

COUNCIL OF REPRESENTATIVES

August 5 & 6, 2020

DRAFT MINUTES

I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its February 28-March 1, meeting.

B.(1A) Council voted to reject suspending Association Rule 30-2.1 and agreed to not publish individual votes on open session agenda items.¹

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) Council voted to elect 95 members listed to initial Fellow status, on the nomination of the indicated divisions and on the recommendation of the Fellows Committee and the Board of Directors.

B.(3) That Council approves forwarding to the Membership for a vote the following amendments to the APA Bylaws (bracketed/strikethrough material to be deleted; underlined material to be added):

ARTICLE II

Membership

1. The Association shall consist of [~~three~~] four classes of members: Fellows, Members, [~~and~~] Associate members, and Graduate Student members.

4. Members of the Association shall be persons who are interested in the advancement of psychology as a science and as a profession and who have met the requirements described below. The designation Member as used in these Bylaws shall be deemed to include Fellows, except where there is an express provision to the contrary. The requirements for acceptance to Member, Associate member, or Graduate Student member status may be waived by the Membership Board, in special cases, for persons in fields other than psychology who have made continuing distinguished contributions to psychology.

5. The minimum requirement for acceptance to Member status shall be the receipt of the doctoral degree based in part upon a psychological dissertation or the doctoral degree based on other evidence of proficiency in psychological scholarship from a program primarily psychological in content. The doctoral degree must have been conferred by a graduate or professional school that is regionally accredited or that has achieved such accreditation within five years of the year the doctoral degree was granted or that is one of equivalent standing outside the United States.

6. Associate members shall be persons who are interested in the advancement of psychology as a science and as a profession and who have met the requirements described below. Associate

¹At its August 2018 meeting, Council voted that at the beginning of each Council meeting, after the meeting agenda has been determined, Council will vote on a motion to 1) suspend Association Rule 30-2.1 and 2) agree to require Council members votes on each open session agenda item, with the exception of procedural votes, (including votes in favor, against, abstaining, recusing or not voting) be published on the Association's website with access for members only. (A 2/3 vote of all Council members present is needed to suspend the Association Rules. If the motion fails, Council members' votes will not be published for that meeting).

members may not vote or hold office in the Association but shall be entitled to all rights and privileges of the Association not specifically denied them in these Bylaws. Associate members shall achieve voting privileges after five consecutive years in the status of Associate membership.

7. The minimum requirement for acceptance to Associate member status shall be (a) completion of at least two years of graduate work in psychology in a regionally accredited graduate or professional school or (b) the master's degree in psychology from a regionally accredited graduate or professional school.

8. Graduate Student members shall be persons who are pursuing graduate studies in the field of psychology and who have met the requirements described below. Graduate Student members may not vote or hold office in the Association, but shall be entitled to all rights and privileges of the Association not specifically denied them in these Bylaws. Graduate Student members shall achieve voting privileges after one year in the status of Graduate Student membership.

9. The minimum requirement for acceptance to Graduate Student member status shall be enrollment in good standing within the past twelve months in a regionally accredited graduate or professional school for graduate work in the field of psychology.

~~[8]~~10. Fellows shall be elected by the Council of Representatives (hereafter referred to as Council) upon recommendation by the Board of Directors. Nomination of a Fellow shall be made by a Division to which the member belongs.

~~[9]~~11. Council shall have the power to designate additional requirements for acceptance to Member, Associate member or Graduate Student member status.

~~[10]~~12. The requirement of a doctoral degree, as defined in Section 5, or the requirement that the five years of acceptable professional experience be subsequent to granting of the doctoral degree, as appropriate, may be waived: (a) for Fellow status, by Council upon submission of evidence satisfactory to Council of outstanding contribution or performance in the field of psychology; (b) for Member status, by the Membership Board upon submission of evidence satisfactory to the Board of significant contribution or performance in the field of psychology.

~~[11]~~13. In addition to the regular membership classes, there shall be a class of International Affiliates, who are not Members of the Association and who shall not represent themselves as such. They shall have such rights and privileges as may be granted by Council, including special rates for subscriptions and publications.

~~[12]~~14. International Affiliates shall be psychologists who reside in countries other than the United States or Canada. An individual desiring affiliation with the Association must, at the time of application, be a member of the psychological association of the country in which the applicant resides or, if no such association exists, shall present evidence of appropriate qualifications. International psychologists who meet the requirements for membership may apply in the usual manner if they so desire.

~~[13]~~15. There shall be a class of High School and Undergraduate Student Affiliates who are not Members of the Association and who shall not represent themselves as such. They shall have such privileges as may be granted by Council, including special rates for subscriptions and publications.

~~[14]~~16. There shall be a class of High School Teacher Affiliates who are not Members of the Association and who shall not represent themselves as such. They shall have such privileges as may be granted by Council, including special rates for subscriptions and publications.

~~[15]~~17. There shall be a class of 2-Year College Teacher Affiliates who are not Members of the Association and who shall not represent themselves as such. They shall have such privileges as may be granted by Council, including special rates for subscriptions and publications.

~~[16]~~18. A Member (to include Fellows), Associate member, Graduate Student member or Affiliate may be dropped from membership or otherwise disciplined for conduct which violates the Ethical Principles of the Association, which tends to injure the Association or to affect adversely its reputation, or which is contrary to or destructive of its objects. Allegations of such conduct shall be submitted to the Ethics Committee.

The Ethics Committee shall formulate rules and procedures governing the conduct of the ethics and disciplinary process. However, such rules and procedures and any changes therein must be approved by the Board of Directors acting on behalf of Council. The Ethics Committee, acting at its own discretion or on direction of the Board of Directors, shall review such rules and procedures periodically and may amend them from time to time, subject to the approval of the Board of Directors, provided, however, that no such amendment shall adversely affect the substantive rights of a Member, Associate member, Graduate Student member or Affiliate whose conduct is being investigated or against whom formal charges have been filed at the time of amendment.

~~[17]~~19. A person who has been dropped from membership pursuant to the rules and procedures of the Ethics Committee may reapply for membership after five years have elapsed from the date of termination of his/her membership. A person who has been permitted to resign under a stipulated agreement may reapply for membership only after the period of time stipulated in the agreement has elapsed, and all other conditions set forth in such agreement have been discharged. In all cases the Member, Associate member, Graduate Student member or Affiliate must show that he/she is ethically as well as technically qualified for membership. Such reapplications shall be considered first by the Ethics Committee, which shall make recommendation to the Membership Board.

~~[18]~~20. Resignations of Members, Associate members, Graduate Student members or Affiliates may be accepted only by the Board of Directors. In the ordinary course, the Board of Directors will, in its discretion, refuse to accept a resignation tendered by a Member, Associate member, Graduate Student member or Affiliate while such Member, Associate member, Graduate Student member or Affiliate is under the scrutiny of the Ethics Committee.

ARTICLE III

Bill of Rights for Members

1. All Members and Fellows shall have the right to vote, to hold office, and to secure fair consideration for governance appointment in the Association. Voting in any Association election may be done by either mail or electronic means.

2. All Members, Fellows, Associate members, Graduate Student members, and Affiliates shall be treated with respect and without discrimination on the basis of race, national or ethnic origin, religion, gender, gender identity, or sexual orientation, age, mental or physical disability. This does not preclude the Association from fulfilling its obligation to carry out activities or programs that have as their goal the amelioration of conditions that may restrict Members from full participation in the Association or its activities and programs.

ARTICLE V

Composition of the Council of Representatives

5. Each APA Fellow, Member, ~~[and]~~ voting Associate member, and voting Graduate Student member shall choose the Division(s) or State/Provincial/Territorial Association(s) through which he/she elected to have his/her interest represented on Council by allocating, at the time of the annual dues statement, a total of ten (10) votes to the Division(s) and/or State/Provincial/Territorial Association(s) through which he/she wishes to be represented the following year. However, only Fellows, Members (or voting Associate or Graduate Student members) of the Divisions or State/Provincial/Territorial Associations so designated will be allowed to nominate and elect their Council Representatives.

ARTICLE VI

Divisions

2. Any Member of the Association may apply for membership in one or more Divisions under the rules of eligibility and election established by the Division. Associate members, Graduate Student members or Members may remain Associate members, Graduate Student members or Members without divisional affiliation. A Division may include in its membership those who do not qualify for or do not desire membership in the Association. It may determine its own qualifications for its membership classes, provided that the designation Fellow shall be reserved for members of the Division who are Fellows of the Association.

ARTICLE XI

Boards and Committees

2. The Membership Board shall consist of no fewer than eight Members and one Affiliate of the Association. At least two of the members shall be Fellows of the Association. The remaining members shall be selected to represent the diverse membership of the Association. Members of the Board shall serve for staggered terms of three years each, except when filling a vacancy on the Board. The Board shall have responsibility for the oversight of membership recruitment and retention activities for the Association. The Board shall have the authority to elect qualified persons to initial Member, ~~[or]~~ Associate member or Graduate Student member status. The Membership Board is responsible for establishing and regulating the APA criteria that the Fellows Committee uses to review and to recommend member nominees for election to Fellow status. The Board shall receive nominations from the Fellows Committee and shall forward recommendations without alterations or comments to the Board of Directors.

5. The Ethics Committee shall consist of not fewer than eight persons, at least seven of whom shall be Members of the Association, elected from different geographical areas, for terms of not less than three years. Members of the Ethics Committee shall be selected to represent a range of interests characteristic of psychology. The Ethics Committee shall have the power to receive, initiate, and investigate complaints of unethical conduct of Members (to include Fellows), Associate members, Graduate Student members, and Affiliates; to report on types of cases investigated with specific description of difficult or recalcitrant cases; to dismiss or recommend action on ethical cases investigated; to resolve cases by agreement where appropriate; to formulate rules or principles of ethics for adoption by the Association; to formulate rules and procedures governing the conduct of the ethics or disciplinary process for approval by the Board of Directors acting on behalf of Council; and to interpret, apply, and otherwise administer those rules and procedures.

The work of the Ethics Committee, including information and recommendation on all cases before it, shall be kept confidential, except as provided by the Ethics Committee in rules and procedures approved by the Board of Directors, consistent with the objectives of the Committee and the interest of the Association.

ARTICLE XIX

Dues and Subscriptions

1. The basic Association dues to be paid annually by Members, Graduate Student members, and Associate members shall be determined by Council and shall include subscriptions to such publications as may be determined by Council.

7. Any Fellow, Member, [~~or~~] Associate member, or Graduate Student member who has been adjudged totally and permanently disabled shall be exempt from further payment of dues. Such members shall retain other rights and privileges of the Association.

ARTICLE XX

Amendments

1. The Association, by vote of the voting Members on the official rolls of the Association at the time of sending, may adopt such Bylaws or amendments to Bylaws as are consistent with the Association's Certificate of Incorporation and are deemed necessary for the management of the affairs of the Association.

2. Amendments may be proposed (a) by Council, (b) by the Policy and Planning Board, (c) by the Board of Directors when approved by Council by a majority vote, or (d) by petition signed by four percent or more of the Members of the Association. A copy of each amendment proposed, with space appropriate for voting and such explanations of the amendments as are deemed necessary, shall be sent to the last recorded address of each Fellow, Member, [~~and~~] voting Associate member, and voting Graduate Student member. Pro and con statements shall accompany amendments unless two-thirds of the representatives present and voting consider such statements to be unnecessary. Forty-five days after the date of sending, the poll shall be closed and the votes counted by the Election Committee, which shall certify the result to Council

at its next meeting, at which time the amendment, if passed by two-thirds of all the Members voting, shall take effect.

Additionally, Council voted record individual votes on the vote to include statements in favor of and against adopting with the bylaw amendment ballot and require publication in a designated location on APA's website.

Council ultimately voted to include statements in favor of adopting and against adopting the above Bylaws amendments along with the ballot that is sent to the membership. The ballot will also include an explanatory statement.

Council also voted to approve amending APA's Association Rules as follows to become effective if and when the above Bylaws changes are approved by the Membership (bracketed/strikethrough material to be deleted; underlined material to be added):

10-1. MEMBERSHIP CLASSES

10-1.1 The APA Bylaws provide for ~~three~~ four classes of membership in the Association: Fellow, Member, ~~and~~ Associate member, and Graduate Student member. Requirements for each class of membership are given in the APA Bylaws.

10-4. APPLICATION PROCEDURES

10-4.1 Application or nomination forms for Member, Associate member, Graduate Student member or Fellow status shall be prescribed by the Membership Board, after consultation with other APA committees involved in their use. Such forms are used to collect information sufficient to establish the applicant's ethical and technical qualifications for membership and to create necessary membership records and APA Directory/Register records.

All applicants for Associate member, Graduate Student member or Member status shall indicate whether or not they have previously been rejected for membership in the Association or had membership voided or have previously been convicted of a felony or sanctioned by any professional ethics body, licensing board, other regulatory body or any professional or scientific organization. All applications for Member, ~~or~~ Associate member, or Graduate Student member status shall carry the following statement, which the applicant shall sign:

"In making this application, I subscribe to and will support the objectives of the American Psychological Association as set forth in Article I of the bylaws, and the Ethical Principles of Psychologists and Code of Conduct, as adopted by the Association, and I affirm that the statements made in this application correctly represent my qualifications for membership, and understand that if they do not, my membership may be voided."

APA may seek evidence from schools and universities that the candidate has attended, state/provincial/territorial or local psychological associations, professional employers, and/or other appropriate sources of information, when the submitted documentation leaves doubt as to the applicant's qualifications for membership in the Association.

Nominations for Fellow status shall be made by divisions to the Fellows Committee. The written nomination shall show that the candidate's doctoral dissertation was on a psychological subject and that the professional experience cited as qualifying an individual for Fellow status was work which the person was properly qualified to perform and that was appropriately supervised. The recommendation shall include the endorsement of at least three, but preferably more, Fellows of the Association. In instances when the nominee is working in a highly specialized area, one of the three endorsers may be a former APA Fellow who is no longer a Member of the Association. The recommendation shall make clear what evidence the division puts forward to support the "unusual and outstanding contribution" of the candidate. The division may assemble the information by whatever means it deems appropriate but shall make reasonable verification of it before submission to the Fellows Committee.

(a) With respect to the nomination of Fellows, each division shall, by such means as it shall determine, solicit nominations from its members of those who are deemed worthy of election to this honor. The division may require the nominator to indicate the evidence available in support of the nomination. It shall be the responsibility of the division to select from these nominees and to prepare the recommendations for submission as provided in the previous section.

(b) Divisions shall be informed that it is the assumption of Council that the final list of Members recommended for election to initial Fellow status contains only those Members officially nominated by the relevant divisions. Divisions are responsible for maintaining appropriate review schedules to meet this requirement. This rule does not deny the right of an individual Council member to challenge any nomination on the list.

10-5. INTERPRETATION OF EDUCATIONAL REQUIREMENTS

10-5.1 In acting upon an application for Graduate Student member, Associate member or Member status in the Association, the Membership Board and/or Membership Staff shall be guided by the following interpretation of the requirements stated in the APA Bylaws:

The applicant's graduate or professional school must have full regional accreditation at the time the applicant is elected to membership, although the applicant's training or degree may have been received during the five years prior to full accreditation. A regionally accredited institution is defined as an institution that is listed as fully accredited by the appropriate regional accrediting body in the Directory of Accredited Institutions of Postsecondary Education, published annually by the American Council on Education, or one of equivalent standing outside the United States.

10-14. STUDENT AFFILIATE

10-14.1 Applications from college and high school students desiring to become Student Affiliates may be accepted at any time by the chief staff officer, who shall have discretion in determining what form of evidence is sufficient to meet the requirements for this application.

A Student Affiliate who interrupts studies for a period not to exceed ten consecutive years shall be considered as a student throughout the break in studies for purposes of determining eligibility for Student Affiliate status.

Student Affiliates may subscribe to any of the journals published by APA or purchase other APA publications at the same reduced rates charged to members.

90-3. AMERICAN PSYCHOLOGICAL ASSOCIATION OF GRADUATE STUDENTS COMMITTEE

There shall be an American Psychological Association of Graduate Students (APAGS) Committee whose mission shall be to (a) promote the highest standards in the research, teaching, and practice of psychology in order to further the education and development of all students involved in the study of psychology; (b) represent all graduate study specialties of psychology, and facilitate exchange of information between these groups; (c) promote graduate student leadership development in order to communicate and advocate the concerns of graduate students; and (d) establish and maintain channels of communication between APAGS and schools, universities, training centers, institutions, and other members of the psychological community.

The APAGS Committee shall consist of nine members, three of whom serve three-year terms (the chair-elect, chair, and past chair), six of whom serve two-year terms. All shall be ~~[graduate student affiliates]~~ Graduate Student members of the Association. Each year, a call for nominations for the four open positions that will become vacant in the following year shall be broadly disseminated. Following the call, the committee shall prepare a slate of candidates for each position and hold an election in which all APAGS members are eligible to vote. Following the election, names of the winners of the election shall be forwarded to the Board of Directors as information.

The APAGS Committee shall report to Council through the APA Board of Directors.

100-2. PETITIONS FOR NEW DIVISIONS

100-2.3 In the event that the petitioners represent an established group of APA members, the additional material to be supplied shall include minutes of the meeting at which action was taken to seek affiliation, a full list of members, lists of officers for current and recent years, and bylaws of the group.

In the event that the group has been newly assembled, the petitioners shall supply (a) minutes of any organizational meeting of the group sponsoring the petitioners and a list of persons attending, (b) provisional bylaws of the proposed division that conform to requirements of the APA Bylaws, (c) a list of provisional members by class (e.g., Associate member, Graduate Student member, Member) if such is proposed, (d) a list of members who are not petitioners, and (e) a list of provisional officers.

If the petitioners feel it would be useful to Council, they may submit a statement amplifying the preface to the petition to make clear why they seek divisional status.

110-8. PRESIDENT-ELECT ELECTION

110-8.1 The election of APA President-elect is conducted by the Election Committee.

110-8.2 Candidates are nominated by Fellows, Members, ~~and~~ Associate members with voting privileges, and Graduate Student members with voting privileges. Nominations are made by

preferential ballots, and up to five names may be listed in rank order. Nomination ballots are sent on or about February 1. The balloting period closes within 45 days. Only APA members are eligible for nomination.

110-8.3 The APA President-elect shall be elected by Fellows, Members, and those Associate members and Graduate Student members who have been granted voting privileges. The election ballot shall be preferential and shall list five candidates. Final election ballots shall be sent on or about September 15. The balloting period shall close within 45 days.

Each candidate is invited to submit a statement, to be sent with the election ballot, of no more than 1,000 words, stating his or her opinion of issues facing psychology and of the role APA should play regarding these issues.

110-8.4 Results are reported to the Board of Directors. Tallied results are reported to Council no more than 30 days after the ballot closes. Election results are published on APA's website.

III. ETHICS

A.(3A) Council voted to postpone item 3A, Division 42 Name Change, to its February 2021 meeting.

B.(21) Council received as information an update on the activities of the Ethics Code Task Force.

C.(22) Council was provided with information on initiatives of the Ethics Committee.

IV. BOARD OF DIRECTORS

No items.

V. DIVISIONS AND STATE AND PROVINCIAL AND TERRITORIAL ASSOCIATIONS

No items.

VI. ORGANIZATION OF THE APA

A.(4) Council voted to approve the following statement on Psychology's Understanding of the Challenges Related to the COVID-19 Global Pandemic in the United States:

Psychology's Understanding of the Challenges Related to the COVID-19 Global Pandemic in the United States

The COVID-19 global pandemic and its ensuing economic crisis have resulted in a cascade of societal challenges, including illness and death, prolonged social isolation, job loss, and reliance on remote work and online education. The pandemic has also cast a bright light on the destructive effects of health, educational, employment, legal, and criminal justice disparities and inequities. We are witnessing a confluence of forces – a rapidly spreading and dangerous disease, coupled with widespread anti-racism protests and a pre-existing mental health crisis – that interact synergistically and have a disproportionate impact on marginalized populations. Many of these already vulnerable populations are at heightened risk for infection, including:

Black, Indigenous and People of Color (BIPOC), older adults, those with certain chronic health conditions, front-line providers, and other essential workers, as well as individuals in nursing homes, jails, prisons, and migrant detention facilities. The discipline and profession of psychology is responding to these challenges across multiple domains to safeguard and promote our nation's health, family life, educational attainment, and work productivity. Most notably, as the science of behavior, psychology is helping to improve and increase adherence to mitigation behaviors (e.g., physical distancing, wearing masks, and handwashing) and to ameliorate widespread stress, anxiety, depression, and hopelessness. These feelings of despair are heightened for many individuals in response to unclear, conflicting, and at times harmful guidance from federal, state, and local government officials regarding mitigation efforts (e.g., wearing masks), coupled with indications of disdain and mistrust of science.

The goal of this policy statement is to identify challenges that the nation is facing or will face relative to the pandemic and associated crises for which psychological science and expertise can be applied through the adoption of a population health approach at multiple levels with attention to equity concerns. The following four key societal domains are highlighted: health and well-being; family and social development; education, training, and learning; and work, organizational, and human performance.

HEALTH AND WELL-BEING

The COVID-19 pandemic has exposed the nation's inequitable systems and structures that marginalize and increase vulnerability among many at-risk populations. This disease is spreading more rapidly as a result of social inequality and injustice, which contributes to disease clustering among those already at higher risk for poor health, thereby multiplying their disease burden. Furthermore, the direct effects of illness, loss of loved ones, fear and prolonged uncertainty, stress from economic fallout and mitigation strategies, and health care inequities all contribute to the psychological stress of the pandemic. The most common immediate effects include: depression, anxiety, and physical reactions, such as insomnia and headaches (Wang et al., 2020). There is also substantial evidence emerging that isolation, stress, and trauma throughout the lifespan have long-term adverse effects on physical and psychological well-being (Girdhar et al., 2020). Furthermore, these effects are magnified in high-risk and disadvantaged groups (APA, 2019a), including those with limited access to psychological resources and effective supports. The COVID-19 pandemic has also increased risk factors for substance use, and addiction (Rothman et al., 2020). More than 35 states have reported increases in opioid-related mortality since the pandemic began (AMA, 2020). Many people with substance use disorders faced challenges in accessing needed services prior to the pandemic, and social, economic, and virus-related anxiety has aggravated these challenges (Ornell et al., 2020). Social isolation and stress related to the pandemic can increase susceptibility to substance misuse, addiction, and relapse (University of Michigan, n.d.), particularly for older adults, front-line workers, and those who experience economic insecurity and/or job loss (Panchal et al., 2020). Researchers are calling for greater investments in preventive modalities that promote emotional resiliency building and help address the factors that make patients susceptible to reliance on opioids and other substances (Silva & Kelly, 2020).

Psychological interventions, such as psychotherapy, targeting specific stressors and symptoms are critical components of an interprofessional approach to addressing the direct and indirect effects of the pandemic. Psychological interventions are effective in addressing the effects of

trauma (McCleary & Figley, 2017; APA, 2017a), depression (APA, 2019a), and anxiety (Barlow, 2008; Vøllestad et al., 2012). The development of psychological symptoms in other disasters and mass casualty events has been mitigated or limited through the application of psychological knowledge and evidence-based practices. These include psychological first aid (APA, 2020c), early interventions to develop social support, and coping skills that promote resilience (APA, 2020b; Kaczurkin & Foa, 2015; Dubey et al., 2020). In response to the current pandemic, for example, psychological interventions have assisted older adults in combatting the anxiety and depression arising from social isolation, which can be exacerbated by “lock downs” of nursing homes or retirement communities (van Dyck et al., 2020). However, access to psychological care remains a barrier for many underserved populations and those for whom health risks limit opportunity for in-person services. Advocacy to increase support for delivery of psychological services through telepsychology and interstate license portability is imperative.

Telehealth (i.e., videoconferencing) and audio-only phone services allow psychologists to have regular contact via phone or video visits with all patients. This ensures that individuals can continue to receive necessary psychological care while reducing risks for transmission of COVID-19. Telehealth, tele-testing, and audio-only phone services are also critically important since they hold great potential to reduce geographic, cultural, and linguistic barriers, but clinicians must apply a health equity lens (Rothman et al., 2020). Utilization of community health workers and other traditional health workers can also be better integrated into health systems (Hansmann & Kind, 2020).

Psychological interventions reinforced by effective communication strategies are needed across populations and settings to increase engagement in COVID-19 testing, social isolation, wearing of masks, and other PPE (when accessible). In settings where these mitigation strategies are not feasible, effective institutional policies and business practices are needed. It is imperative that communications from federal, state, and local government officials, others in positions of authority, and the news media provide clear and accurate information about effective mitigation efforts to reduce stress (APA, 2020d) and the spread of the virus (Bursztyn et al., 2020). These messages should be informed by psychological science, which offers evidence-based approaches to help increase cooperation with contact tracing (and the supportive isolation for those likely affected), as well as vaccinations, when available. Psychologists can also promote messages and interventions to enhance psychological resilience and capacity to cope with adversity.

Direct interventions are needed for those with COVID-19 and their families, whether or not the patient is hospitalized. The virus can have significant long-term health consequences that could require ongoing intervention and management, as well as a need to address subsequent distress and uncertainty, along with the potential fear and stigma of those who might have the virus (Jutte et al., 2015). Further, psychologists who practice in medical, surgical and rehabilitation hospitals have been available to provide important clinical services to patients who have had to be treated with mechanical ventilation secondary to COVID-19. These patient care services include addressing psychological symptoms of anxiety when intubated and fear when being weaned from mechanical ventilation, as well as addressing possible PTSD and cognitive symptoms (Jutte et al., 2015) after ICU and ventilation treatment (Perren & Brochard, 2013; Chahraoui et al., 2015). Finally, as the death rate rises, increasing numbers of families will be coping with grief and loss (Verdery et al., 2020) and psychological interventions for individual, families and community grief may be beneficial (Weir, 2020).

High risk for COVID-19 is further exacerbated by health and health care disparities related to receiving adequate prevention and treatment of major chronic conditions, such as diabetes, cardiovascular disease, and asthma. While behavioral lifestyle interventions are effective and evidence-based (Mayberry et al., 2019), their effectiveness is limited by the presence of social needs (e.g., food insecurity, insufficient housing, lack of transportation, and unemployment) that interfere with optimal engagement in health behaviors (Shippee et al., 2020). With over 40 million Americans applying for unemployment, a large proportion being racial/ethnic minorities, the prevalence of these social needs will only continue to rise. There will be a need to ramp up behavioral health studies and implementation of existing digital programs that promote weight management, diabetes management, and cardiovascular health.

News media reports tend to focus on the dominant culture's experience of the pandemic, which can present a distorted perception of reality since they do not shine a light on the most vulnerable -- including people of color, older adults, essential workers, people with disabilities, people with low incomes, and others. However, psychological science underscores that diverse populations experience pandemics differently, as do individuals who have prior experience with epidemics, such as HIV/AIDS (Paul, 2020). People with low incomes, for example, often enter a natural disaster or event with increased vulnerability (e.g., financial, food, or housing insecurity), which may take years from which to recover (Joseph et al., 2014; Rhodes et al., 2010). Many African-American men are afraid to wear masks in public out of concern for increasing their risk for negative encounters with police (Thomas, 2020). While media attention has been directed to the plight of nursing homes, other institutional settings, such as facilities for people with disabilities, homeless shelters (Kuehn, 2020), correctional settings (Montoya-Barthelemy et al., 2020), and migrant detention facilities, are also hard hit by the pandemic. So too are "essential workers" -- disproportionately people of color -- who work in settings with high levels of interpersonal contact (Kantamneni, 2020).

Psychological science has helped to understand how these systems and settings increase risks, whether for coronavirus infection or its collateral consequences, such as psychological distress. Some of these settings are overcrowded and/or disproportionately populated with people of color, and include individuals needing behavioral health services (Alexander et al., 2020). The policies and practices of these institutions can even promote and further racism toward a population that is deprived of mechanisms to advocate for self-care and safer conditions (Kovera, 2019), subjecting already vulnerable individuals to greater risk for infection. For example, incarcerated individuals may be at higher risk to become infected with COVID-19, and interactions with psychologists and other professionals who might be carriers of, or become infected with, the virus need to be considered, especially given that some staff professionals travel from prison to prison (Wallace et al., 2020).

The challenges point to the need for an intersectional analysis of COVID's impact with other psychosocial vulnerabilities, such as homelessness and poverty (Hankivsky & Kapilashrami, 2020). These health determinants can be exacerbated by systemic discrimination and societal bias on the basis of race, ethnicity, sexual orientation or gender identity, ability status, and other marginalized identities (Pew Research Center, 2020). Racial/ethnic minorities are more likely to acquire, have complications from, and die from COVID-19 (Centers for Disease Control and Prevention, 2020). This higher risk is due to many factors, including the disproportionate share of people of color in "essential" jobs -- as discussed above -- and the higher rate of chronic health

conditions in these populations, which are complex in origin but are powerfully shaped by social, economic, environmental, and behavioral factors. Among them are structural factors and everyday experiences rooted in racism and discrimination. Structural inequities – such as residential and school segregation – set the stage for poorer health among many people of color because they limit educational attainment and economic mobility, disproportionately expose these populations to sources of environmental degradation, limit access to healthy foods (e.g., surrounding so-called “food deserts”) and even make doctors and clinics harder to find (Smedley, 2012).

FAMILY/SOCIAL DEVELOPMENT

The effects of COVID-19 on psychological health and well-being (APA, 2020b; APA, 2020d) have multiple pathways, impacting individuals across the lifespan to various degrees. Experiences during childhood have long-term effects on physical, neurological, social-emotional, and behavioral development that can last throughout the lifespan (Dubey et al., 2020), leaving a generation especially vulnerable to the adverse effects of the pandemic.

Research has shown that early socialization is essential for healthy brain development in children (Blakemore, 2010; Hari et al., 2015; CDC/ Harvard, 2014) and that promoting active socialization and learning can lead to multiple cognitive and psychological benefits and resilience (NASP, 2020). However, due to the social isolation arising from COVID-19, many children are unprepared to deal with the stress and tension that their families are experiencing (Lee & Ward, 2020). Sources of prolonged stress may involve caregivers and family members impacted by medical illness, including death and loss of ability to grieve; economic distress from job loss and related concerns, such as homelessness and food insecurity, and social isolation resulting from mitigation strategies that include physical distancing, stay-at-home orders, and school closing. Excessive stress, particularly what has been termed toxic stress, can have damaging effects on child development, learning, and health (Shonkoff & Phillips, 2000). With social isolation, children are experiencing disappointment and grief, which are contributing to mental health problems. Parents are also struggling to maintain their children’s engagement and interest in learning (Harris, 2020).

There are unique and important risk factors for multigenerational families and those providing foster care, caring for a vulnerable person, and/or living in close quarters (e.g., sharing a small apartment). More Americans – 64 million - are living in multigenerational households than ever before (Pew Research Center, 2018). These families have the important responsibility and increased psychological burden of behaving as if everyone in the family constellation is at higher risk for COVID-19 in order to protect those who are more vulnerable.

Since the pandemic began, access to quality child care has diminished, which continues to disproportionately affect women (Glynn, 2018). Access to child care is vital to family well-being and professional effectiveness. Psychologists report that some women are experiencing heightened anxiety and depression due to having to care for their children and manage online schooling while simultaneously pursuing their own demanding career roles (Miller, 2020). In a recent survey, U.S. adults reported an average level of stress significantly higher than in 2019 (APA, 2020d), with parents of children under age 18 reporting even higher average levels of stress; 46% reported their stress as ‘high’ whereas only 28% of adults without children reported the same. Parents are faced with novel, challenging decisions daily - such as whether their

children should attend school in the fall or visit peers or grandparents and how much screen time they should be allowed - which results in mental fatigue and exhaustion and can compromise decision making and overall well being (APA, 2020d).

The conditions during COVID-19 related to health, finances, family, and other stressors may lead to additional adverse events, including increased incidence of physical and psychological abuse, and/or violence (SAMHSA, 2020). There are many reports of increased interpersonal violence in the United States and across the world during the pandemic, as evidenced by increased utilization of emergency hotlines and first responder services (UNWomen, 2020). Some vulnerable children are deprived of their most nurturing relationships with school personnel, who also serve as mandated reporters for child abuse. The negative impact appears to be more pronounced in under-resourced populations, such as those with high levels of unemployment, who are living in close quarters and have fewer opportunities to physically distance during conflict.

Psychologists play a critical role in delivering services to mitigate risk factors that can magnify the impact of trauma and social isolation and to provide interventions (including for interpersonal violence) that significantly reduce the long-term adverse effects and improve outcomes (Herman et al., 2019; McLaughlin & Lambert, 2017). Supporting families and developing safety nets in schools is a critical strategy for treating the immediate and long-term effects of COVID-related stress in families.

EDUCATION, TRAINING, AND LEARNING

Due to the COVID-19 pandemic, students and educators across the breadth of education have needed to adapt to an ever-changing situation where teaching and learning must now be reimagined. There is an urgent need to address the effects of the COVID-19 pandemic on education and training, with an emphasis on ameliorating pre-existing and worsening inequity. Most affected have been disenfranchised racial and ethnic minority individuals and communities, as well as minority-serving institutions (Gasman & Jones, 2020). Major concerns across the breadth of education are highlighted below in the areas of technology, educational attainment, basic needs, and special accommodations, as well as impacts on educators.

Technology

The necessary shift to online education for public health has nonetheless presented a number of challenges for students and educators. The challenges are experienced disproportionately by underrepresented students, particularly for low-income and students of color (Gonzales et al., 2020), highlighting disparities that exist in relation to technology usage, access, and knowledge (i.e. *Digital inequities*, Thomas et al., 2019; *digital inequalities*, Kvasny, 2006). Many students do not have access to technology at home, must share a computer with other household members, and have inadequate or no internet connectivity (Nuamah et al., 2020; Pew Research Center, 2019). Disruptions and digital obstacles are more common for low-income families, many of whose children are completing their schoolwork on a cell phone (43%), through public Wi-Fi (40%), or are unable to complete their work at all (Vogels et al., 2020). An alarming consequence is the exacerbation of the racial, socioeconomic, and rural achievement gaps that existed prior to the pandemic, including learning gaps that occur during summer break (Auxier & Anderson,

2020; Irving, 2020). Unique technology-related concerns exist at every level of education. Young children, in particular, may require more assistance and monitoring from adults in the home, who themselves may be working from home, or have other children. Children are experiencing negative effects with online instruction, such as the loss of social interaction with peers and teachers (Weingarten, 2020). In college, research experiments, laboratory classes, and clinical practica may not be feasible to complete online whether due to logistics or privacy reasons.

At the continuing education level, over one-quarter of older adults do not use the internet (Pew Research Center, 2019), and these numbers are higher among low-educated, rural, and racial or ethnic minority older adults (Anderson, 2019; Pew Research Center, 2019). Provision of training in use of new technologies is required to allow older adults access to necessary psychotherapies and other telehealth services. Further, psychology state licensing boards may require face-to-face continuing education. Even when technological access and ease of use are adequate, stigma is still associated with online instruction, which may be exacerbated by the sudden nature of the crisis (Hodges et al., 2020). Research supports evidence-based principles for the design of effective online instruction (Hodges et al., 2020; Mayer, 2014, 2020); however, educators must be supported to receive adequate training in ways that do not further overburden educators economically or logistically. Given the importance of technology in adapting to the pandemic for public health, issues related to technology access, reliability, usability, and technological disparities will be among the most important to address.

Impacts to Educational Attainment and Outcomes

This shift to online education in the midst of the pandemic will undoubtedly affect educational attainment and outcomes. For example, primary and secondary students' acquisition of learning outcomes has diminished since the shift to online education, and the losses have been greater for students who were already struggling academically (Kuhfeld et al., 2020). Learning gaps emerge for vulnerable children over extended breaks, such as summer vacations, and it can be expected that these vulnerable children will differentially have poorer learning outcomes relative to their peers with the transition to online education (Rand Review, 2020). Peer and teacher-student relationships are significant contributors to students' engagement in, and enjoyment of, school (Harris, 2020; NRC/IOM, 2004; Thapa et al., 2013). Further, minority students may feel less connected in an online learning environment (Ke & Kwak, 2013) and experience greater barriers to campus engagement, similarly important to postsecondary educational outcomes and attainment (Kuh et al., 2006; Shin, 2008). The aforementioned technological barriers will also hinder academic performance and may impact attrition (Jaschik, 2020).

At the graduate level, Health Service Psychology (HSP) programs, as well as basic psychological science graduate programs, face unique challenges. Attainment and assessment of HSP competencies require practice and observation (Borden & McIlvried, 2010). Preliminary evidence indicates that remote supervision works similarly, although not identically, to in-person supervision (Inman et al., 2019; Rousmaniere et al., 2014; Sorlie et al., 1999). The therapeutic relationship is a key to therapeutic success (Safran & Muran, 2003; Wampold & Imel, 2015), which may be more challenging via telepsychology. Yet, given the economic downturn and need for physical distancing, HSP trainees remain understandably concerned about their training (Bell et al., 2020), particularly as some training clinics have suspended some or all services (Hames et al., 2020). Basic psychological science students (and educators) may

experience barriers to conducting research that is laboratory-based and difficult or impossible to conduct virtually and thus hinder attainment and assessment of research competencies. Graduate students experiencing greater external stressors resulting from the pandemic—stressors which students of color, low-SES students, and women students were already more likely to experience (Lantz & Davis, 2017; Wilcox et al., 2019)—may find their academic performance and progress hindered further. This has serious implications for the diversity of the psychology workforce pipeline. Concerns have also arisen about the plight of international students enrolled in U.S. colleges and universities faced with campus closures and online education.

Effects of Basic Needs Disruption on Education

It is well-established in the literature that unmet basic needs have detrimental effects on educational outcomes and attainment. Food, income, and housing insecurity, child supervision, barriers to psychosocial engagement, and safety issues have become more pronounced as a result of the pandemic (APA, 2020; Goldrick-Rab et al., 2020; Nuamah et al., 2020), with Black students experiencing these disruptions at higher rates (e.g., Goldrick-Rab et al., 2020). Students of color and low-SES students already evidenced higher rates of unmet basic needs prior to the pandemic (e.g., Goldrick-Rab et al., 2017; Goldrick-Rab et al., 2019). Critically, adversity in basic needs is related to student disengagement from schooling and ultimately to attrition (e.g., Goldrick-Rab et al., 2019). Housing insecurity interrupts access to online instruction and, in some cases, may move students into other school districts or enrollment zones. Schools are a primary provider of behavioral health services to children and adolescents (Rones & Hoagwood, 2000), and school closures have interrupted access to behavioral health and, in the case of primary and secondary education, separated children from a ‘secure base’ where their behavioral health and safety needs are noticed and addressed (Nuamah et al., 2020).

Of note, food insecurity among college students, most notably students of color and low SES students, is higher than the national average (Freudenberg et al., 2011; Gaines et al., 2014; Maroto et al., 2015; Morris et al., 2016; Hughes et al., 2011; Patton-López et al., 2014). Food insecurity has been demonstrated to be related to poorer psychological and physical health (Farahbakhsh et al., 2017; Hughes et al., 2011; Patton-López et al., 2014), lower GPAs (Maroto et al., 2015; Morris et al., 2016; Patton-López et al., 2014), and difficulty concentrating (Farahbakhsh et al., 2017). Poorer physical and mental health, poorer academic performance, and family income have been linked to attrition (e.g., DeBerard et al., 2004; Eisenberg et al., 2009; Ishitani, 2006). Furthermore, students of color and low-SES students, as well as the current student generation more broadly, are less likely to have “financial reserves” (Kurz et al., 2018; Lopez et al., 2020). Such financial precarity may be further exacerbated for graduate students, who already experience stagnant stipends and benefits, and the rising costs of both education and cost of living (Lantz & Davis, 2017; Wilcox et al., 2019). Potential disruptions to access student loans, assistantships, and other forms of graduate student support may negatively affect living situations, food security, and well-being—and potentially increase vulnerability to COVID-19.

Some graduate students will fear for their safety and security and that of their extended family members with whom they reside, which is heightened when the student must go to campus in person or potentially lose the placement (Bell et al., 2020). Students who are also employed as frontline workers may not have the privilege of working from home. Psychologists and

educators in the workforce are not immune from such financial precarity and safety concerns; they may also be experiencing job losses, reduction in pay, financial, housing, and food insecurity, and health and safety concerns. Given the multitude challenges confronting both educators and learners during the pandemic, flexibility built into policies may help them navigate other obligations (e.g., caregiving).

Furthermore, psychosocial engagement and development are key to both educational process and outcomes. In K-12 schools, opportunities to make and be with friends is the aspect of school that students value most highly (NRC/IOM, 2004), while effective teacher-student relationships promote students' attachment to the classroom (Rudasill et al., 2010). By disrupting these key relationships, physical distancing has diminished students' engagement in schooling and learning (Harris, 2020). Low-income students and students of color already experience more challenges in developing a sense of campus belonging, which is likely to be exacerbated by the pandemic (Nguyen & Herron, 2020; Pew Research Center, 2020). In addition to campus engagement, mentorship in postsecondary education is a crucial part of student development (Gruber et al., 2020). In the midst of increasing demands on educators resulting from the pandemic, faculty may have less time to invest in mentoring students, which may negatively impact students' personal and professional development. This is further true for graduate students, as professional socialization is a primary purpose of in-residence graduate education, as well as professional development opportunities, such as conferences.

Special Accommodations

The COVID-19 pandemic has also resulted in myriad barriers to educational attainment for students with disabilities (Kutscher & Tuckwiller, 2019), which are likely to increase due to lack of assistive resources (i.e., in-person note-takers, aides, technology). State-funded early intervention services, interrupted by the pandemic, are typically provided to 2-3% of children (Macy et al., 2014). Moreover, with reduced access to pediatricians and other medical providers and services, children are not being identified for referral, and their access to vital interventions is being delayed. This is particularly troubling for lower-income and ethnic minority families who already experience significant disparities in access to early intervention screenings and services (Macy et al., 2014; Marks et al., 2015). Five to six percent of preschool-age children and 10-12% of school-age children receive special education through the Individuals with Disabilities Education Act (Macy et al., 2014). Given the U.S. Department of Education requirements (2020), dramatic changes will likely be necessary to implement Section 504 and Individualized Education Program plans since many services provided through such accommodations cannot be provided digitally, and parents may not be able to be reasonably expected to bridge the gap. Children with complex medical and/or behavioral challenges will be particularly impacted by these limitations; use of adjunct assistive technology may not be appropriate for children with disabilities who may not understand or be able to use the technology to communicate (Van Allen et al., 2011; Schaeffer, 2020).

At the college level, past research has demonstrated that students with disabilities who utilized campus-based assistive services were more likely to persist through degree completion (Newman et al., 2020). However, such services may be more difficult or impossible to provide through distance learning. This gap may require more inclusive course design and greater professional development for educators to assist with the needs of students with disabilities. Smith and Ayers (2006) argue that careful planning in the design of online courses with an

equity-minded approach is key and offer suggestions for culturally responsive distance education learning strategies at community colleges (Newman et al., 2020). Identification of students who may require greater assistance, however, creates concerns related to privacy. For example, the CDC (2020) encourages higher education administrators to discuss with students in high-risk categories their need for accommodations; however, this requires the disclosure of private health information. In this regard, it will be important to reduce stigma and ethically consider how to safeguard both the privacy and well-being of all students.

Impacts on Educators

Finally, it is important to note that educators are also coping with personal and professional effects of the COVID-19 pandemic. Teachers report feeling anxious, fearful, worried, overwhelmed, and sad (Cipriano & Brackett, 2020). Furthermore, K-12 teachers report that online instruction is inferior to classroom instruction and that they are exhausted from trying to manage all the new challenges associated with distance learning (Weingarten, 2020; Gewertz, 2020). There is evidence that women and early-career educators may be less productive and less effective in their teaching roles than their male counterparts due to their increased demands from overseeing their own children's schooling and child care responsibilities (Flaherty, 2020; Malisch et al., 2020; Vincent-Lamarre et al., 2020). This reduced work productivity may result in delayed tenure clocks or even tenure denial. Educators are often required to provide their own technology and home office space, with limited or no reimbursement (Will, 2020), which is more keenly felt by those who are disproportionately undercompensated (e.g., women, educators of color, adjuncts; and substitute teachers). Professional development opportunities related to online teaching for educators are limited, ultimately affecting student outcomes and exacerbating disparities (Tawfik et al., 2016). Administrators are also encouraged to discuss the need for accommodations for remote teaching with educators and staff who are in high-risk categories (CDC, 2020); however, this requires disclosure of health and other personal factors, including the health of at-risk family members, which may involve some risk for contract, pre-tenure, and other disproportionately vulnerable educators. It will be important to ethically consider how to safeguard both the privacy and well-being of educators and staff, recognizing that jeopardizing their health and safety subsequently jeopardizes the health and safety of students.

WORK, ORGANIZATIONAL AND HUMAN PERFORMANCE

The COVID-19 pandemic has dramatically disrupted the work that people are able to perform, forcing some out of work (U.S. Bureau of Labor and Statistics, 2020), radically disrupting operations, and exposing workers to new risks and challenges. Two key questions face workers and employers as they deal with the impact of COVID-19: 1) How are the changes in the workplace likely to impact worker, team, and organizational performance, and what can be done to maintain performance at the highest possible level?; and 2) How are the changes in unemployment and the work context likely to affect worker well-being, and what can be done to maintain a healthy workforce?

Individual, team, and organizational performance (Klein & Kozlowski, 2000) are likely to be affected differently by pandemic-related disruption, including remote work. Among U.S. workers fortunate enough to retain their jobs, approximately half are now exclusively working remotely from home (Guyot & Sawhill, 2020), compared to roughly 7% prior to the start of the pandemic

(World Economic Forum, n.d.). A survey of U.S. workers who shifted to remote work as a result of COVID-19 indicates that 45% believe that they have become more productive and just 14% believe they are less productive (K. Oehler, personal communication, June 26, 2020). Yet, another survey found that 35% of employers are grappling with changes in employee productivity since the onset of COVID-19 in the U.S. (Society for Human Resource management, 2020). Key contributors to positive individual performance include clear goals (Locke & Latham, 2002) job-relevant knowledge and skills (Noe, 2020), high-quality feedback (Kluger & DeNisi, 1996) and engagement and motivation (Macey & Schneider, 2008). Surveys indicate that employers are investing in employee engagement, but that workers still feel less connected (Society for Human Resources Management, 2020). Team performance depends on clear membership, compelling goals, structures that enable collaboration and sharing of information, effective means of solving problems and resolving conflict, and outstanding coaching (How employees are feeling right now, 2020). The fact that most current work teams had the opportunity to work face-to-face before the pandemic should be helpful (Kraut & Resnick, 2012), but going forward it will be a challenge to integrate new members with reduced onsite contact. Another challenge will be team performance monitoring, which benefits from informal interactions (Driskell et al., 2018). Both team and organizational performance depend on workforce engagement, which requires fostering alignment with an organizational vision, demonstrating concern for workers and their well-being, adopting workplace policies that workers consider to be fair and reasonable, and ensuring that workers receive the support they need from their managers and leaders to be successful. Organizations need to ensure that pandemic-related policies are deemed fair, reasonable, and supportive by employees.

Workplace well-being is central to psychological health (Kossek et al., 2012) and constitutes a core employer obligation (Benoit, 2019). Remote and onsite work each present challenges and opportunities. Regarding remote work, a recent Australian study found that 39% of those working at home reported high or very high levels of psychological distress, a three-fold increase from 2018 (Katz, 2020). Such stress can be caused by social isolation, challenges to work-life balance, technology challenges, threats to autonomy, and concerns about career prospects (Abel & McQueen, 2020). Despite these challenges, the increased flexibility afforded by remote work is valued by workers (Cooper & Kurland, 2002). Keys to implementing remote work effectively include time for online social interaction, support for work-life balance, regular check-ins regarding job performance and career prospects, and effective use of technology and tools (Allen et al., 2015). While remote work has increased substantially, many jobs can only be done onsite—for example, food service, driving, caregiving, correctional work, and retailing. It is imperative for organizations to create a safe work environment for them (How employees are feeling right now, 2020). Yet, modifications for safety can make work more complex and slower, decreasing productivity (Society for Human Resource Management, 2020). Organizations can support their onsite workers by providing training on resilience and dealing with challenging interpersonal situations, while offering access to emotional support groups, behavioral health services (US Department of Veterans Affairs National Center for PTSD, 2020) and high quality, affordable childcare.

The necessary reliance on remote work currently poses particular challenges for the legal and criminal justice system. Possible risks to the administration of justice can arise from the inability of detainees to consult with counsel (who are not allowed to enter jails), the use of virtual arraignments, hearings and trials, prolonged pre-trial detention, and delays in the conduct of forensic mental health assessments (Godoy, 2020). Due to health safety concerns, detainees are

also unable to receive visits from family and friends, which can exacerbate feelings of isolation and depression (Penal Reform International, 2020). Persons of color are disproportionately affected due to their disproportionate representation among the prison population (Alexander et al., 2020). It is essential to safeguard the fundamental rights of all detainees, as well as to take action to safeguard their physical and psychological health.

One growing segment of the workforce meriting special consideration is *unemployed persons* (US Bureau of Labor and Statistics, 2020). Recent studies have shown that young adults (18-29) and Hispanic/Latinx and Black Americans were most likely to have experienced getting laid-off, losing a job, having difficulty accessing food and shelter, or taking a reduction in pay during COVID-19 (Coven & Gupta, 2020; Lopez et al., 2020; Schaeffer & Rainie, 2020). Psychological support can be provided as components of One-Stop Career Centers and job search services. Also hit particularly hard by the pandemic are *workers in precarious or low-paying jobs*, including housekeepers, food servers, custodial staff, drivers, and retail workers. These work conditions are associated with lack of protection and benefits, depression, and food and housing insecurity (US Bureau of Labor and Statistics, 2020). In the COVID-19 era, these challenges now include working in potentially unsafe conditions and pressure to continue to show up for work, no matter one's physical or psychological health. Psychologists, organizational leaders, and policy makers can support unemployed, precarious, and low-wage workers by advocating for raising the minimum wage (World Economic Forum, 2020), advancing policies that support decent and dignified work for all (Blustein et al., 2019) and ensuring consistent protections for workers (Austin, 2020).

Workers with elevated health risks and levels of stress include other groups of particular concern. Black workers face particular health risks, since they are over-represented in essential jobs in the health and transportation sectors where physical distancing is impossible (Gould & Wilson, 2020). Health care and long-term care workers (Lu, 2020), as well as workers classified as essential who work in high-risk industries, such as meatpacking, restaurants, transportation, teaching, hair styling, child care, and eldercare workers, also face elevated levels of stress and COVID-19 infection risk (Lu, 2020). Correctional officers and incarcerated individuals are exposed to environments that are often overcrowded and unsanitary (Blakinger & Hamilton, 2020; Park & Meager, 2020). With elevated physical health risks come threats to psychological health. Practical steps to mitigate these risks include workspace redesign, COVID-19 testing, contact tracing, safe spaces to quarantine, adequate health insurance, paid sick leave, and hazard pay. Working parents and others with dependent care needs also experience special challenges securing care that will allow unimpeded time to work, which can result in significant work-family conflict and stress (Poms et al., 2009). Older workers may face greater health risk, as well as technology challenges that can be overcome readily with training (Charness et al., 2001). Finally, *workers experiencing high levels of stress* due to the pandemic are in need of psychological support. Effective strategies include allowing for part- or full-time remote work, as necessary; part-time employment; and flexible work hours that include breaks for exercise and outdoor activities (Lau et al., 2019).

CONCLUSION

The discipline and profession of psychology -- with its strong foundation in science - is working with other disciplines, policymakers, and other stakeholders, including our global psychology partners, to help to reduce the morbidity and mortality caused by the coronavirus and to address its resultant widespread collateral damage in such areas as family life, educational attainment, and work productivity. Prolonged social isolation due to the pandemic has placed inordinate stress on many interpersonal/familial relationships and has threatened normal child development, which is dependent on interaction with peers and others. Likewise, our educational system has been upended with the necessity of implementing online instruction across levels, which is not equally accessible to low-income and other marginalized students. Employers have also become dependent on remote work, which is not an option for front-line providers and other essential workers, with many other individuals becoming unemployed in the midst of layoffs and closures arising from the economic crisis. The expertise and diversity of the psychology field – which includes clinicians, researchers, educators, and consultants across numerous specialty areas – offers the synergy to develop compelling solutions to challenges arising from this global pandemic, including the disparities and inequities that have been exacerbated across our health, educational, employment, legal, and criminal justice systems.

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B.(5) Council voted to receive the report of the Work Group on Enhancing Council's Effectiveness as a Policy-Making Body.

Additionally, Council voted to refer the report to CLT and the Work Group on Enhancing Council's Effectiveness as a Policy-Making Body for a 45-day comment period.

C.(5A) Council voted to approve forwarding to the Membership for a vote the following amendments to the APA Bylaws (bracketed material to be deleted; underlined material to be added):

Article V. Composition of the Council of Representatives

1. Council shall be composed of Representatives of Divisions, Representatives of State, Provincial and Territorial Psychological Associations, members of the Board of Directors, the Officers of the Association (the chief staff officer shall serve without vote), ~~and~~ [and] the Chair, Chair-elect or other designee from the Executive Committee of the American Psychological Association of Graduate Students (APAGS) and one Representative from each affiliated Ethnic Minority Psychological Association. In the event that any Representatives of a given Division, State/Provincial/Territorial Association or Ethnic Minority Psychological Association cannot be present, Council will seat one member as an Alternate Representative for that meeting, provided such member is an officer of or has been designated in advance by the relevant Division, State/Provincial/Territorial Association, or Ethnic Minority Psychological Association. Representatives shall hold office until their successors are elected and qualify, except that a Representative who has been elected to the Board of Directors shall continue to be a member of Council after the expiration of the individual's term as Representative, and after the election and qualification of the individual's successor as Division or State/Provincial/Territorial Association Representative, until the expiration of the individual's term as a member of the Board of Directors.

4. Council Representatives of a Division or State/ Provincial/Territorial Association shall be members of the Division or State/Provincial/Territorial Association, and Members of the American Psychological Association, and shall be elected for a period not to exceed three years.

If during that three-year period the Division or State/Provincial/Territorial Association is allocated fewer seats, the Division or State/Provincial/ Territorial Association shall recall the appropriate number of Representatives. The term of office of the recalled member is thereby terminated. Council members from the Ethnic Minority Psychological Associations shall be members of their respective constituencies and members of the American Psychological Association and shall be selected for a period not to exceed three years.

5. Each APA Fellow, Member, and voting Associate member shall choose the Division(s) or State/Provincial/Territorial Association(s) through which he/she elected to have his/her interest represented on Council by allocating, at the time of the annual dues statement, a total of ten (10) votes to the Division(s) and/or State/Provincial/Territorial Association(s) through which he/she wishes to be represented the following year. However, only Fellows, Members (or voting Associate members) of the Divisions or State/Provincial/Territorial Associations so designated will be allowed to [nominate and] elect their Council Representatives. The representative of each of the Ethnic Minority Psychological Association shall be designated by the respective association.

7. A Council member who has served for six consecutive years shall not be eligible for election or appointment for a period of one year as a Representative from any Division, State/ Provincial/Territorial Association, Ethnic Minority Psychological Association, or coalition.

Article XVI. Ethnic Minority Psychological Associations

1. An Ethnic Minority Psychological Association may, upon vote of Council, be affiliated with the American Psychological Association provided that the Council deems it in the best interests of the Association for such Ethnic Minority Psychological Association to be so affiliated.

2. For purposes of this article, the following Ethnic Minority Psychological Association shall be deemed affiliated with the American Psychological Association: the American Arab, Middle Eastern and North African Psychological Association; the Asian American Psychological Association; Association of Black Psychologists; National Latinx Psychological Association; and the Society of Indian Psychologists.

3. Each Ethnic Minority Psychological Association that is affiliated with the American Psychological Association shall be afforded one voting representative serving on the Council of Representatives of the American Psychological Association. Any Ethnic Minority Psychological Association that opts not to send a voting Representative to Council may instead send a non-voting delegate, in accordance with rules promulgated by Council.

4. Each Ethnic Minority Psychological Association shall exercise such control over its members so that membership in such association shall not imply membership in the American Psychological Association.

5. In the event that Council finds that any conditions of affiliation are not being fulfilled by an Ethnic Minority Psychological Association or that its affiliation is no longer in the best interest of the American Psychological Association, the principal officers of the Ethnic Minority Psychological Association shall be so informed and the affiliation may thereafter be terminated by a two-thirds vote of Council.

6. The American Psychological Association shall not be responsible for the acts or omissions of the Ethnic Minority Psychological Associations, except as specifically authorized by these Bylaws or other duly promulgated rule of Council.

Note: Subsequent articles to the Bylaws will be renumbered.

Additionally, Council voted record individual votes on the vote to include statements in favor of and against adopting with the bylaw amendment ballot and require publication of those votes in a designated location on APA's website.

Council ultimately voted to only include an explanatory statement with the bylaw amendment ballot that is sent to the membership.

D.(23) Council received as information an update on the work of the Advocacy Coordinating Committee.

VII. PUBLICATIONS AND COMMUNICATIONS

A.(6) Council voted to approve the creation of a new journal published by APA, titled *Journal of Chinese Career and Work Psychology*.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(7) Council voted to approve the following amendments to Association Rule 90-4 (bracketed material to be deleted; underlined material be added):

90-4. COMMISSION FOR THE RECOGNITION OF SPECIALTIES AND ~~[PROFICIENCIES]~~ SUBSPECIALTIES IN PROFESSIONAL PSYCHOLOGY

There shall be a Commission for the Recognition of Specialties and ~~[Proficiencies]~~ Subspecialties in Professional Psychology. The Commission shall (a) facilitate the development, implementation and review of effective and coordinated policies and procedures to improve quality and process in recognition of specialties and ~~[proficiencies]~~ subspecialties in professional psychology; (b) review petitions from organizations requesting the Association's recognition of a professional specialty or ~~[proficiency]~~ subspecialty, (c) establish mechanisms for the periodic evaluation and renewal of such recognition; and (d) make recommendations regarding consistency in the use of the terms "specialty" and "~~[proficiency]~~ subspecialty" by the Association. The Commission shall select from among recognition petitions it reviews those deemed appropriate to recommend to the Council of Representatives as meriting formal confirmation. Council shall confirm the recognition of a specialty or ~~[proficiency]~~ subspecialty in professional psychology only when such recommendation for recognition shall have been placed before it by the Commission following the completion of an evaluation conducted according to the Commission's procedures.

Subject to review by the Board of Directors, the Commission shall have the authority for adopting procedures for reviewing specialty and ~~proficiency]~~ subspecialty petitions. The Commission may make proposals to the Council of Representatives regarding: (a) the principles that define

specialties and [~~proficiencies~~] subspecialties and the criteria for their recognition, and (b) the processes by which the Association confers and maintains its recognition of specialties and [~~proficiencies~~] subspecialties.

B.(8) Council voted to adopt the following as APA policy: (1) Revised Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties, and approves December 31, 2030 as the expiration date for the Guideline; (2) Principles for the Recognition of Subspecialties; (3) Revised Principles for the Recognition of Specialties; and, (4) Revised Procedures for the Recognition of Specialties and Proficiencies.

C.(9) Council voted to approve the recognition of Clinical Psychopharmacology as a specialty in professional psychology for a period of seven years.

D.(10) Council voted to approve the continued recognition of Clinical Child and Adolescent Psychology as a specialty in professional psychology for a period of seven years.

E.(11) Council voted to approve the continued recognition of Police and Public Safety Psychology as a specialty in professional psychology for a period of seven years.

F.(12) Council voted to approve the continued recognition of School Psychology as a specialty in professional psychology for a period of seven years.

G.(13) Council voted to approve an extension of recognition of Counseling Psychology as a specialty in professional psychology for an additional period of one year, to expire in August 2021.

H.(14) Council voted to approve an extension of recognition of Sleep Psychology as a specialty in professional psychology for an additional period of one year, to expire in August 2021.

I.(24) Council received as information an update from the Board of Educational Affairs/Board of Professional Affairs Task Force to Delineate Competencies for Students Completing Master's Level Programs in Health Service Psychology.

X. PROFESSIONAL AFFAIRS

A.(15) Council voted to approve withdrawal of Council New Business Item NBI 25A/Aug 2013, Guidelines for Psychologists Regarding the Assessment of Trauma for Adults.

B.(19) Council received as information an update on the business pending item, Healthcare Practice Guideline Policy (NBI #13B/March 2018).

C.(25) Council received as information an update on the work of the Advisory Steering Committee for Development of Clinical Practice Guidelines and APA Guideline Development Panels and plans for 2020.

XI. SCIENTIFIC AFFAIRS

A.(16) Council voted to adopt the following Resolution on Ownership of Exotic Animals as Pets as APA Policy:

APA Resolution on Ownership of Exotic Animals as Pets

INTRODUCTION

Humans have coexisted and interacted with other animals in various ways, including as household pets. And there is gathering evidence that ownership of pets such as domesticated dogs and cats, combined with supportive psychosocial mechanisms, contributes to enhancing and sustaining physical and psychological wellbeing (McNicholas, Gilbey, Rennie, Ahmedzai, Dono, & Ormerod, 2005; O'Haire, 2010). However, ownership of exotic animals as pets presents myriad multifaceted challenges not associated with traditional pet ownership. While there is no single widely accepted definition of exotic animals, for the purpose of this resolution, exotic animal is defined as non-domesticated, carnivorous and/or dangerous animals, typically found in the wild, and often not native to the United States, such as but not limited to lions, tigers, bears, nonhuman primates, elephants, kangaroos, antelopes, and anteaters (USDA, 2017). Furthermore, unlike most other human endeavors involving other animals that are regulated at the federal, state, and/or local levels, such as food production, research, and entertainment, there is no single system of regulatory oversight for exotic pet ownership, as federal, state and local laws and regulations apply, which vary widely across jurisdictions (Lucca, 2013; Nyhus, Ambrogio, Dufraine, Shoemaker, & Tilson, 2009).

RATIONALE

Unlike livestock, dogs, and cats, exotic animals are not domesticated and have not evolved to live in close contact with humans. As such, their behavior is adapted for interacting with others of their species, not with humans. This presents a number of significant challenges that pose a risk to the health and well-being of both humans and the animals themselves.

First and foremost, ethical justifications for people to own exotic animals are lacking.

Furthermore, as exotic animals are rare in captivity and their behavior and biology can differ significantly from domesticated animals, private owners rarely have access to the behavioral management and veterinary expertise required to properly care for these animals (Soulsbury, Iossa, Kennell, & Harris, 2009; USDA, 2000). Second, many species require access to members of their own species for normal social and psychological development and private owners often cannot provide the necessary social environment (Soulsbury et al., 2009). Third, human caregivers can carry diseases that cause limited symptoms or are easily treatable in people but can be deadly to other animals (Montali, Mikota, & Cheng, 2001). These diseases are easily transmitted between humans and non-human animals through contact. For example, in humans, the herpes simplex virus 1 can be dormant and flare up, or cause symptoms such as blisters around the mouth, when the immune system is compromised due to illness, fatigue, stress, etc. This same virus, though, can be fatal to nonhuman primates, such as marmosets (Huemer, Larcher, Czedik-Eysenberg, Nowotny, & Refinger, 2002).

In addition to the concerns for the wellbeing of the exotic animal, there are serious and potentially fatal consequences for other humans and nonhuman animals who come into contact with exotic animals. Species-typical social behaviors that exotic animals show to one another can result in disease transmission and/or severe injury to human caregivers (Favoretto, de Mattos, Morais, Alves Araujo, & de Mattos, 2001). For example, many new world monkeys, including capuchins engage in a behavior called urine-washing, which consists of depositing urine on the hands and rubbing it all over their bodies. While this ritualized behavior may serve a healthy social communication function among the monkeys, it can pose a health risk to

humans through contamination of the living environment (Penakalapati, Swarthout, Delahoy, McAliley, Woodnik, Levy, & Freeman, 2017). Similarly, aggressive play fighting, which is a normal behavior among nonhuman primates, can cause serious physical harm to human caregivers (Nyhus, Tilson, & Tomlison, 2003; Soulsbury et al., 2009; USDA 2000). Exotic animals can also carry diseases that cause limited symptoms in their own species but can be deadly to humans (Center for Disease Control and Prevention, 2003). For example, Herpes B virus, which is extremely common in macaques, can be transmitted to humans through bites and scratches. While macaques are not affected by the virus, it can cause a potentially fatal brain disease (meningoencephalitis) in humans (Ostrowski, Leslie, Parrott, Abelt, & Piercy, 1998). Finally, escape by or inappropriate release of exotic animals can have a range of detrimental effects on public health and safety (Hopper & Lloyd, 2011; Martinez, 2009; Marano, Arguin, & Pappaioanou, 2007; Walsh, 2009) and on the ecosystem (Dorcas, Wilson, Reed, Snow, Rochford, Miller, et al., 2012; Reuter, Gilles, Wills & Sewall, 2016).

WHEREAS The American Psychological Association values the well-being of humans and non-human animals (APA, 2017, 2019);

WHEREAS Private ownership of exotic animals poses a health hazard to humans as well as may compromise public safety (Chomel, Belotto, & Meslin, 2007; Osborne, 2019; Smith, Smith, & D'Auria, 2012; Stack, 2019);

WHEREAS Private ownership of exotic animals poses physical and psychological health hazards to the animals themselves (Grant, Montroe, & Wills, 2017);

WHEREAS Private owners of exotic animals rarely have access to the behavioral management and veterinary expertise required to properly care for the animals (Grant, Montroe, & Wills, 2017);

WHEREAS There is no single system of regulatory oversight for exotic animal ownership, with regulations varying widely across state and local jurisdictions (Lucca, 2013; Nyhus, Ambrogi, Dufraigne, Shoemaker, & Tilson, 2009);

THEREFORE BE IT RESOLVED that the American Psychological Association joins with other organizations (American Society of Primatologists, 2001; Association for the Prevention of Cruelty to Animals, 2019) in opposing the private ownership of exotic animals including nonhuman primates, large cats, large reptiles, and other carnivores in the absence of a comprehensive system of regulatory oversight for protecting the wellbeing of the animals as well as ensuring public health and safety (Schuppli, Fraser, & Bacon, 2014).

BE IT FURTHER RESOLVED that the American Psychological Association endorses recommendations by other scholarly organizations for increased regulatory oversight of exotic animal ownership (American Veterinary Medical Association, 2019; American Society of Primatologists, 2001; British Veterinary Association, 2014, 2015).

BE IT FURTHER RESOLVED that the American Psychological Association recommends that the types of exotic animals that can be safely owned as pets be determined by a national panel of experts in diverse fields including animal behavior, conservation, ecology, veterinary medicine, and public health, convened by a respected entity such as the National Academies of Sciences,

Engineering, and Medicine, only exotic animals on the list be legally allowed to be owned as pets, and that the list of acceptable exotic pets be regularly reviewed and updated.

BE IT FURTHER RESOLVED that the American Psychological Association recommends that the ownership of exotic animals be based on the Convention on International Trade in Endangered Species of Wild Flora and Fauna (1973) and be strictly regulated by requiring registration with and licensing by the United States Department of Agriculture (USDA); attestation that the owners will comply with the Animal Welfare Regulations (9 CFR §1.1); documentation of appropriate health screening by qualified veterinarians on a regular basis, and inspection of the premises on which the animals are maintained by the Animal Plant Health Inspection Service (APHIS); and that such programs be funded by user fees.

THE BE IT FURTHER RESOLVED that in situations in which private owners cannot properly care for their exotic animals qualified authorities (e.g. governmental wildlife agencies, accredited animal facilities) should be consulted to find appropriate placement or release mechanisms to ensure that the ecosystem is not jeopardized by unauthorized release of these animals into the wild.

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XII. PUBLIC INTEREST

A.(17) Council voted to archive the following 2002 *Resolution on Ageism*:

Resolution on Ageism

Whereas psychologists have documented the role of ageism in assessment and treatment of older adults, the degree to which aging does (or does not) affect human behavior and performance, the effects of age stereotypes, the extent to which ageism is a factor in workplace discrimination, among other concerns related to age and behavior; and

Whereas over the past several years APA has affirmed its opposition to discrimination and stereotyping based on gender, race, physical disability, sexual orientation, and ethnicity; and

Whereas most recently (February 1999) APA affirmed by Council resolution its support of Affirmative Action and equal opportunity for all persons regardless of race, gender, age, religion, disability, sexual orientation and national origin; and

Whereas APA embraces diversity in all efforts and programs and recognizes the dimension of age as an important element of diversity;

Therefore, be it Resolved, that the American Psychological Association rejects ageism in all its forms and is committed to support efforts to eliminate it from our society.

Council also voted to adopt as APA policy the following 2020 *Resolution on Ageism*:

APA Resolution on Ageism

Introduction

Negative stereotypes of aging (ageism) continue to raise serious problems that lead to discrimination and unfair treatment of older adults. Since the adoption of the first APA Resolution on Ageism in 2002, there has been a wealth of empirical evidence documenting that ageism, including negative self-perceptions, are associated with a host of negative psychological and physical outcomes in older adults and societal impacts across health care, employment, education and training, and policy settings. While ageism is a construct that can impact individuals across the life span, and there is increased research attention to ageism directed toward younger people (e.g. Chasteen, Horhota, & Crumley-Branyon, 2020; Bratt, Abrams, & Swift, 2020), the focus of this resolution is the older adult population (defined as individuals 65 years and older). Although old age is defined differently across contexts such as housing, job discrimination, determination of eligibility for benefits, and across societies (O’Rand & Henretta, 2018), “older adults” typically refers to persons 65 years of age and older and is widely used by gerontological researchers, policy makers and in other APA policies, such as the Guidelines for Psychological Practice with Older Adults (APA, 2014).

Resolution

WHEREAS ageism is stereotyping and discrimination against individuals or groups on the basis of their age (Butler, 1969); ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs (Cuddy, Norton, & Fiske, 2005; World Health Organization, 2020);

WHEREAS research has demonstrated the pervasive and institutionalized nature of prejudice against older persons in the United States (Nelson, 2015; Ng, Allore, Trentalange, Monin, & Levy, 2015) and globally (Chang, Kanno, Levy, Wang, Lee, et al. 2020; Lou & Dai, 2017); that expressions of ageism (and respect for older adults) can vary across cultural groups and societies (Hess et al, 2017; Peterson & Ralston, 2017); and that ageism remains prevalent with disregard to its effects (Donizzetti, 2019; Levy, 2001; Nelson, 2015);

WHEREAS psychologists have documented the degree to which aging does (or does not) affect human behavior and performance, ageism’s effects on age stereotypes, health status, treatment and outcomes, and the extent to which ageism is a factor in discriminatory practices and policies including discrimination in health care, workplace, criminal justice systems (Phelan & Ayalon, 2020), built environment e.g. access to sidewalks and alternatives to stairs (APA, 2020; Haselwandter, et al., 2015), education and training (Boswell, 2012; Eymard, & Douglas, 2012; Levy, 2018), and policy arenas (Lloyd-Sherlock, Ebrahim, McKee, & Prince, 2016; North, & Fiske, 2013);

WHEREAS ageism is ubiquitous in the mass media in the United States (AARP, 2019) and promoted by stereotypes in advertisements, entertainment, greeting cards, and news stories

that present older people as physically or cognitively disabled, lonely and depressed, or objects of ridicule (Levy, 2016; Cuddy, Norton, & Fiske, 2005; Kite, Stockdale, Whitley, & Johnson, 2005; Thayer & Laura, 2019);

WHEREAS Stereotype Embodiment Theory (Levy, 2009) and related research has shown that older adults often assimilate negative age stereotypes from the surrounding culture, leading to negative self-definitions that have a detrimental effect for older individuals on a wide range of health outcomes, including increased risk for coronary heart disease, stroke, diabetes, chronic lung disease, chronic illness and, depressive symptoms (Jackson, Hackett, & Steptoe, 2019), increased prevalence of suicidal ideation, anxiety, and post-traumatic stress disorder in older adult veterans (Levy, Pilver, & Pietrzak, 2014); higher levels of biomarkers of Alzheimer's disease (Levy, Ferrucci, Zonderman, Slade, Troncoso, & Resnick, 2016), and decreased likelihood of engaging in preventative health behaviors (Levy & Myers, 2004); and, worse memory performance, functional health, will to live, and life expectancy (Levy, 1996; Levy, Ashman, & Dror, 2000; Levy, Slade, & Kasl, 2002; Levy, Slade, Kunkel, & Kasl, 2002; Meisner, 2012; Sargent-Cox, Anstey, & Luszcz, 2012);

WHEREAS ageism may impact the health care older adults receive such as older adults being: less likely to receive a mental health evaluation and referral after being identified at risk for suicide in an emergency department compared to young adults (Arias et al., 2017); receiving less treatment, and encountering more limitations in life-sustaining treatments, even when controlling for severity of illness (Ayalon et al., 2020; Brandberg, Blomqvist, & Jirwe, 2013; United Nations, 2020); and being less likely to be included in clinical trials compared to younger adults due to medical complexity, even for diseases that disproportionately affect older adults such as cancer (Hurria et al., 2015), leading to knowledge gaps regarding the use and benefit of new treatments in older adults (Chang et al., 2020); and older adults with Alzheimer's disease and other dementias, and residents of nursing homes, are at particularly high risk for stigma and devaluation of their lives (Evans, 2018; Lion et al., 2019; O'Connor & McFadden 2012) which is a global problem (Farina, Suemoto, Burton, Oliveira, & Frost, 2020; Małgorzata et al., 2019) and at risk for disrespect, mistreatment, and poor quality of care across diverse settings (Timmons et al., 2016; Williams et al., 2017; Zarowitz, Resnick, & Ouslander, 2018);

WHEREAS ageism in the workplace (e.g., 3 in 5 older workers have either seen or experienced age discrimination in the workplace [Perron, 2018]) has negative consequences for older adults including being less likely to be selected for job interviews and training opportunities than younger adults (Abrams, Swift, & Drury, 2016; Harris, Krygsman, Waschenko, & Laliberte Rudman, 2017); being less likely to be recruited or supported in service roles, such as Teach for America (Morrow-Howell, Gonzales, James, Matz-Costa, & Putnam, 2018), experiencing age-based discrimination compared to younger workers (Shippee, Wilkinson, Schafer, & Shippee, 2019); the US Supreme Court in *Babb v. Wilkie* (2020) has affirmed the importance of protecting older workers from age discrimination; and experiencing age-based discrimination compared to younger workers (Shippee, Wilkinson, Schafer, & Shippee, 2019); and concerns about age discrimination in the workplace are global problems (Harada, Sugisawa, Sugihara, Yanagisawa, & Shimmerl, 2019);

WHEREAS ageism is also a serious concern in the criminal justice system, with many older adults being victims of elder abuse (Phelan & Ayalon, 2020; Pillemer, Burnes, Riffin, & Lachs, 2016) and financial exploitation (Lichtenberg, 2016), and having poorer outcomes when they are victims of

civil and criminal offenses, which are often not investigated or taken seriously due to undue skepticism about their testimony (Pittman, Toggia, Leone, & Mueller-Johnson, 2014) or viewed as less serious because of factors such as the denigration of the value of older adults' lives (Callan, Dawfry, & Olson, 2012; Goodwin & Landy, 2014);

WHEREAS social norms generally include sanctions for statements of prejudice and discrimination based on race or sex, yet ageist statements often go unchallenged such as the growth of older people portrayed as a threat, e.g. as a "Silver Tsunami" or natural disaster (Chrisler, Barney, & Palatino, 2016; Frameworks Institute, 2015);

WHEREAS causes of ageism are diverse and have been explained by multiple theoretical mechanisms (Lev, Wurm, & Ayalon, 2018) that include Terror Management Theory (Bodner, 2009; O'Connor, & McFadden, 2012); and Social Identity Theory (Chonody, & Teater, 2016);

WHEREAS ageism is a stressor that may chronically activate the physiological system with adverse health effects, and has been shown as a mediator between income inequality and older people's self-rated health (Vauclair et al., 2015; 2016);

WHEREAS ageism intersects with sex, race, ethnicity, gender identity and expression, sexual orientation, disability, health, socioeconomic status, social class, and multiple devalued identities accumulate to create compounded disadvantages (Ferrer, Grenier, Brotman, & Koehn, 2017; Purdie-Vaughns & Eibach, 2008); and individuals with multiple stigmatized identities face greater risk for poor health outcomes due to multiple types of marginalization (Adelman, Greene, & Ory, 2000); and contexts such as rural/urban setting, and access to and familiarity with technology can heighten such disadvantages (Skoufalos, Clarke, Ellis, Shepard, & Rula, 2017);

WHEREAS ageism negatively affects older adults with disabilities whose needs are multifaceted, and older people with disabilities are often ostracized, made to feel ashamed, and unequal when others define them by their health condition versus as individuals (Larsson & Jönson, 2018; Sheets, 2005);

WHEREAS older adults with disabilities are at risk for double jeopardy (the combined effects of age and disabilities) (Shaw, Chan & McMahon, 2021) and at grave risk for experiencing institutional ageism, which impedes older adults from securing similar rights and accommodations given to younger people with disabilities in order to be full participants in their society (Larsson & Jönson, 2018);

WHEREAS gendered ageism, or the combination of ageism and sexism, results in double jeopardy: Older women are discriminated against both because they are women and because of their age (e.g., Krekula, Nikander, & Wilińska, 2018), with many studies showing greater ageism toward older women compared to older men (Barrett & Von Rohr, 2008; Chonody, 2015; Chrisler et al., 2016; Clarke, & Korotchenko, 2016; Calasanti, King, Pietilä, & Ojala, 2016). However, while some men are relatively immune to ageism (Calasanti, King, Pietilä, & Ojala, 2018; Clarke, & Korotchenko, 2016), research on cultural images of men's aging has shown that aging men often lose their power and status due to retirement and a loss of bodily performance (Kornadt, Voss, & Rothermund, 2013);

WHEREAS racial and ethnic minority older adults also face a double jeopardy, due to the additive effects of age and race, resulting in far poorer health for older African-American and Hispanic older adults compared to White older adults, with this difference magnified compared to results in younger adults (Carreon, & Noymer, 2011), and that across the lifespan, African-American and Hispanic older adults face a health insurance double jeopardy that leaves them uninsured for longer periods through their lives compared to White older adults (Kirby & Kaneda, 2013);

WHEREAS the Institute of Medicine (IOM, 2012) identifies older LGBTQI adults as an at-risk and under-served population and older sexual minority adults, compared to their heterosexual peers, have a higher risk of disability, worsened mental health, and poorer health behaviors (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013);

WHEREAS older adults living with HIV experience intersecting or layered stigmas due to their sexual orientation, age, race and ethnicity, gender identity/expression, disability, or drug use (Earnshaw, Bogart, Dovidio, & Williams, 2013; Stangl, Lloyd, Brady, Holland, & Baral, 2013);

WHEREAS socioeconomic status can compound experiences of ageism, with the common perception that older people are not contributors to society, together with a societal context characterized by income inequality, is likely to increase older people's vulnerability to age prejudice (Abrams, Russell, Vauclair, & Swift, 2011; Garstka, Schmitt, Branscombe, & Hummert, 2004);

WHEREAS the ageist views that pervade society decrease trainee interest in pursuing careers focused on older adults, leading to gross workforce shortages (IOM, 2008; IOM 2012; Whitbourne & Montepare, 2017), including in psychology where less than 2% of psychology health service providers specialize in Geropsychology (APA, 2016) and these shortages have a notable negative impact on older adults' ability to receive care that adequately meets their unique needs;

WHEREAS ageism can also become formalized and adopted as a part of public policy and it has been argued that focusing healthcare policy on "premature mortality," defined by the World Health Organization as deaths that occur between the ages of 15 and 70, devalues lives of people over this arbitrary age of 70; thus such institutionalized devaluation of older individuals may perpetuate negative attitudes about older people and the value of their lives in policy discussions (Lloyd-Sherlock, et al., 2016) including the failure of any comprehensive federal response to the growing challenges of older adults in areas of caregiving, funding for long-term care, and Medicare reimbursements for end of life services (Belluck, 2015; Blancato & Ponder, 2015; United Nations, 2020);

WHEREAS similar to other forms of bias and discrimination, effective interventions including professional education about aging (Brown, Kother, & Wielandt, 2011; Chonody, 2015), intergenerational contact with older adults that can reduce prejudice (Abrams, et al., 2006; Levy, 2018; Lytle & Levy, 2019; Mellor, McCabe, Rizzuto, & Gruner, 2015), and implicit-age-stereotype interventions (Busso, Volmert, & Kendall-Taylor, 2019; Levy, et al. 2016), exist to reduce ageist beliefs, counteract ageist myths (e.g., myths that all older people are the same and most older adults experience significant cognitive decline that jeopardizes their everyday function, including job performance) and the impact of ageist stereotypes (Burns, et al., 2019).

THEREFORE BE IT RESOLVED that the American Psychological Association continues to reject ageism in all its forms and commits to support efforts to eliminate it from our society.

BE IT FURTHER RESOLVED that the American Psychological Association:

Recognizes age as a risk factor for discrimination and includes consideration of ageism within all discussions of equity, diversity and inclusion; bias, stigma, and discrimination; and health disparities and health equity.

Maintains a commitment to combating ageist language in all its communications, including with the public, through adherence to the Bias-Free Language Guidelines of its Publication Manual and condemn the continued and willful use of ageist language and/or images.

Encourages its Offices, Boards, Committees, Divisions, as well as State and Territorial Psychological Associations to educate their colleagues about research and interventions to combat ageism and promotes psychology and aging as an important career path within the profession.

Scrutinizes its own practices to assure that older members of the Association are treated with fairness and dignity.

Encourages the inclusion of aging content and a lifespan developmental focus in curricula across levels of psychology training, including education on the contributions of older adults to society, a balanced view of aging (vs. deficit- and disease-focused), and the prevalence and negative effects of ageism in order to reduce discrimination based on personal characteristics. Training should also include aspects of history, culture, and intersectionality that might magnify the effects of ageism.

Encourages students and psychologists to become familiar with resources that provide accurate and science-based information on the aging process and evidence-based practice such as the APA Guidelines for Psychological Practice with Older Adults, and Age and Health-related Changes: Reality vs. Myth

Encourages psychology training in the intersection of age with sex, race, gender, sexual orientation, disability, health and socioeconomic status, social class, and other stigmatized identities and encourages psychologists to be informed about the implication of these intersections for mental health and strategies for appropriately addressing their impact through relevant literature and trainings.

Encourages the development of resources and tools to cultivate age-supportive practices and proactively deter ageism in research and clinical care including training for health care professionals and psychologists that includes supervised experience with older adults where relevant.

Promotes and facilitates psychologists' acquisition of competencies with respect to how they can be active agents of change to reduce the marginalization of older adults via ageist beliefs.

Encourages a more productive public narrative about the heterogeneity of older adults and positive benefits of longer lifespans that addresses systemic occurrences of ageism across multiple societal settings (e.g., employment and healthcare).

Supports appropriate interdisciplinary and inter-organizational collaborations to address entrenched ageism.

Encourages APA to work with government agencies and private funding sources to promote research and prevention and intervention efforts to counter ageism and its impact.

Supports appropriate legal and policy interventions to fight age discrimination across diverse settings including healthcare, employment, education and criminal justice.

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B.(20) Council received as information an update on the business pending item, Police Citizen Contact New Business Item from Peace Psychology Division Violence Summit (NBI #21A/Feb 2017).

XIII. ETHNIC MINORITY AFFAIRS

No items.

XIV. INTERNATIONAL AFFAIRS

No items.

XVI. FINANCIAL AFFAIRS

A.(26) Council received as information the 2019 Audited Financial Statements.

On Wednesday afternoon, Dr. Melba Vasquez was presented with the 2020 APA President's Lifetime Achievement Award.

Additionally, on Wednesday afternoon, Dr. Kathleen Brown, Advocacy Coordinating Committee chair, and Katherine McGuire, APA Chief Advocacy Officer, provided Council with an advocacy update.

On Thursday morning, Jean Carter, PhD, APA Treasurer, provided Council with the financial report.

The following new business item was submitted at the August 2020 meeting (referral groups will be provided when available): 18A, Resolution on Interrogation of Criminal Suspects.

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