mainstream oriented and European-heritage grounded in its traditions, theories and evidence base, and often does not incorporate perspectives, content, and data relevant to other U. S. perspectives (e.g. rural, minority, indigenous, immigrant) or generated in other countries, (Arnett, 2008; Castillo, 2001; Draguns, 2001; Heinrich, Heine, & Norenzayan, 2010 ; Legare & Harris, 2016; Nagai, 2007; Segal, Lonner & Berry, 1998); and

WHEREAS most research studies published in U.S. psychology journals, based on U.S. convenience samples (e.g., undergraduate students), are assumed to be representative of

population demographics (Adair & Huynh, 2012; Arnett, 2008; Heinrich et al., 2010), and samples with data from outside the U.S. are often dismissed as non-representative (Canetto, Yang, Borrayo, & Timpson, 2003, Fine, 2012); and

WHEREAS psychologists outside the United States have generated frameworks, methods, practices, and research relevant in the United States and globally (Adair, 2006; Allwood & Berry, 2006; APA, 2004; Christopher, et al., 2014; Cheung, 2012; Kitayama & Cohen, 2010; Silbereisen, Ritchie & Panday, 2014; Van de Vijver, 2013); and

WHEREAS the majority of studies published in U.S. psychology journals utilize quantitative methods, although qualitative, participatory or community-based methods may be better suited for cross cultural research and although there is increased visibility of and attention to mixed methods research (Den Hartog , & Dickson , 2004; Denzin & Lincoln, 2001; Karasz 2011; Psaki, 2016; Sparrow & Davis, 2000); and

WHEREAS assessment methods and interventions primarily developed and normed in English, with samples from high income countries, have often been used widely throughout the world without considering cultural differences that affect assessment and intervention validity and without the use of strategies to ensure fair use across groups (Achenbach, et al., 2008; Braun, Fine, Greif & Devenny, 2010; Dana, 2000; Hambleton & Zenisky, 2011; Hill, Pace & Robbins, 2010; Mezzich, 2002; Nakane & Nakane, 2002); and

WHEREAS psychologists have an ethical responsibility to understand and consider the cultural values, mores, history, and policies of the societies and countries to which they apply U.S.-generated research, guidelines, or practices (American Psychological Association, 2002; Berry, 2013; Bernal, Jimenez- Chafey & Domenech, 2009; Dadlani, Overtree, & Perry-Jenkins, 2012); and

WHEREAS U.S. psychology would benefit from the expansion of its knowledge base through the inclusion of global perspectives, theories, research findings, and practices from outside the U.S. (Adair, Coelho, & Luna, 2002; Arnett, 2008; Brock, 2006; Heinrich, Heine & Norenzayan, 2010; Legare & Harris, 2016; Lutsky, et al, 2005; Marsella, 2009); and

WHEREAS it is important to recognize that a comprehensive global perspective combines worldwide, transnational and intercultural themes, encompassing societies, nations and countries; recognition of variety and diversity within and across societies, nations, and countries; and recognition of variety and diversity in individual and group experiences within those societies, nations and countries; and

WHEREAS high-income countries, including the U.S., are becoming increasingly global (Banks, 2004; Fearon, 2003; Fisher, 2013 ; Hugo, 2005; Marsella & Pedersen, 2002; Woolf, Hulsizer & McCarthy, 2002); and

WHEREAS partnerships across countries, cultural groups, and disciplines have promise for reciprocal benefit and increased synergy in solving global problems and promoting new discoveries (Chin & Trimble, 2014; Chiu & Ying-Yi Hong, 2005; APA, 2011, Committee, 2014; National Research Council, 2014); and

WHEREAS many U.S. psychological organizations promote international engagement;
THEREFORE, be it resolved that the American Psychological Association will:

1. Promote inquiry that includes comprehensive global perspectives and content in psychological theory, practice, education, research, advocacy and policy.
2. Encourage critical reflection on the meaning and use of psychological constructs and definitions that are assumed to be universal and generalizable.
3. Encourage the development and dissemination of sound assessment and intervention methodologies and education that respect local communities and are grounded in ethical principles of psychology.
4. Acknowledge and consider research findings, publications, training programs, guidelines, and regulatory processes developed outside the United States.
5. Recommend language changes in APA communications and publications to avoid U.S.-centric perspectives and to include global and diversity perspectives. Examples of these language changes include:
 - a. Use “in the United States” for research, tests, training curricula, and practices that are developed and tested with U.S. samples;
 - b. Include “the global implications” of research findings, tests, and practices where relevant;
6. Encourage psychologists to use language that reflects awareness of global frameworks. For example:
 - a. Evaluate language in statements of research findings, opinions, policies and conclusions to ensure that these statements do not present U.S. perspectives as though they were universal and universally generalizable. Restrict the use of the term “Western” to geographical location. “Western” should not be used to refer to ideas or experiences from Europe or the United States (as in “western culture”).
 - b. Replace terms such as “exhaustive literature search” with a more precise description of which databases were searched. When databases in languages other than English are searched provide information for accessing those databases.
 - c. Be explicit about the national origin of the literature reviewed in literature summaries and note where the data were collected.
 - d. Be cautious of claims of universality or generalizability beyond the specific populations studied. Make statements about “people in general” only when theory or evidence are about a representative global population.
 - e. Be mindful of not assuming U.S. norms or U.S. readership when using terms such as “we” or “our” or “us.”
7. Recommend that APA boards and committees routinely and systematically incorporate comprehensive global perspectives in their work and develop criteria against which to evaluate this impact:

- a. Strategies might include assessing whether a statement, policy or guideline is intended to refer to the U.S. only or to be generalizable, asking whether statements have referenced the international literature, or reflecting on whether U.S. definitions of populations of population dimensions (such as dimensions of diversity) are universally applicable to the issue at hand.
- b. Evaluation criteria might include attention to language (as noted in #5), source of references, inclusion of examples from outside the U.S. context, and the like.
8. Promote collaborative international partnerships grounded in a comprehensive global perspective; initiatives that facilitate international partnerships; training in global competencies; and develop guidance and best practices for ethically sound, culturally responsive ~~[aware]~~ international collaborations.
9. Encourage psychologists to understand that international collaborations are often influenced by power hierarchies, and that dominant frameworks marginalize subordinate frameworks on global and local levels.
10. Encourage U.S. undergraduate and graduate psychology programs to promote opportunities for students to learn other languages and experience other cultures.
11. Encourage U. S. psychologists to learn and use local languages in conducting professional work in communities domestically and internationally.
12. Promote comprehensive global focused curricula for high school, undergraduate, and graduate psychology.
13. Promote comprehensive global perspectives across association activities including publication practices, public interest, science, education, and professional initiatives.

Resolution on support of universal design and accessibility in education, training and practice

WHEREAS universal design concepts support the diverse population of individuals with disabilities who make up 13.0 ~~[18.7%]~~ of the US ~~[civilian, non-institutionalized]~~ population, and have a range of disabilities impacting physical, sensory, emotional, or cognitive functioning (U.S. Census Bureau, 2021 ~~[1-0]~~); WHEREAS universal design is the process of creating products, technology and ~~[built]~~ building environments to be usable by all people, to the greatest extent possible for all people, without the need for further adaptation (Burgstahler, 2012; North Carolina Office on Disability and Health ~~[NCODH]~~ 2004, 2007);

WHEREAS universal design principles are based on architectural concepts that clearly benefit individuals with physical disabilities, the application of these principles to the built environment and educational information extends support to diverse needs based on a range of disabilities, developmental levels, youth and age related differences, gender or gender expression needs, diverse cultural, religions and beliefs, ~~[diversities]~~ and varying levels of education (Burgstahler, 2012; Lid, 2014; McGuire & Scott, 2017; McGuire-Schwartz & Arndt, 2007; NCODH 2004, 2007; Pace & Schwartz, 2008; Hanass-Hancock, 2009);

WHEREAS universal design principles help make products and services more available and easier to use, expand options for use by all individuals regardless of age, disability, or life status, and

address current attitudinal, architectural, and sociopolitical barriers that exclude individuals from full participation (Burgstahler, 2012; Gill, Kewman, & Brannon, 2003; Groce, 2004; NCOHD 2004, 2007);

WHEREAS universal design promotes understanding of the interaction between the environment or built products (Burgstahler, 2012; Gill, Kewman, & Brannon, 2003);

WHEREAS universal design helps increase attitudes of inclusion ~~[decrease attitudinal barriers regarding]~~ around disability, ~~[which is often the most significant barrier keeping]~~ thereby allowing disabled persons to ~~[from performing]~~ to their fullest potential, and avail ~~[-thereby depriving]~~ society of a valuable resource pool (Altay & Demirhan, 2014; Carpenter & Paetzold, 2013; Chan et al., 2009; LaVigna, 1995; Marini & Stebnicki, 2012; Powell, 2013; Santuzzi, Waltz, Finkelstein, & Rupp, 2014; Whiteneck et al., 2004; Yunker, 1988);

WHEREAS psychological research has greatly helped to demonstrate the pervasive nature of attitudinal barriers associated with disability that result in stigmatization and marginalization (Carpenter & Paetzold, 2013; Corrigan, 2014; Green et al., 2005; Markowitz, 1998; Sartorius, 2006; Van Brakel, 2006);

WHEREAS current accommodations provided by the Americans with Disabilities Act and its amendments do not fully address the ongoing attitudinal, architectural, and socio-political barriers that exclude individuals from full participation in higher education and result in underrepresentation within the workforce [due to disability, minority statuses, or socioeconomic disparities] (Plantinga, Johansen, Schillinger, & Powell, 2012; Powell, 2013; Santuzzi, Waltz, Finkelstein, & Rupp, 2014; U.S. Census Bureau, 2010);

WHEREAS further improvements in accessibility will need to involve moving beyond the required physical accommodations, such as ramps, to the application of the universal design process and principles within plans for all built environments, communities, products, instruction, and provision of services (Burgstahler, 2012; NCOHD, 2004, 2007; Powell, 2013);

WHEREAS the use of universal design principles for the physical environment and presentation of materials in educational facilities and training programs can be a step toward changing societal attitudes about diversity, increasing inclusion of students with disabilities, and allowing greater employment opportunities for all graduates (Powell, 2013);

WHEREAS including universal design throughout training programs and supervisory approaches demonstrates a way to increase culturally competent approaches for addressing disability as diversity and promoting inclusion of students with disabilities in higher education (Andrews et al., 2013; Lund, Andrews, & Holt, 2014);

WHEREAS universal design principles can be used in psychology practices and healthcare facilities to address health disparities among underserved or marginalized populations that result, in part, from the intersection between diverse identities and institutional or societal factors limiting access to services (Johnson & Woll, 2003; NCOHD, 2007; Hanass-Hancock & Alli, 2015);

WHEREAS psychologists must have a model that incorporates universal design in education, training, and provision of services if they are to work to promote education of diverse identities, address barriers to access, assessments, and clinical services to meet the psychological and health needs of consumers (American Educational Research Association [AERA], American

Psychological Association [APA], National Council on Measurement in Education [NCME] 2014); and

WHEREAS the APA opposes prejudice and discrimination based on any demographic characteristics (e.g., age, gender, sexual orientation, race, socioeconomic status) including disability, as reflected in its adopted resolutions and guidelines (i.e., Resolution on the Americans with Disabilities Act, 2008; Policy Statement on the Full Participation for Psychologists with Disabilities, 1997; Guidelines for Assessment of and Intervention with Persons with Disabilities, [2011]2022);

THEREFORE BE IT RESOLVED that the American Psychological Association reaffirms its commitment to increasing accessibility and strives to proactively increase full participation through the promotion of universal design concepts.

BE IT FURTHER RESOLVED that the American Psychological Association will: Encourage the use of universal design concepts in education, training programs, and professional development, including APA-sponsored educational workshops, professional meetings, and the annual convention. Based on available resources on universal design (NCODH, 2004; Powell, 2013), a focus for promoting universal design will include the following:

- Request input from members with disabilities or other diverse needs, consider issues, and attempt to proactively pursue inclusivity in APPROVEDing policies;
- Promote the importance of removing or ameliorating physical, cognitive, and sensory barriers to full participation by encouraging accessibility, such as broad access to events, overall facility adherence to accessibility, accessible set-up of rooms and meeting spaces, provision of captioning and accessible materials, and meeting activities (i.e., food breaks, off-site tours or associated activities) supported by APA;
- Utilize facilities that are barrier-free to the extent possible, and provide for ways to address problems in facilities when barriers are identified realized;
- Promote the need for presentations and educational materials that are in an accessible format and in which the readability is suitable for the audience;
- Promote the importance of utilizing universal design concepts in practice and the provision of health care services (NCODH, 2007), promote use of universal design in the physical environment, equipment, provision of education (verbal or written) and materials, and encouraging training of providers to increase awareness and sensitivity to diverse needs of consumers;
- Encourage the use of universal design concepts to increase accessibility of psychological services to the public in the ways information is communicated, the way in which educational materials are presented (e.g., easy to understand, multiple formats available), and the physical environment is structured; and
- Encourage the dissemination and application of psychological research to strengthen and inform implementation efforts of universal design concepts and the social and psychological impact of utilizing universal design.

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Resolution on the maltreatment of children with disabilities

Whereas the published literature uses varying definitions of the terms disability and child maltreatment, often combines diverse forms of disability, and frequently assesses exposure to only one type of maltreatment, even though most children who are maltreated experience multiple forms (Hibbard et al., 2007; Turner et al., 2011; Sullivan & Knutson, 2000);

Whereas disability in children is generally defined in U.S. Federal law by the Individuals with Disabilities Education Act as including autism, intellectual disability, hard of hearing [~~impairments~~] or deaf [~~(including deafness)~~], speech or language disabilities [~~impairments~~], visual disabilities [~~impairments~~] (including blindness), psychiatric disabilities [~~emotional disturbance~~] (including schizophrenia), orthopedic disabilities [~~impairments~~], other health disabilities [~~impairments~~] due to chronic or acute health problems (such as asthma, attention deficit disorder and diabetes), specific learning disabilities, and traumatic brain injury;

Whereas maltreatment is most commonly defined by American states as physical abuse, sexual abuse, neglect, and emotional maltreatment and more specifically by the U.S. Department of Health and Human Services (DHHS) as physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, educational neglect, any abuse, any neglect, and any maltreatment (Administration on Children, Youth, and Families, 2013; Sedlak et al., 2010);

Whereas U.S. children with disabilities are undercounted because not every child receives a clinical diagnostic assessment, and clinical data often do not match legal definitions, although reliable numbers are essential for the development of public health programs and services (Administration on Children, Youth and Families, 2013; Hibbard et al., 2007; Jones et al., 2012);

Whereas variation in the way states and DHHS define and collect data on disability status of abused or neglected children makes it problematic to accurately estimate prevalence rates of maltreatment among children with disabilities, and, thus, more difficult to prevent and combat the problem as well as provide services (Child Welfare Information Gateway, 2012; Kendall-Tackett et al., 2005);

Whereas a meta-analysis of 17 studies found that children with disabilities are a distinct high-risk group for physical and sexual abuse, and are almost four times more likely to be victims of violence than are children without disabilities; in particular, children with disabilities are 3.6 times more likely to be physically assaulted and 2.9 times more likely to be sexually assaulted than children without disabilities (Jones et al., 2012);

Whereas in 39 reporting states, child victims with disabilities accounted for 13.3% of all maltreatment victims in the U.S. in 2012 and were 1.5 times more likely to experience substantiated maltreatment two years after their first report than child victims without disabilities (Administration on Children, Youth and Families, 2013; Fluke et al., 2008);

Whereas children with disabilities are more likely to be seriously injured or harmed from assaults than children without disabilities [disability], thus often further damaging already compromised health and development (Helton & Cross, 2011; Sedlak et al., 2010);

Whereas children with disabilities are over 2 times more likely to experience emotional neglect than children without disabilities, and that this is likely to be an undercount (Hornor, 2012; Sedlak et al., 2010);

Whereas children with multiple disabilities are at higher risk of abuse and neglect than children with single disabilities (Heinonen & Ellonen, 2013; Sullivan & Knutson, 2000);

Whereas the risk for abuse and neglect differs among disabling conditions so that not all forms of disability are associated with equivalent levels of risk, and that the level of risk differs by the type of victimization, for example, that children with conduct disorders and those with modest to severe speech and language [disorders] disabilities are at increased risk of neglect, and physical, sexual, and emotional abuse compared both to children without disabilities and to children with visual disabilities [impairment] and with autism (Spencer et al., 2005; Sullivan & Knutson, 2000; Turner et al., 2011);

Whereas there exists a lack of a strong empirical knowledge base on predictors and consequences of maltreatment of children with disabilities because of methodological challenges of sample selection, study design, statistical analysis, and inconsistent definitions (Jones et al., 2012; Leeb et al., 2012);

Whereas few studies consider additional risk factors, confounding factors and mediating and moderating variables for child maltreatment such as child characteristics (e.g., birth weight, gestational age, age at victimization, type and severity of disability, sex, gender nonconformity, intersecting identities, sexual orientation, nationality, race/ethnicity), family characteristics (e.g., economic resources and socioeconomic status, family structure, caregiver age, caregiver physical and mental health, disciplinary tactics), and external factors (e.g., social support, neighborhood residential mobility, geographical location, and population density, such as rural, frontier, remote, and/or urban) (Helton & Cross, 2011; Jaudes & Mackey-Bilaver, 2008; Jones et al., 2012; Mersky et al., 2009; Murphy, 2011; Turner et al., 2011);

Whereas parents of children with disabilities are more likely to report greater caregiving demands and high levels of parenting and emotional stress, depression and anger than parents of children without disabilities (Benson & Karlof, 2009; Neece et al., 2012; Resch et al., 2012; Solem et al., 2011);

Whereas social support and parent training for parents of children with emotional and physical disabilities has been found to facilitate attachment and decrease parental stress (Kazdin & Whitley, 2003; Rabineau, Mabe, & Vega, 2008; Solem et al., 2011; Vaughan et al., 2012);

Whereas numerous studies have reported that the primary reasons for grandparents and other relatives assuming custodial care are abuse and neglect, frequently associated with parental

substance abuse (Heller & Ganguly, 2002; Mccallion & Janicki, 2014; Smith & Dolbin-MacNab, 2013);

Whereas there is a strongly documented need for accessible, affordable, culturally competent, disability-competent, and evidence-based mental health services that are sensitive to youth and family strengths and needs (Gabrielli & Lund, 2021; Rabineau et al., 2008; Stancin & Perrin, 2014; Tolan & Dodge, 2005; Vaughan et al., 2012);

Whereas geographic access to social services within communities influences child maltreatment, such that urban neighborhoods in which residents have geographic access to mental health and substance abuse have lower rates of parental neglectful behaviors, and that CPS workers report that case families with children with disabilities in rural areas often suffer from few geographically available social services and providers, long driving distances, and lack of transportation (Lightfoot & LaLiberte, 2006; Maquire-Jack & Klein, 2015);

Whereas research on bullying victimization has found higher rates among students in special education than students in general education, and increased verbal abuse, relational, and physical aggression directed against students with disabilities (including learning, physical, and psychological) than against their peers without disabilities (Blake et al., 2014, 2016a,b; Hartley, Bauman, Nixon, & Davis, 2015; Mishna, 2003; Rose, Monda-Amaya, & Espelage, 2011);

Whereas there is a need for disability-related training for mandated reporters of suspected child abuse or neglect and for collaboration between child protective services and organizations that provide services to children with disabilities (Lightfoot & LaLiberte, 2006; Manders & Stoneman, 2009; Shannon & Tappan, 2011; Ziviani et al., 2013);

Whereas there is no standard approach in Child Protective Service (CPS) agencies to managing cases involving children with disabilities, and a lack of coordination and collaboration which results in critical gaps in the provision of integrated services to maltreated children with disabilities and their families (Horwath & Morrison, 2007; Lightfoot & LaLiberte, 2006; Shannon & Tappan, 2011; Ziviani et al., 2013);

Whereas services recommended for families of children with disabilities in suspected child abuse cases are more likely to be child-focused than caregiver- focused than those for families of children without disabilities, and that CPS workers have been reported to empathize with abusive parents of children with disabilities, especially those with emotional/behavioral disabilities, as well as to acknowledge lack of information regarding disabilities (Corr & Santos, 2017; Lightfoot & LaLiberte, 2006; Manders & Stoneman, 2009; Shannon & Tappan, 2011);

Whereas in agreement with the Convention on the Rights of Persons with Disabilities (CRPD), adopted by the United Nations General Assembly in December 2006, and which the APA has affirmed; and the Indian Child Welfare Act, passed by the U.S. Congress in 1978, all children, including those with disabilities, are entitled to care and out-of- home placement that takes into account their culture, ethnicity and disability status (UNICEF, 2007; Indian Child Welfare Act, 1978);

Whereas formal partnerships among federal agencies, professional associations, and families and caregivers would facilitate the transfer of knowledge among research, practice, and policy related to children's mental health (Corr & Santos, 2017; Proctor et al., 2009);

Whereas there is clear evidence that child maltreatment is not only a national but also an international problem and that there is general consensus across many nations that child abuse should be prevented and that children with disabilities are especially vulnerable (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Westcott & Jones, 1999);

Therefore be it resolved that the American Psychological Association:

Recommends a national strategy to accurately count the number of children with disabilities who are maltreated. The federal government needs to standardize definitions of disability and child maltreatment, data collection methodologies, and recordkeeping across all the states and territories;

Encourages both national and international research to clarify the current state of knowledge regarding maltreatment of children with disabilities. Such research should add disability status to all studies of child maltreatment and to evaluation studies of child maltreatment interventions, utilize consistent definitions of disability and child maltreatment, identify multifactorial risk factors for child maltreatment, assess the impact of multiple types of maltreatment on children with disabilities, and identify the multiple-service needs of children with disabilities and their families;

Encourages the further development and provision of effective evidence-based family-focused prevention and interventions such as early childhood services, home visiting programs, the medical home model, parent and grandparent support groups, and respite care that build on the strengths of the child and family. Such programs should address family quality of life, such as reducing stress, isolation, depression, and anger, teaching caregivers positive behavior management techniques and coping strategies, and providing families practical support such as transportation, identification of service providers, and financial support.

Recommends that such services as described above should be appropriate to child characteristics such as developmental level, physical and sensory ability, gender, and intersecting identities and to caregiver characteristics such as physical and mental health to prevent and address the sequelae of child maltreatment;

Recommends that all programs for maltreated children and their families need to be disability accessible and embedded in communities with high rates of child protective services involvement and low rates of geographical access, whether urban, rural, or suburban, and also offered alternatively through telephone and computer when feasible for both providers and family members;

Recommends the consistent inclusion of students with disabilities in bullying intervention programs, given their elevated level of risk of victimization;

Recommends the development of enhanced, disability-relevant training for CPS workers and all mandated reporters of suspected child abuse or neglect regarding crisis response, specifically, the identification and treatment of maltreated children with disabilities, and the utilization of investigation teams and foster care services that include disability specialists;

Strongly encourages collaboration between professionals in the child maltreatment and disability communities (e.g., lawyers, law enforcement personnel, child advocates, mental health professionals), and dissemination of research on the special needs of maltreated children with disabilities to both of these groups and to education and training programs in psychology.

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Resolution on transgender and gender identity and gender expression non-discrimination
WHEREAS transgender, ~~[gender variant and gender nonconforming]~~ gender diverse people frequently experience prejudice and discrimination and psychologists can, through their professional actions, address these problems at both an individual and a societal level;

WHEREAS the American Psychological Association opposes prejudice and discrimination based on demographic characteristics including gender identity, as reflected in policies including the Hate Crimes Resolution (Paige, 2005), the Resolution on Prejudice Stereotypes and Discrimination (Paige, 2007), APA Bylaws (Article III, Section 2), the Ethical Principles of Psychologists and Code of Conduct (APA 2002, ~~[3.01 and Principle E]~~ amended 2010 and 2017);

WHEREAS transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse people benefit from treatment with therapists with specialized knowledge of their concerns (Lurie, 2005; Puckett et al., 2022; Rachlin, 2002), and that the Ethical Principles of Psychologists and Code of Conduct state that when scientific or professional knowledge ...is essential for the effective implementation of their services or research, psychologists have or obtain the training....necessary to ensure the competence of their services..." (APA 2002, ~~[3.01 and Principle E]~~ amended 2010 and 2017);

WHEREAS discrimination and prejudice against people based on their actual or perceived gender identity or expression detrimentally affects psychological, physical, social, and economic well-being (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Resolution on Prejudice Stereotypes and Discrimination, Paige, 2007; Riser et al., 2005; RodriguezMadera & Toro- Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

WHEREAS transgender and gender diverse people may be denied basic non-gender transition related health care (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; GLBT Health

Access Project, 2000; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Riser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

WHEREAS transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse people may be denied appropriate gender affirming and/or transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender ~~[transition]~~ affirming treatments (De Cuypere et al., 2005; Kuiper & Cohen-Kettenis, 1988; Lundstrom, et al., 1984; Newfield, et al., 2006; Pfafflin & Junge, 1998; Rehman et al., 1999; Ross & Need, 1989; Smith et al., 2005);

WHEREAS transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse people may be denied basic civil rights and protections (Minter, 2003; Spade, 2003) including: the right to civil marriage which confers a social status and important legal benefits, rights, and privileges (Paige, 2005); the right to obtain appropriate identity documents that are consistent with a gender ~~[post transition]~~ affirmed identity; and the right to fair and safe and harassment free institutional environments such as care facilities, treatment centers, shelters, housing, schools, prisons and juvenile justice programs;

WHEREAS transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse people experience a disproportionate rate of homelessness (Kammerer et al., 2001), unemployment (APA, 2007) and job discrimination (Herbst et al., 2007), disproportionately report income below the poverty line (APA, 2007) and experience other financial disadvantages (Lev, 2004);

WHEREAS transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse people may be at increased risk in institutional environments and facilities for harassment, physical and sexual assault (Edney, 2004; Messinger et al., 2022; Minter, 2003; Peterson et al., 1996; Witten & Eyler, 2007) and inadequate medical care including denial of gender ~~[transition]~~ affirming treatments such as hormone therapy (Edney, 2004; Peterson et al., 1996; Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Newfield et al., 2006; Riser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

WHEREAS many transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse children and youth face harassment and violence in school environments, foster care, residential treatment centers, homeless centers and juvenile justice programs ((Bazargan & Galvan, 2012; D'Augelli, Grossman, & Starks, 2006; Fernández-Rouco et al., 2017; Gay Lesbian and Straight Education Network, 2003; Grossman, D'Augelli, & Slater, 2006);

WHEREAS psychologists are in a position to influence policies and practices in institutional settings, particularly regarding the implementation of the Standards of Care published by the World Professional Association of Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association) which recommend the continuation of gender ~~[transition]~~ affirming treatments and especially hormone therapy during incarceration (Meyer et al., 2001);

WHEREAS psychological research has the potential to inform treatment, service provision, civil rights and approaches to promoting the well-being of transgender, ~~[gender variant and gender non-conforming]~~ and gender diverse people;

WHEREAS APA has a history of successful collaboration with other organizations to meet the needs of particular populations, and organizations outside of APA have useful resources for

addressing the needs of transgender, ~~[gender variant and gender non-conforming]~~ and gender diverse people;

THEREFORE BE IT RESOLVED that APA opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies;

THEREFORE BE IT FURTHER RESOLVED that APA supports the passage of laws and policies protecting the rights, legal benefits, and privileges of people of all gender identities and expressions;

THEREFORE BE IT FURTHER RESOLVED that APA supports full access to employment, housing, and education inclusive of gender identity and expression;

THEREFORE BE IT FURTHER RESOLVED that APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender, ~~[gender variant and gender non-conforming]~~ and gender diverse individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender, ~~[gender variant and gender non-conforming]~~ and gender diverse individuals;

THEREFORE BE IT FURTHER RESOLVED that APA encourages legal and social recognition of transgender and gender diverse individuals consistent with their gender identity and expression, including access to identity documents consistent with their gender identity and expression which do not involuntarily disclose their status as transgender for transgender people who permanently socially transition to another gender role;

THEREFORE BE IT FURTHER RESOLVED that APA supports access to civil marriage and all its attendant benefits, rights, privileges and responsibilities, inclusive of gender identity or expression;

THEREFORE BE IT FURTHER RESOLVED that APA supports efforts to provide fair and safe environments for transgender, ~~[gender variant and gender non-conforming]~~ and gender diverse people in institutional settings such as supportive living environments, long-term care facilities, nursing homes, treatment facilities, and shelters, as well as custodial settings such as prisons and jails;

THEREFORE BE IT FURTHER RESOLVED that APA supports efforts to provide safe and secure educational environments, at all levels of education, as well as foster care environments and juvenile justice programs, that promote an understanding and acceptance of self and in which all youths, including youth of all gender identities and expressions, may be free from discrimination, harassment, violence, and abuse;

THEREFORE BE IT FURTHER RESOLVED that APA supports the provision of adequate and necessary mental and medical health care treatment for transgender, ~~[gender variant and gender nonconforming]~~ and gender diverse individuals;

THEREFORE BE IT FURTHER RESOLVED that APA recognizes the efficacy, benefit and medical necessity of gender ~~[transition]~~ affirming treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments;

THEREFORE BE IT FURTHER RESOLVED that APA supports access to appropriate treatment in institutional settings for people of all gender identities and expressions; including access to appropriate health care services including gender ~~[transition]~~ affirming therapies;

THEREFORE BE IT FURTHER RESOLVED that APA supports the creation of educational resources for all psychologists in working with individuals who are transgender, and gender diverse ~~[gender variant and gender non-conforming]~~;

THEREFORE BE IT FURTHER RESOLVED that APA supports the funding of basic and applied research concerning gender expression and gender identity;

THEREFORE BE IT FURTHER RESOLVED that APA supports the creation of scientific and educational resources that inform public discussion about gender identity and gender expression to promote public policy development, and societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals inclusive of gender identity or gender expression;

THEREFORE BE IT FURTHER RESOLVED that APA supports cooperation with other organizations in efforts to accomplish these ends.

Resolution Opposing Child Sexual Abuse

WHEREAS, the American Psychological Association is steadfast in its stand against the sexual abuse of children, (children is defined as “individuals who have not reached the physical or mental age of consent”), and

WHEREAS, the welfare, appropriate treatment and protection of children is a priority of the highest order for the American Psychological Association, and

WHEREAS, the Committee on Children, Youth, and Families of the American Psychological Association was established in 1986 to “...contribute to the formulation and support of policies that facilitate the optimal development of children and youth within families...”, and

WHEREAS, children and youth who have been sexually abused often experience health problems, eating disorders, learning difficulties, behavioral problems, fearfulness, social withdrawal, anxiety, depression, posttraumatic stress disorder, and suicidal thoughts, engage in risky sexual behavior and substance misuse (Hailes et al., 2019), and

WHEREAS, psychologists as researchers, educators, service providers and policy advocates have played important roles in advancing knowledge regarding the consequences, effective treatment, and prevention of child sexual abuse, and

WHEREAS, the vast body of research studies published by the American Psychological Association over the past ~~[20]~~ 40 years had advanced the field and contributed to the development of sound public policy, and

WHEREAS, the American Psychological Association repudiates and disassociates itself from any organization or publication that advocates sexual interaction between children and adults,

THEREFORE, be it resolved that the American Psychological Association reaffirms its long established position that sexual relations between children and adults are abusive, exploitative, reprehensible and properly punishable by law.

Hailes, H. P., Yu, R. Danese, A., & Fazel, S. (2019). Long-term outcomes of childhood sexual abuse: An umbrella review, The Lancet, 6(8), 830-839. [https://doi.org/10.1016/S2215-0366\(19\)30286-X](https://doi.org/10.1016/S2215-0366(19)30286-X)

Resolution reaffirming support for research and teaching with nonhuman animals

Research with nonhuman animals has contributed significantly to advances in the field of psychology (Carroll & Overmier, 2001; Dettmer and Bennett, 2021; Laborda, Miguez, Polack, & Miller, 2012; Maestripieri & Roney, 2006; Mehta & Gosling, 2008). It has laid the foundation for understanding diverse behavioral and biological processes underlying phenomena such as attention, perception, learning, memory, social behaviors, emotion, and decision making, accounting for diverse behavioral, cultural, and social contexts. Research with nonhuman animals has also furthered our understanding of similarities and differences across species, which has both intellectual and practical significance. Knowledge about other species has been crucial in guiding conservation efforts in various habitats across the world (Higham, 2016; O'Brien & Robeck, 2010; Swaisgood, Zhou, Zhang, Lindburg, & Zhang 2003; Zimble-DeLorenzo & Stone, 2011).

~~[Nonhuman animal research has proven invaluable for exploring the complexity of diverse behaviors across genetic, molecular, cellular/neuronal, circuit, network, cognitive, and behavioral levels.]~~ The assembly and application of findings from nonhuman animal research ~~[has contributed to]~~ is the foundation for numerous clinical applications that have significantly improved the health and well-being of both human and nonhuman animals (Carroll & Overmier, 2001; Raffel, Hoverman, Halstead, Michel, & Rohr, 2010; Raffel et al., 2013; Shively et al., 2021; Tizzi, Accorsi, & Azzali, 2010). Importantly, maintaining high standards of research animal wellbeing is not only of ethical importance to scientists, but is also critical to collecting data that allow for robust conclusions upon which scientific breakthroughs are grounded. Nonhuman animal research has proven invaluable for exploring the complexity of diverse behaviors across genetic, molecular, cellular/neuronal, circuit, network, cognitive, and behavioral levels.

Whereas The American Psychological Association has long acknowledged the importance and contributions of nonhuman animal research to advancing scientific knowledge and promoting the wellbeing of human and nonhuman animals (APA, 1990; Dewsbury, 1992); and

Whereas Nonhuman animal research is comprehensively regulated through an integrated oversight system comprising federal, state, and local regulations (U. S. Department of Agriculture, 2013), as well as institutional peer review (National Institutes of Health, Office of Laboratory Animal Welfare, 2015) and peer review by funding agencies, both of which attest to the necessity of the research, its scientific validity, and the humane and ethical treatment of the animals involved; and

Whereas Scientists bear several responsibilities for the conduct of research with nonhuman animals, which include ensuring humane care and treatment that is sensitive to species-specific needs; being informed about and adhering to relevant laws and regulations pertaining to such research; and communicating respect for these research subjects to employees, students, and colleagues (APA, 2012, 2013, 2016; National Research Council, 2011; Public Health Services, 2015); and

Whereas The majority of scientists support and encourage the use of nonhuman animals in scientific research (Pew Research Center, 2015); and

Whereas Observational learning through classroom demonstrations and hands-on learning through the conduct of experiments with nonhuman animals are integral to science education (Akins, Panicker, & Cunningham, 2005, National Research Council, 1989, National Science Teachers Association, 2008); and the early exposure of students to such experiences engenders creativity, original thought, critical thinking, and problem-solving skills (APA, 2003; Madrazo, 2002); and

Whereas Students exposed to nonhuman animal research are more likely to develop and retain a better appreciation for such research (Akins, Panicker, & Cunningham, 2005; Edwards, Jones, Bird, & Parry, 2014; Offner, 1993); and

Whereas The APA recognizes the general public may not fully appreciate the nature of nonhuman animal research and its benefits to society, due to overabundance of misinformation and simultaneous dearth of accurate information available in the public domain (Speaking of Research, n.d.); and

Whereas The APA recognizes the concerted efforts of entities opposed to research with nonhuman animals and dedicated to the abolition of such research (Speaking of Research, 2013); and

Whereas The American Psychological Association ~~{deplores}~~ condemns harassment of scientists, students, and technical personnel engaged in nonhuman animal research, as well as destruction of nonhuman animal research facilities (APA, 2004; 2014);

Therefore be it resolved that the American Psychological Association reaffirms its earlier resolution (APA, 1990) and joins with other scholarly organizations (Alzheimer's Association, 2015; American Association for the Advancement of Science, 1990; American Heart Association, 2010; Federation of American Societies for Experimental Biology, 1994; Society of Toxicology, 1999) in continuing to support and promote ethically sound and scientifically valid research with nonhuman animals; and

Therefore be it further resolved that scientists support the efforts to improve research animal wellbeing through the implementation of evidence-based policies and regulations that do not compromise the scientific integrity of the research (Thulin et al, 2014); and

Therefore be it further resolved that the American Psychological Association supports the integration of student research projects with nonhuman animals in institutions capable of providing proper oversight and supervised by teachers who are trained in the care and treatment of nonhuman animals in laboratory and/or field settings (Akins, Panicker, & Cunningham, 2005); and

Therefore be it further resolved that scientists support initiatives that further the education of students, colleagues, and the general public on the merits of nonhuman animal research and its benefits to public health, the environment, and society at large; and

Therefore be it further resolved that the APA and affiliated societies and research institutions ~~{publically}~~ publicly defend research with nonhuman animals and the scientists who conduct

such research from the sustained, multi-pronged attacks by entities opposed to such research; and

Therefore be it further resolved that the American Psychological Association encourages affiliated societies and research institutions to endorse this resolution.

Suggested Citation

American Psychological Association. 2017. Resolution Reaffirming Support for Research and Teaching with Nonhuman Animals. Retrieved from: <http://www.apa.org/about/policy/use-animals>

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Support for science education in grades preK-12

WHEREAS education in all branches of science—behavioral, biological, physical, and social—is basic to understanding the modern world, and WHEREAS education in all branches of science is necessary for informed participation in a democratic society and for productive work in a modern industrial nation, and

WHEREAS there is growing evidence of decline in support of and commitment to precollege science education in the United States while other industrial nations are placing heavy emphasis on science education at all levels,
THEREFORE BE IT RESOLVED that the American Psychological Association urges that all public and private schools in the United States provide, within a balanced curriculum, a strong and uninterrupted program of science education which shall include regular instruction in all aspects of science for all pupils from pre-kindergarten through twelfth grade.

Support for the free exchange of scientific information

WHEREAS the welfare and the strength of the United States are dependent on the vigor of its scientific activity; and

WHEREAS restriction of the free flow of scientific information within the United States and between nations inhibits the progress of science, and WHEREAS governmental actions restricting the dissemination of unclassified scientific information threaten our scientific preeminence; and WHEREAS the federal government has the authority to classify information shown to be essential to national security;

BE IT THEREFORE RESOLVED that the American ~~[Psychological]~~ Psychological Association ASSERTS its conviction that all unclassified scientific information should be disseminated freely, and DECLARES its profound opposition to all attempts to interfere with the free exchange of scientific information at meetings of scientific societies and in scientific journals.

Use of "Dr."

That the American Psychological Association (APA) adopt as ~~[the]~~ a standard that it will recommend to the media for the use of 'Dr.' the following: Doctor should be used in references to all individuals who hold doctoral degrees – MD, PhD, PsyD, EdD or other — in any context or format where the title 'doctor' is used for any of them.

Use of division expertise

Council moved that, Central Office Staff and APA Boards and Committees will consult with appropriate APA Divisions ~~[with respect to legislation, policy, guidelines, and public statements, to take advantage of divisional expertise when relevant]~~ to take advantage of divisional expertise when relevant with respect to legislation, policy, guidelines, and public statements.

Use of the term "clinical" in specialty and proficiency titles

That the Commission for the Recognition of Specialties and Subspecialties ~~[Proficiencies]~~ in Professional Psychology (CRSS~~[P]~~PP) ~~(formerly the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology)~~ may consider any new specialty or subspecialty ~~[proficiency]~~ that incorporates the modifier "clinical" in its title if the petition for recognition of that specialty or subspecialty ~~(or former proficiency)~~ was received by CRSS~~[P]~~PP on or before January 1, 1998; and Council may act upon the recommendations forwarded by CRSS~~[P]~~PP pertaining to such petitions.

That subsequent to January 1, 1998, new specialty or proficiency petitions for recognition using in their titles modifiers that duplicate existing general practice specialty designations (i.e., clinical, counseling, school, industrial/organizational) will not be accepted for review by CRSS~~[P]~~PP with the use of such title.

~~[That, consistent with recommendation #1, the proficiency Geropsychology, approved by Council at the February 1998 meeting, be allowed to retain the modifier "clinical" in its title, such that the name of the proficiency shall be "Clinical Geropsychology."]~~

That the term "Health Service Psychologist" or "Health Service Provider in Psychology" be the preferred term in language used to describe practicing psychologists or professional psychology students in relation to statutes, rules or regulations, and commercial policies that pertain to eligibility for health services reimbursement and health professions education and training. In using that term, or for instances in which other language is already used (e.g., use of the term "clinical" as a modifier for "psychologist" or "psychology") and change in that language is unlikely, it is further recommended that language used in the interpretive rules or implementing regulations be consistent with the definition of psychologists as health service providers approved by the Council of Representatives in February 1996, as follows:

Psychologists who are duly trained and experienced in the delivery of preventive, assessment, diagnostic, and intervention services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level.

Or, as ~~recently~~ accepted by the Health Care Financing Administration, in defining the term "clinical psychologist" that was in that agency's regulatory language, to the following effect:

A clinical psychologist is an individual who holds a doctoral degree in psychology; and (2) is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

That the APA be consistent in its use of the term "specialty" or "specialties" in publishing information about APA member interests, educational background, or teaching, research, and practice focus, reserving use of those terms for reference to formally recognized professional practice specialties in psychology.

1996 - Present

Recognized Specialties, Subspecialties, and Proficiencies in Professional Psychology

~~{2001~~

~~Specialty in professional psychology: Forensic psychology~~

~~Specialty in Professional Psychology: Forensic Psychology~~

~~Proficiency in professional psychology: Psychological treatment of alcohol and other psychoactive substance disorders~~

~~Proficiency in Professional Psychology: Psychological Treatment of Alcohol and Other Psychoactive Substance Disorders~~

~~2003~~

~~Industrial and organizational psychology as a specialty in professional psychology~~

~~Industrial and Organizational Psychology as a Specialty in Professional Psychology~~

~~2004~~

~~Developing and evaluating standards and guidelines related to education and training in psychology: Context, procedures and criteria —~~

~~Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology: Context, Procedures and Criteria~~

~~{PDF, 125KB}~~

~~2005~~

~~Clinical child psychology as a specialty in professional psychology~~

~~Clinical Child Psychology as a Specialty in Professional Psychology~~

~~Clinical psychology as specialty in professional psychology~~

~~Clinical Psychology as Specialty in Professional Psychology~~

~~2006~~

~~Psychoanalysis in psychology as a specialty in professional psychology~~

~~Psychoanalysis in Psychology as a Specialty in Professional Psychology]~~

Violence against children and Youth by governments

Whereas violence toward children and youth which is encouraged or tolerated by governments of any country represents an affront to civilized society and a social concern of all responsible people;

Whereas psychologists cannot in good conscience remain silent in the face of such abuse;

Whereas the American Psychological Association is also obligated to support our colleagues in other countries when they courageously speak out against such abuses;

Whereas the American Psychological Association has in the past spoken out against the government sponsored violations of children's rights (e.g., the imprisonment of Black children in South Africa);

Therefore be it resolved that the American Psychological Association will, as a matter of policy, consider, upon documentation of such abuses of children's rights, resolutions and actions protesting such abuses and expressing solidarity with our colleagues who protest such abuses within their own country ~~{(Fox, 1989).}~~

References

Delgado, M. (2020). State-sanctioned violence: Advancing a social work justice agenda. Oxford Press.

Unicef (2020). Ending violence against children: Six strategies for action.

WHO (2016). Inspire: Seven strategies for ending violence against children.

Policy on listing of convention sessions

~~[Council directed the Convention Program Committee]~~ At the discretion, BCA and the Convention Office are permitted to list pre- or post-convention sessions, limited attendance meetings, and meetings for which a fee is charged, provided the committee judges the meeting to be: (a) of interest to the membership, and (b) the requesting organization be nonprofit making, or governmental, or an organization affiliated with the APA.

B. The Board voted to 1) determine that the *Guidelines for the Practice of Telepsychology* poses no undue risk to the Association and 2) refer the item to the Council Leadership Team for a content review and to make a recommendation to Council.

C. The Board voted to recommend that Council reject the following motion:

That, pursuant to Article XIV of the APA Bylaws, the Council of Representatives deems it in the best interest of the American Psychological Association (APA) for the Association of Jewish Psychologists (AJP), the ethnic minority psychological association of Jewish psychologists, to be affiliated with APA, and for AJP to be afforded one voting representative serving on the Council of Representatives. Should AJP opt not to send a voting representative to Council, AJP may instead send a non-voting delegate in accordance with the Association Rules. All other provisions of Article XIV of the APA Bylaws shall also apply to the AJP's affiliation with APA

C. The Board voted to 1) receive the document *Neuropsychological Test Norming in Diverse Populations* and 2) approve the establishment of a working group sponsored by the Committee on Psychological Tests and Assessment (CPTA) to develop a report focused on advancing neuropsychological assessment in diverse populations, including research, practice and training, and promoting equity in neuropsychological assessment. The working group will have a term of no more than two years and report at least every six months to CPTA and the Board of Directors on its progress

D. In executive session, the Board voted to approve the 2025 continuing committee appointments (attached).

E. In double executive session, in response to the Finance Committee's recommendation that the Board of Directors direct a re-evaluation of the current structure and activities of Elected and Appointed Leader (EAL) groups; and that this re-evaluation should consider the best framework for successfully and cost-effectively achieving the strategic priorities as approved by Council in February 2024; as well as considering psychological science and APA's commitment to Equity, Diversity and Inclusion; the Board voted to establish a Workgroup to examine the board and committee structures across the Association. This Workgroup will consist of two Board of Directors members, two members of the Council of Representatives who are not on the Board of Directors, one member from each of the major boards (i.e., Board for the Advancement of Psychology in the Public Interest, Board of Professional Affairs, Board of Scientific Affairs, Board for the Advancement of Psychology in the Public Interest and the Policy and Planning Board). Further, because it is anticipated that the work of this Workgroup will continue into 2025, all members of the Workgroup should be in the first or second year of their respective terms on these bodies, to avoid turnover and continue connection to these governance bodies. The specific scope of practice will be determined at a later date, but as soon as practicable.

F. In double executive session, the Board voted to reject the following motion recommended by the Finance Committee:

That the Board of Directors requests that the CEO evaluate the feasibility, benefits, and possible unintended consequences of implementing changes necessary to hold the one in-person meeting each board and committee holds annually at APA convention as well as the financial savings that would result from the change. This evaluation should include any changes to Bylaws or Association Rules that might be needed to implement the change.

G. In double executive session, on recommendation of the Finance Committee, the Board voted to request that the CEO 1) explore the changes necessary to implement having EALs be reimbursed based on an established per diem and other flat fees for travel-related expenses (not including air/rail travel or hotel travel costs which would be paid by APA directly) and 2) provide the Finance Committee and the Board with a detailed plan for implementing the changes as well as the information on the financial savings that would result from the change.

H. In double executive session, on recommendation of the Finance Committee, the Board took the following actions regarding the Spring Consolidated Meetings beginning in 2025:

- 1) Voted to approve moving the plenary and other group hybrid sessions at the Spring Consolidated meeting to virtual.
- 2) Voted to eliminate the reception at the hotel.

I. In double executive session, the Board took the following actions regarding future Council meetings:

- 1) Voted to reject the recommendation of the Finance Committee to move Council's plenary sessions to virtual.
- 2) On recommendation of the Finance Committee, voted to approve eliminating the reception at the hotel at Council's February and August meetings beginning in 2025.

BOARD OF DIRECTORS

July 16, 2024

APPROVED MINUTES

Board Members Present: Cynthia de las Fuentes, PhD; Debra M. Kawahara, PhD; Thema S. Bryant, PhD; Michael L. Hendricks, PhD, ABPP; Kathleen S. Brown, PhD; Arthur C. Evans Jr., PhD; Quincy Guinadi, PsyD; Elizabeth Louis, PhD; Tamara S. Lyn, PhD, ABPP; Mary Ann McCabe, PhD, ABPP; Arlene Noriega, PhD; Lindsay Patterson, CIA, CPA; Hideko Sera, PsyD; Talee Vang, PsyD

Board Members Absent: Luz Maria Garcini, PhD, MPH; Noelle Lefforge, PhD, ABPP

A. The Board voted to 1) determine that the *Guidelines for Psychological Evaluations in Child Protection Matters* poses no undue risk to the Association and 2) refer the item to the Council Leadership Team for a content review and to make a recommendation to Council.

B. The Board voted to 1) determine that the *Guidelines for Interventions in Professional Practice with Adults with Complex Trauma Histories* poses no undue risk to the Association and 2) refer the item 2 to the Council Leadership Team for a content review and to make a recommendation to Council.

C. The Board voted to determine that the *Guidelines on Key Considerations for Working with Adults with PTSD and Traumatic Stress Disorders* poses no undue risk to the Association and 2) refer the item to the Council Leadership Team for a content review and to make a recommendation to Council.

D. The Board voted to accept the audited financial statements of APA Consolidated, APA 750 LLC, APA 10G LLC and APA Service, Inc. for the year ended December 31, 2023, and the Supplemental Financial Report (A-133).

E. The Board voted to reappoint BDO USA LLP to conduct the Association's 2024 & 2025 audit/tax work contingent upon negotiation of acceptable engagement terms, or request that management conduct a formal search through a Request for Proposal process.

F. The Board took the following actions regarding President-Elect Debra Kawahara's Presidential Activities Fund:

- 1) Approved allocating \$30,000 from President-Elect Debra Kawahara's Presidential Activities Fund to support informational sessions at high schools around the United States to increase the diversity and reach of psychology by introducing high school students to how psychological science and practice have been applied to a wide range of careers.
- 2) Recommended allocating up to \$20,000 from President-Elect Debra Kawahara's Presidential Activities Fund to add a community service project to support her initiative on Disaster Preparedness, Response and Recovery and requested that the Finance Committee approve that this amount be used to supplement the Board of Directors retreat in Maui, Hawaii in January 2025. The January 2025 retreat will include the Board observing, gathering information, and learning from indigenous leaders and survivors of the Maui wildfires as well as first responders

and providers about the immediate and ongoing long-term effects, challenges, and consequences of the Maui wildfires, effective and ineffective responses, lessons learned, and recommendations.

G. The Board received an update on the Accessibility and Inclusion Maturity Model.

H. The Board received as information the statement on *Artificial Intelligence and the Field of Psychology* that Council will be asked to adopt as APA policy at its August 6 & 7, 2024, meeting.

I. In executive session, the Board voted to approve the appointment of Alton Carswell, PhD, to the Committee on Sexual Orientation and Gender Diversity for a three-year term (2025-2027).

J. In executive session, the Board voted to approve the following members to be included on Slate IV for the Membership Board on the 2024 Board and Committee Election Ballot: Jodi Gerson, PsyD, and Eboni Winford, PhD.