

Council of Representatives
August 5 & 6, 2025

APPROVED MINUTES

I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its February 21 & 22, 2025, meeting.

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) Council voted to elect the 96 members listed to Fellow status, on the nomination of the indicated divisions and on the recommendation of the Fellows Committee and the Board of Directors.

B.(22) Council was provided with an update on the new business in progress item, Expansion of Membership Eligibility to Master's-Level Psychology Professionals (NBI #17E/February 2025).

III. ETHICS

No items.

IV. BOARD OF DIRECTORS

No items.

V. DIVISIONS AND STATE AND PROVINCIAL AND TERRITORIAL ASSOCIATIONS

No Items.

VI. ORGANIZATION OF THE APA

A.(3) Council voted to extend the expiration date for the 1) Competencies for Psychology Practice in Primary Care and the Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists to December 31, 2026 and 2) Standards for Educational and Psychological Testing to December 31, 2028.

B.(3A) Council voted to reject the following motion:

That Council approves the following amendments to the Association Rules
(bracketed/strikethrough material to be deleted; underlined material to be added):

60-1. COUNCIL LEADERSHIP TEAM

60-1.1. ~~There shall be a Council Leadership Team (CLT). that shall~~ The CLT's role is to assist, support, and empower Council in its governing functions. To fulfill this role, CLT will facilitate various processes on Council's behalf, ensuring continuous communication through reports and meetings. Transparency between the Council

Leadership Team and Council members will ensure that CLT's work aligns with Council's priorities and requests. CLT's responsibilities will include the following:
a) inform Council of the activities of the Board of Directors; b) manage a procedure to select and oversee Council's strategic issue discussions; ~~b~~c) assist the Agenda Planning Group in prioritizing and determining the appropriate disposition of new items coming through the triage system; ~~e~~d) assist the President in determining the priorities for Council and the order of business for meetings of Council; ~~e~~e) initiate and oversee the work of any boards and committees reporting directly to Council; ~~e~~f) provide a recommendation to Council on all motions brought before Council for its consideration; ~~f~~g) regularly review the structure and function of Council (including orientation of new members) and handle complaints about Council functions and operations; and ~~g~~h) lead Council in reviewing and approving the strategic plan and ensure that APA policies are aligned with APA's mission and strategic plan.

To support Council members in fulfilling their fiscal responsibilities to APA, CLT will ensure that the same financial information and orientation provided to the BOD will be given to Council members.

210-1. FINANCE COMMITTEE

210-1.2 The Finance Committee shall, on an annual basis, complete a review of the various policies that govern the Association's financial strategies. The policy review will include an emphasis on the Association's Investment Policy, policies relevant to the financial status of any subsidiaries of the Association, the ways in which the budget supports strategic priorities, and any other policies that address financial planning and management. A full written report including what was included in the review, the results, and recommendations will be provided to Council within 60 days of completion of the review. Council may request a Town Hall meeting for further discussion. Council may request a Town Hall meeting for further discussion.

210-2. BUDGET

210-2.1 Council delegates to the Board the authority for decision-making related to budget and financial matters. At least annually, a report on the Association's budget and finances will be provided to Council on behalf of the Board of Directors.

The Finance Committee shall review the annual budget as proposed by the Chief Staff Officer and recommend approval and/or revisions as it deems appropriate. The Board will review the proposed budget and recommendations from the Finance Committee and will formally seek input from Council about the proposed budget. The Board of Directors review should also include consideration of how the proposed budget aligns with approved strategic priorities and input received from Council. After the Board's initial review of the proposed budget and within a timeframe which allows the Finance Committee to meet required timelines, the Board will submit a preliminary budget to Council for review and input. The Board shall then approve the annual budget with a vote of 2/3 majority of members voting.

Following the approval of the budget by the Board of Directors and before the start of the budget year, the Board shall provide the budget and any relevant documents to the Council for review. CLT shall provide at least one virtual meeting for Council to discuss the budget and to provide feedback to the Board. That meeting shall be recorded, and the recording shall be accessible to Board of Directors and Council members. If there are any significant concerns about the approved budget, Council may ask the Board of Directors to address those concerns and make any necessary adjustments during the fiscal year. At least annually, a report on the Association's budget and finances will be provided to Council on behalf of the Board of Directors.

This section shall be reviewed by Council based on evaluation reports submitted by the Board of Directors and the Finance Committee at three-year intervals beginning the first meeting of Council in ~~2023~~ 2028.

210-2.3 To achieve these goals, the ~~chief executive officer~~ Chief Executive Officer (CEO) shall be responsible for developing the Association's annual budgets to be submitted to the Board of Directors for approval. These budgets shall be reviewed, modified, and approved ~~first by the Finance Committee and then the Board of Directors prior to submission as information to Council.~~ according to the process described in 210-2.1. ~~prior to submission as information to Council.~~ Council approval is required for any single, unbudgeted item that exceeds ~~\$3~~ \$2 million or any sale of Association real estate. The strategic planning process should represent the avenue by which the Association's priorities are set and new initiatives are approved.

This section shall be reviewed by Council based on evaluation reports submitted by the Board of Directors and the Finance Committee, at three-year intervals for effectiveness beginning the first meeting of Council in ~~2023~~ 2028.

Council also voted to reject the following motion:

That Council approves the following amendments to the Association Rules (bracketed/strikethrough material to be deleted; underlined material to be added):

110-10 CHIEF STAFF OFFICER SELECTION AND CONFIRMATION

110-10.1 The Board of Directors shall appoint a search committee to identify candidates for the position of ~~chief staff officer~~ Chief Staff Officer. The Search Committee shall be made up of seven individuals, including a Chair selected by the President, three Council members selected by CLT, and three Board members selected by the President. The Chair and Chair-Elect of CLT may serve as Board members on this committee. CLT members shall not serve as Council members on this committee. ~~After the Board of Directors has completed its deliberations on the candidates and has selected the nominee for the position, the Board shall forward the nomination to the Council of Representatives for a confirmation vote.~~

The Search Committee will review the job description for the Chief Staff Officer and will seek input from Council members and Board members regarding possible revisions to

the job description and regarding important areas to include in the interviews with candidates. The Committee may engage an independent consultant to assist the committee.

The Search Committee shall identify a list of potential candidates. Up to three preferred candidates from the list will be identified for the position, who will then be interviewed by the Search Committee and rank ordered. The Search Committee will then refer the confidential list of potential candidates and the rank-ordering of the three preferred candidates to the Board of Directors who shall select the top candidate from the entire list. The candidate shall prepare a presentation and Town Hall for the Council in executive session after which Council will vote to confirm the candidate.

110-10.2 Confirmation requires a two-thirds affirmative vote of those voting. Those eligible to vote will be members of the current Council of Representatives. The votes may be conducted by electronic means.

110-10.3 ~~There is a minimum seven day electronic balloting period for the confirmation vote.~~ The confirmation vote will be by confidential ballot sent by the Recording Secretary of the Association. Voters shall indicate on the ballot whether or not they confirm the nominee. Ballots will be returned to the Recording Secretary, who will supervise the tabulation of the vote. CLT will designate the start and end dates of the voting process with a minimum of seven days and a maximum of 30 days. Results of the vote, with a tally of votes cast, shall be reported to Council by the Recording Secretary within two weeks following the close of balloting.

~~This section shall be evaluated by Council at three year intervals beginning the first meeting of Council in 2023.~~ in the calendar year after each implementation.

110-10.4 In the event that the confirmation vote fails to reach the two-thirds threshold, other candidates on the confidential list shall be reconsidered by the Board of Directors. If no candidates on the list are approved by the Board, then the search committee shall be tasked to identify additional candidates to refer to the Board in the same manner they used in 110-10.1. When a new candidate is approved by the Board the procedures stated in 110-10.1 to 110-10.3 shall be followed.

110-11. CHIEF STAFF OFFICER EVALUATION

110-11.1 The Board of Directors is charged with the supervision of the CEO and with the evaluation of the CEO using input from others. In addition, the performance of the chief staff officer shall be subject to an annual evaluation by a review committee of seven individuals, including a Chair selected by the President, three Council members selected by CLT, and three Board members selected by the President. The Chair and Chair-Elect of CLT may serve as Board members on this committee. CLT members shall not serve as Council members on this review committee. At the time of the evaluation, the review committee shall request formal input from Council. An independent consultant may be engaged to assist the committee. The Board of Directors is charged with the development of procedures and instruments designed for that purpose such

as a 360 degree or similar evaluation which the review committee will use to conduct the evaluation. The Board may delegate the choice of procedures and instruments to the review committee. Upon the completion of their evaluation of the chief staff officer's performance, the Board will communicate the results to Council in confidence. The review committee shall report the results of their evaluation to the Board of Directors and Council in confidence. The Board shall then utilize these results to guide decisions about both bonus and salary for the Chief Staff Officer. If Council has concerns or questions about these decisions, they may request a meeting with Board to discuss them. The Board and the review committee shall submit reports to Council evaluating the effectiveness of the process.

This section shall be reviewed by Council at three-year intervals beginning the first meeting of Council in ~~2023~~ 2028.

110-12. CHIEF STAFF OFFICER RECONFIRMATION

110-12.1 ~~At such time as the chief staff officer is subject to reconfirmation, the evaluation form used for the committee appointed to conduct the Chief Staff Officer's annual review will conduct an evaluation as described in Association Rule 110-11.1 shall to address the chief staff officer's performance specifically in terms of his/her their reconfirmation. At the time of the evaluation, the review committee shall request formal input from Council about reconfirming the CEO.~~

110-12.2 Reconfirmation of the Chief Staff Officer requires a two-thirds affirmative vote of the Board of Directors and of Council. Those eligible to vote for reconfirmation shall be the current Board of Directors and Council. The votes may be conducted by electronic means.

This section shall be reviewed by Council based on evaluation reports submitted by BOD as to its effectiveness at three-year intervals beginning the first meeting of Council in ~~2023~~ 2028.

110-12.3 ~~The reconfirmation vote shall be by confidential ballot sent by the Recording Secretary of the Association. Voters shall indicate on the ballot whether they approve or disapprove the reconfirmation. The Recording Secretary will announce the confidential results to Council within two weeks following the close of balloting. This section shall be reviewed by Council at three-year intervals beginning the first meeting of Council in 2023. This section shall be reviewed by Council based on evaluation reports submitted by Board of Directors and Council in the calendar year after each implementation.~~

C.(16) Council received as information an update on the Council Liaison Program.

D.(17) Council was provided as information an update from the Diversity Impact Statement Committee.

E.(18) Council received as information a report from the Advocacy Coordinating Committee.

VII. PUBLICATIONS AND COMMUNICATIONS

No items.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(4) Council voted to approve a one-year extension of recognition of Addiction Psychology, Sport Psychology, and Biofeedback and Applied Psychophysiology as proficiencies in professional psychology, as well as Clinical Health Psychology, Couple and Family Psychology, Group Psychology and Group Psychotherapy, Clinical Neuropsychology, Industrial-Organizational Psychology, Behavioral and Cognitive Psychology, Serious Mental Illness Psychology, School Psychology, Clinical Child and Adolescent Psychology, Police and Public Safety Psychology, and Clinical Psychopharmacology as specialties in professional psychology.

B.(5) Council voted to adopt as APA policy the *Guidelines for Clinical Supervision in Health Service Psychology* and approves December 31, 2035 as the expiration date for the guidelines.

X. PROFESSIONAL AFFAIRS

A.(6) Council voted to approve the following operational principles to guide the current and future work to develop a licensure pathway for master's level health service psychology (M-HSP) that is competitive with other master's level mental health providers and distinct from doctoral psychologists:

- The title and scope of practice for M-HSP practitioners should meet public health needs and protect and educate the public about this group of providers
- Master's level practitioners in psychology should have an appropriate title that does not include "psychologist" but establishes its base in psychology
- M-HSP practitioners should have a scope of practice that ensures they are competitive in the marketplace with other behavioral health master's level practitioners outside of psychology
- M-HSP practitioners should be able to provide some services, independently without supervision and within a defined standard appropriate to the master's level of education, training, and supervision, including psychotherapy and diagnostic intake
- M-HSP are included in health service psychology (HSP)
- M-HSP are distinct from other mental health practitioners (in that they are grounded in psychology science, education and training)
- The doctoral degree is the highest credential in psychology. The scope of practice for doctoral psychologists is distinct from that of M-HSPs, reflecting more advanced training, broader competencies, and a higher level of preparation across clinical, scientific and leadership domains. This distinction reinforces the doctorate's recognized professional contribution, advanced expertise, and professional standing within the field.
- The licensure pathway for M-HSP should be consistent with the scope of practice and not

inherently more burdensome than that of other master's behavioral health professionals

B.(7) Council voted to adopt as APA policy the *Guidelines for Psychology's Role in Pediatric to Adult Health Care Transition* as APA policy and approves December 31, 2035 as the expiration date for the Guidelines.

C.(8) Council voted to adopt as APA policy the *APA Professional Practice Guidelines for Psychologists in the Assessment of Psychological Trauma in Adults* and approves December 31, 2035, as the expiration date for the Guidelines.

D.(9) Council voted to adopt as APA policy the *APA Professional Practice Guidelines on Psychologists' Involvement in Pharmacological Issues* and approves December 31, 2035, as the expiration date for the Guidelines.

E.(9A) Council voted to postpone the item, NBI #19A/Aug 2024: Policy and Position Statement on the Use of Seclusion and Restraint and Policy Initiatives: Avoiding Institutional Harm and Promoting Evidence-Based Practices in Psychiatric Settings, to its February 2026 meeting.

F.(9B) Council voted to adopt as APA p as APA policy the following *Maternal Mental Health Resolution on Racially Minoritized Women*:

Maternal Mental Health Resolution on Racially Minoritized Women*

State of Affairs: Maternal Health and Mental Health Disparities

WHEREAS the United States continues to have a maternal health crisis, with racially minoritized women reporting higher rates of maternal mortality and morbidity compared to their non-Hispanic white counterparts (World Health Organization, 2023). Black women, for example, are three times more likely to experience life-threatening pregnancy complications and nearly four times more likely to experience pregnancy-related deaths (Creanga et al., 2014; Howell, 2018). Indigenous and Alaska Native women also have double the rates of maternal mortality compared to non-Hispanic White women. Asian/Pacific Islander women also experience slightly higher rates of maternal mortality than White women. Hispanic women report slightly lower rates of maternal mortality compared to White women (Kaiser Family Foundation, 2022). Many of these disparities exist among racially minoritized women at higher rates than non-Hispanic White women, regardless of education and socioeconomic status (Braveman, 2015). Thus, socioeconomic status (SES) alone cannot explain these differences. These maternal health risks can elevate the risk for maternal mental health risks for racially minoritized women;

WHEREAS maternal mental health conditions are the most common complication of pregnancy and birth, affecting 800,000 families each year in the U.S. (Fawcett et al, 2019, Gavin et al., 2005). Mental health conditions are the leading cause of maternal deaths, with suicide and overdose being the leading cause of death in the first year following pregnancy (CDC, 2024). These maternal mental health and substance use disparities (behavioral health) increase when race, ethnicity, gender, SES and other social drivers are considered;

Comorbidities

WHEREAS there are comorbidities at the intersection of behavioral health and physical health that are important to consider. For example, mental health conditions were the leading underlying cause of pregnancy-related death among Hispanic and non-Hispanic White women (CDC, 2024). However, cardiac and coronary conditions were the leading underlying cause of pregnancy-related deaths among non-Hispanic Black women and hemorrhage was the leading underlying cause of death among non-Hispanic Asian women (CDC, 2024). American Indian/Alaska Native and Indigenous women have the highest rates of pregnancy-associated, drug-related death and suicide than any other racial or ethnic group (Margerison et al., 2022);

WHEREAS birthing trauma, vicarious trauma, race-based trauma as well as the range of other trauma experiences (e.g., IPV, sexual and physical assault, human trafficking, etc.) across the life span impact the mental wellbeing of racially minoritized women. Moreover, it is important for ~~[physical]~~ health and behavioral health professionals across disciplines to be aware of the intersection of behavioral health and physical health in seeking to mitigate these disparities for racially minoritized women;

Social Drivers

WHEREAS systemic racism in healthcare and mental health care, economic policies, and social services contributes to racial disparities in maternal mental health outcomes. Access to quality preventative care, childcare, healthy food options, safe and stable housing, and other social drivers impact the mental wellbeing of racially minoritized women. A large body of research indicates that experiences of discrimination in healthcare settings are a primary social driver that contributes to maternal mental health disparities (Bohren et al., 2024). Discriminatory practices in insurance access, hospital policies, and workforce protections exacerbate maternal health disparities for racially minoritized women;

WHEREAS there is a paucity of research that focuses solely on maternal mental health and perinatal behavioral health conditions amongst racially minoritized women. There is also a lack of national data on maternal mental health screening practices by race and ethnicity. Further, there is a lack of data disaggregated by other intersectional social identities, such as SES, age, gender identity, disability status, etc.;

Limitations and Barriers to Accessing Care

WHEREAS racially minoritized women experience adverse social drivers that prevent access to maternal mental health treatment including: limited access to prenatal care, lack of transportation, housing, income, paid sick leave, paid parental leave, access to childcare, geography, access to insurance, language translation, and embedded cultural barriers including immigration status, and behavioral health stigma;

WHEREAS embedded cultural values about mental health vary across cultures and internalization of certain cultural values can be both protective and maladaptive. For example, for many Asian American women, depression can be viewed as a sign of weakness (Ta Park et al., 2017). Many Latinx women experience pressure to adhere to the concept of *marianismo*, which focuses on sacrifice to the detriment of one's own mental health (Ceballos et al., 2016). In addition, Black women experience pressure to adhere to the "Strong Black Woman" or "Superwoman" schema, which is also associated with an obligation to present an image of

strength, suppression of emotions, and prioritizing others needs above personal wellbeing (Woods-Giscombe et al., 2016). Thus, racially minoritized women experience some cultural barriers that, combined with structural barriers, can lead to reduced help-seeking and limited access to maternal mental health services;

WHEREAS according to the Maternal Mental Health Leadership Alliance, over 50 percent of cases of postpartum depression in racially minoritized women go under-reported. Further, according to the US Government Accountability Office, 40 percent of Black women suffer from maternal mental health conditions, and experience postpartum depression at a rate higher than their non-Black women counterparts. Latinx women have also been found to express somatization of symptoms at a greater rate than non-Latinx women (Escovar et al., 2018). Further, Latinx women who are undocumented experience more stress due to their undocumented status, which also contributes to a higher risk for postpartum depression (Policy Center for Maternal Mental Health, 2024);

WHEREAS racism and discrimination can lead to chronic stress, which can have negative effects on maternal health and pregnancy outcomes, such as higher rates of perinatal depression and preterm birth (Lewis, 2023; Liu et al., 2025; Markin & Coleman, 2023; Kaiser Family Foundation, 2022)~~[For example,]~~as well as epigenetic changes that affect child health and development (e.g., National Scientific Council on the Developing Child, 2020) and child mental health outcomes (e.g., Tung et al., 2024). In addition, *weathering*, defined as premature aging due to long term stress and discrimination (Geronimus, 1992), impacts racially minoritized women and can make pregnancy riskier for Black women at an earlier age and can also lead to Black women experiencing more chronic health conditions, such as diabetes and obesity further impacting pregnancy risk;

WHEREAS cultural factors, adverse social drivers, and racial discrimination can impact maternal mental health, birth outcomes and postpartum outcomes; these factors are more likely to be harmful for racially minoritized birthing women who have a physical and behavioral health disability (Akobirshoev, et al., 2019; Long-Bellil, et al., 2020; Valentine, et al., 2024);

Lack of Culturally Responsive Healthcare Workforce

WHEREAS stigma and under-utilization of care is further exacerbated by a lack of obstetric health care and mental health professionals specializing in providing culturally responsive maternal health and mental health care;

WHEREAS approximately 80 percent of psychologists in the United States identify as White, despite the fact that the U.S. population is becoming increasingly more racially and ethnically diverse (American Psychological Association, 2022). There is a growing behavioral healthcare workforce shortage, with a dearth of mental health providers who live in rural areas or who can speak multiple languages, which can limit access to culturally responsive and linguistically congruent care for racially minoritized individuals (National Institute for Health Care Management Foundation, 2023);

WHEREAS while certification in perinatal mental health exists (e.g., Postpartum Support International PMH-C certification), there is currently no standardized professional certification

or training requirement for clinicians who encounter perinatal individuals who have mental health conditions or predisposition to mental health conditions;

WHEREAS many racially minoritized birthing women in the United States do not have access to coverage for midwives, doulas, and other community health workers to help them overcome the challenges embedded within the United States healthcare system.

WHEREAS while the American College of Obstetricians and Gynecologists recommends screening for perinatal depression at specific intervals during pregnancy and post-partum in the “4th trimester,” lack of universal mental health education and screening, particularly during pregnancy, creates missed opportunities to counsel patients on symptoms and management of depression, anxiety, and other mental health disorders and to inform them about prevention and treatment resources available to them in clinical care and community settings;

Research and Data Recommendations

BE IT RESOLVED that the APA supports the routine disaggregation of international, national and state perinatal mental health data by racial and ethnic groups to more accurately reflect the distinct experiences and outcomes of racially minoritized women.

BE IT RESOLVED that in line with maternal mental health screening practices recommended by the American College of Obstetricians and Gynecologists, American Academy of Pediatrics and the U.S. Preventive Services Task Force, the APA calls for the development of a national funded implementation strategy to monitor maternal mental health screening practices, with publicly available data disaggregated by race and ethnicity to ensure racially minoritized women receive equitable and timely access to care.

BE IT RESOLVED the APA urges the collection and use of intersectional data that captures how intersecting identities, such as race, gender, socioeconomic status, immigration status, and disability, shape perinatal mental health outcomes for racially minoritized women.

Access to Care Solutions

BE IT RESOLVED the APA recommends that Federal and State legislative and economic policies that help to eliminate maternal mental health disparities and empower racially minoritized communities should be increased, prioritized, funded and implemented.

BE IT RESOLVED the APA urges states to establish innovative payment models to incentivize high-quality maternity, mental health, substance use and trauma care and support during and after pregnancy.

BE IT RESOLVED the APA believes it is critical to invest in and evaluate integrated behavioral health care in primary and specialty obstetrical and other women’s health settings to increase access to perinatal, pregnancy, and postpartum health and mental health services.

BE IT RESOLVED the APA urges states to establish innovative multidisciplinary clinical services which include behavioral health providers prior to pregnancy to educate, screen, evaluate, and treat persons from racially minoritized communities to prevent and/or reduce their risk for perinatal mental health and substance use conditions impacting their health as well as pregnancy outcomes.

BE IT RESOLVED the APA calls on greater investment in digital and telehealth tools to improve maternal health outcomes for birthing individuals in underserved urban, rural, and frontier communities, undocumented women, and for birthing individuals who are incarcerated. These maternal mental health resources should be linguistically congruent and culturally responsive to promote maternal wellness.

BE IT RESOLVED to better understand the causes of the maternal health crisis in the United States and inform solutions to ameliorate the crisis, the APA encourages the creation of quality assessments to measure access to maternal health and mental health care across the nation.

BE IT RESOLVED the APA upholds that it is imperative that the US and countries across the Globe value, honor and invest in community-led maternal wellness initiatives that integrate culturally responsive, non-traditional, and Indigenous healing practices and settings, including birthing centers, non-traditional medical settings, and provide shared decision making between birthing individuals and their practitioners.

BE IT RESOLVED for all birthing individuals to access maternal health and mental health care, the APA recommends state funded investments to support long-term, respectful, collaborative relationships with community organizations and leaders.

Workforce Solutions

BE IT RESOLVED the APA supports increasing the number of racially minoritized individuals in the behavioral health workforce. Increasing racially diverse representation in behavioral health can improve trust between patients and providers, and reduce the chances of negative health outcomes for racially minoritized birthing individuals, including maternal mental health conditions.

BE IT RESOLVED the APA affirms that to overcome challenges in the United States perinatal and postnatal health care, it is necessary to increase access to midwives, doulas, birth workers, and other community health workers.

BE IT RESOLVED the APA recommends investments in training and supporting community health workers, midwives, doulas, and other birth workers to provide culturally sensitive and empathic perinatal mental health services, including expanding peer-led maternal mental health support programs within healthcare and community settings.

BE IT RESOLVED the APA calls on accreditation organizations, graduate and postgraduate clinical training programs and licensing boards to require training for people who encounter pregnant people, including obstetricians, gynecologists, labor and delivery nurses, midwives, other women's health providers, psychiatrists, psychologists, psychiatric nurses and nurse practitioners, social workers and other behavioral health providers to help screen, evaluate, treat, and prevent perinatal mental health issues before and during pregnancy and postpartum. This training should also include an understanding that a range of pharmacological and non-pharmacological psychological and behavioral approaches are often components of treatment for mental health and substance use disorders and may play a vital role in enhancing recovery, stabilizing families, and improving long-term outcomes for families, mothers, and children.

BE IT RESOLVED the APA recommends investments in growing the Black women mental health workforce and investing in Black women–led community-based organizations to aid in addressing the physical, mental and social factors outside of Black women’s control that lead to significantly higher maternal risk in this population.

BE IT RESOLVED in order to properly assess maternal mental health among racially minoritized women and birthing people to be heard and empowered during pregnancy and postpartum periods, the APA calls on health and mental health providers to utilize empathic, culturally sensitive and culturally responsive screening tools and treatment interventions.

BE IT RESOLVED the APA believes it is critical to maximize the number of mental health and integrated behavioral health care providers in primary and specialty obstetrical and other women’s health settings to deepen the mental health infrastructure to effectively support racially minoritized pregnant and postpartum people.

BE IT RESOLVED the APA advocates for state, national and international funding and policies supporting education, research, practice, and policies promoting and protecting all women’s human rights including the specific maternal mental health needs of racially minoritized women.

**Note: The spirit of this Resolution is to apply to all racially minoritized birthing individuals regardless of gender identity. The term “women” is utilized throughout this Resolution as the majority of current empirical work is limited to birthing individuals who identify as women.*

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E.(19) 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 2025.

XI. SCIENTIFIC AFFAIRS

A.(9C) Council voted to approve the following motion:

That the APA Chief Executive Officer submit an annual update to the Council of Representatives on APA's progress in implementing the 12 recommendations of the APA Task Force report "Addressing the Climate Crisis: An Action Plan for Psychologists."

That this annual update describes all APA activities related to climate change and include coverage of goals internally and externally, plans, roles of directorates and offices, key contacts for leadership, collaborations with other organizations, accomplishments, and challenges; and

That information about any ongoing and/or planned APA financial and staff resources devoted to climate change activities be included in annual budget materials.

B.(25) Council was provided with an update on the new business in progress item, Report on Consensual Non-Monogamy (NBI #17C/February 2025).

XII. PUBLIC INTEREST

A.(10) Council voted to archive the following *2020 APA 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).

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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); and

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; and

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); and

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, and 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, Provincial 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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Council also voted to adopt as APA policy the following *2025 Resolution on Ageism*:

APA Resolution on Ageism

Introduction

Ageism is a pervasive and deeply ingrained form of discrimination based on chronological age that negatively impacts individuals across the lifespan. However, its effects are particularly detrimental to older adults, as emphasized by the American Psychological Association's Guidelines for Psychological Practice with Older Adults (APA, 2024). This discrimination is rooted in stereotypes and prejudices that devalue older individuals, restrict their opportunities for equitable participation in society, and perpetuate systemic inequities (Butler, 1969). Research highlights the ubiquity of ageism, with a national sample of the U.S. population revealing that 93% of adults aged 50-80 reporting experiences of "everyday ageism," which often leads to internalized negative ageism—where individuals adopt societal stereotypes about aging into their self-concepts, adversely affecting mental and physical health (Allen et al., 2022; Levy, 2022). These stereotypes, reinforced by structural and individual-level discrimination, disproportionately affect marginalized communities, compounding the challenges faced by those within intersecting systems of oppression, including racism, sexism, classism, ableism, and heterosexism (Choi-Allum, 2024; Chan et al., 2024). Mass media further perpetuates these stereotypes, portraying older adults as frail, dependent, or cognitively impaired, limiting their self-image and belief in their potential (Bascu et al., 2024; Ng & Chow, 2021). Despite protective legislation like the Age Discrimination in Employment Act of 1967, these stereotypes continue to shape workplace practices, healthcare delivery, and societal norms. Recognizing the harm caused by these inequities, this resolution not only addresses the profound impacts of ageism but also advocates for systemic changes that promote dignity, respect, and inclusion for individuals of all ages.

Ageism Effects on Health

WHEREAS individuals who experience everyday ageism report a higher prevalence of chronic health conditions, poorer mental health, and increased symptoms of depression, with

internalized negative ageism being linked to declines in cognitive and physical health, aligning with stereotype embodiment theory, which posits that internalized societal stereotypes about aging become more salient and impactful with age, leading to negative consequences on daily functioning and overall health (Lin et al., 2024; Chang et al., 2020; Levy, 1996; Levy, 2009; Levy et al., 2016; Levy, 2022);

WHEREAS ageist attitudes among healthcare providers can result in underdiagnosis and undertreatment of mental health conditions in older adults by perpetuating erroneous assumptions that poor mental health, including depression, is a natural part of aging, while diagnostic frameworks like the DSM-5-TR may fail to recognize the distinct presentation of symptoms in older adults, including the influence of chronic medical conditions, medication side effects, and age-specific risk factors (Whitbourne & Martins, 2020; Carter et al., 2022);

WHEREAS verbal and nonverbal expressions of ageism by healthcare providers may lead older adults to internalize these biases, dismiss symptoms of depression or anxiety, and avoid seeking treatment, contributing to underrecognized mental health challenges and increased risks of suicide-related behaviors, particularly among men aged 75 and older, among whom suicide rates are highest, with firearms accounting for 79% of suicides in older male adults (Wuthrich & Frei, 2015; Centers for Disease Control and Prevention, 2024; Levy, 2004);

WHEREAS older adults contemplating suicide often do not present with severe depression and may visit their primary care physicians within a year of suicide without receiving appropriate mental health interventions or follow-up care, partly due to providers underestimating depressive symptoms and failing to account for psychological and medical risk factors, highlighting the need for multidisciplinary training to improve detection and care for mood disorders in older adults (Raue et al., 2014; Schmutte et al., 2022; De Leo, 2022; DeBois et al., 2024; Okolie et al., 2017);

WHEREAS societal ageism extends to academia, contributing to a workforce shortage in geropsychology, with only 3% of health service psychologists specializing in geropsychology despite the growing need to address mental health challenges in the aging population, underscoring the importance of increasing coursework and training on aging across all levels of psychology education, as outlined by the Pikes Peak model of competency in geropsychology (American Psychological Association, 2022; Whitbourne & Montepare, 2017; Knight et al., 2009; Garrison-Diehn et al., 2022; Levy, 2018);

Ageism and Work

WHEREAS the Age Discrimination in Employment Act (ADEA) of 1967 made it illegal for employers to fire or refuse to hire workers based on age, specifically protecting workers aged 40 and older from discriminatory practices that favor younger employees, yet ageism persists in the workplace in various forms, including biases against older workers' abilities, stereotyped beliefs about their attitudes, and both overt and subtle discriminatory practices (O'Loughlin et al., 2017);

WHEREAS women and workers in jobs that are vulnerable to loss or change are disproportionately affected by subtle forms of workplace age discrimination, such as interpersonal slights, and an AARP survey conducted in 2024 revealed that nearly two-thirds of

workers aged 50 and older reported experiencing age discrimination, with over half being asked to provide a graduation date during the hiring process and over 90% affirming the prevalence of age discrimination (Stypinska & Turek, 2017; Choi-Allum, 2024);

WHEREAS ageist stereotypes about older workers are perpetuated in online platforms, such as LinkedIn, where portrayals intersect with gender-based stereotypes, compounding challenges for older employees, particularly women, who face additional stress and restricted employment opportunities due to the intersection of ageism and other stigmatized identities (Xu & Previtali, 2022; Ndobbo et al., 2022);

WHEREAS workplace ageism can manifest as metastereotypes, wherein older workers believe others perceive them as possessing undesirable traits based solely on their age, leading to lower well-being, job satisfaction, and negatively impacting performance, as explained by social cognitive career theory, which highlights that interpersonal bias and a lack of recognition for contributions reduce self-esteem, vocational satisfaction, and mental health (Finkelstein et al., 2014; Foley & Lytle, 2015; Oliveira, 2022);

WHEREAS older workers who perceive that their contributions are undervalued are more likely to experience dissatisfaction, disengagement, and negative effects on their overall well-being, perpetuating inequities and limiting opportunities for meaningful participation in the workforce (Foley & Lytle, 2015; Oliveira, 2022; Levy, 2018);

Ageism in Language and Communication

WHEREAS elderspeak, a condescending speech pattern directed at older adults, mimics the tone used for babies and young children and reflects the broader phenomenon of infantilization, which assumes older adults are incapable of acting on their own behalf, thereby undermining their autonomy and dignity and contributing to feelings of disrespect and devaluation (Levy, 2009);

WHEREAS elderspeak represents an implicit form of ageism that not only lowers comprehension for older adults, particularly those with presbycusis (age-related hearing loss caused by cochlear changes), but also negatively impacts individuals with neurocognitive disorders, who may become resistant to care when they perceive healthcare workers as demeaning or infantilizing, further complicating the provision of support and treatment (Shaw & Gordon, 2021; Levy et al., 2016);

WHEREAS the use of elderspeak extends beyond healthcare settings, permeating media and societal interactions, normalizing infantilizing attitudes toward older adults and reinforcing ageist stereotypes, a pattern that begins early in life, as studies show children as young as seven years old adopt this speech pattern, perpetuating ageist attitudes across generations (Flamion et al., 2020);

WHEREAS combating the negative effects of elderspeak requires raising awareness about the dignity and autonomy of older adults, promoting respectful communication, and challenging societal norms that encourage or tolerate infantilizing language as outlined below;

Ageism and Intersectionality

WHEREAS ageism intersects with other systemic inequities, including sex, race, ethnicity, gender identity, sexual orientation, disability, health, religion, socioeconomic status, and social class, compounding disadvantages for individuals with multiple devalued identities, as evidenced by global findings of pervasive ageism across all 45 countries studied over 25 years, with significant adverse health effects particularly impacting older adults with less education (Chan et al., 2024; Chang et al., 2020; Hall et al., 2024; Steward et al., 2023);

WHEREAS older women often face unique challenges of invisibility, social devaluation, and irrelevance through stereotyping, such as "grandmotherizing." These challenges are compounded by cultural norms that may limit self-advocacy, as traditional roles and historical inequities have often restricted women's access to power in areas such as finance, employment, and decision-making. As they age, some women may internalize these limitations, feeling unworthy or constrained by beliefs about what they can or cannot do (Cecil et al., 2022; Westwood, 2023; Pearl & Percec, 2019; Gendron et al., 2023; Levy, 2016);

WHEREAS ageism interacts with other systems of oppression, including racism, sexism, classism, heterosexism, and cis-sexism, compounding disadvantages for individuals with multiple marginalized identities. Structural racism, for example, intersects with ageism in healthcare, exacerbating health inequities and barriers to care for older adults from racially and ethnically minoritized communities (Farrell et al., 2022);

WHEREAS social determinants of health, such as socioeconomic status, access to healthcare, and environmental factors, intersect with ageism to shape health disparities, with research identifying ageism as a critical social determinant of health that contributes to adverse outcomes across diverse settings (Mikton et al., 2021);

Countering Ageism

WHEREAS ageism, compounded by other forms of discrimination, can have devastating impacts on individuals, prompting global and national efforts such as the U.S. "Reframing Aging" movement, which promotes equitable aging through public education, intergenerational programs, and policies to reduce discrimination, and the World Health Organization's "#AWorld4AllAges" campaign, which supports legal, educational, and societal actions to counter ageism (Reframing Aging, 2024; World Health Organization, 2024);

WHEREAS inclusive language and positive messaging about aging play key roles in combating ageism, with the communicative ecology model of successful aging (CEMSA) emphasizing the importance of avoiding stereotypes and negative terminology, planning positively for the future, and promoting optimism and self-efficacy among older adults, supported by evidence that shifting beliefs about aging improves mental health and well-being (Fowler et al., 2015; Gettings & Kuang, 2022; Prati, 2024);

WHEREAS the age-friendly movement, aligned with the United Nations Sustainable Development Goals, seeks to reduce physical and social barriers, enhance accessibility and inclusion, and maximize individuals' intrinsic capacities and functional abilities, ensuring even those with capacity loss can meaningfully engage in valued activities, thereby promoting well-being and challenging societal ageism (Levy et al., 2022; World Health Organization, 2023);

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:

Discourages all forms of discrimination, including ageism, and recognizes age as a risk factor for discrimination, incorporating it into discussions of equity, diversity, and inclusion (EDI); bias, stigma, and discrimination; and health disparities and health equity.

Commits to combating ageist language and imagery in all communications, adhering to the Bias-Free Language Guidelines of its Publication Manual and the Inclusive Language Guide, while condemning the continued use of ageist language and stereotypes.

Promotes the education and training of psychologists and affiliates by encouraging Boards, Committees, Divisions, and State, Provincial, and Territorial Psychological Associations to advance research and interventions to combat ageism, advocate for psychology and aging as a vital career path and foster rigorous training on evidence-based methods for supporting the aging population.

Encourages the promotion of continuing education (CE) opportunities for psychologists across a range of specialties and expertise, recognizing that all psychologists may benefit from exposure to basic information about aging and working with older adults. For those interested in deeper training, the APA will facilitate systematic CE opportunities to enhance knowledge and skills for addressing the complex needs of older populations.

Encourages the inclusion of aging content and a lifespan developmental focus in psychology curricula and continuing education across all educational levels, integrating topics such as the contributions of older adults, the prevalence and negative effects of ageism, and strengths-based approaches to wellness. Training should also address historical, cultural, and intersectional factors that magnify the effects of ageism.

Supports psychologists in acquiring competencies for addressing the needs of older adults, including promoting awareness of APA resources such as the APA Guidelines for Psychological Practice with Older Adults (2024), Age- and Health-related Changes: Reality vs. Myth, the Multicultural Guidelines, the Race and Ethnicity Guidelines, and the Accessibility and Inclusion Maturity Model (AIMM).

Fosters training on the intersection of age with other identities, including sex, race, gender, sexual orientation, disability, socioeconomic status, and social class, and encourages psychologists to use informed strategies and evidence-based practices to address these intersections effectively.

Advocates for federal and state funding to support research on the health and behavioral needs of older adults, including brain health, the effects of trauma, and community-based initiatives that improve health and wellness.

Develops resources and tools to promote age-supportive practices, encouraging psychologists and healthcare providers to engage in supervised experiences with older adults, develop culturally competent services, and deter ageism in clinical care and research settings.

Encourages the development of public narratives that reflect the heterogeneity of older adults, the positive contributions of longer lifespans, and the systemic occurrences of ageism in settings such as employment, healthcare, and media.

Supports interdisciplinary collaborations with agencies, professional organizations, and media to address entrenched ageism through public policy, prevention, intervention, and advocacy efforts.

Advocates for legal and policy interventions to combat age discrimination in healthcare, employment, education, criminal justice, and other societal domains.

Encourages psychologists to address the behavioral health needs of older adults, focusing on maintaining social connections to reduce isolation and loneliness, mental stimulation to reduce cognitive decline, and evidence-based practices to support psychological well-being and promote strengths-based wellness approaches.

Explores new partnerships and coalitions to advance the role of psychological science in policy solutions for older adults and to secure funding and resources that promote their health and well-being.

Recognizes the critical importance of research in advancing the understanding of aging, ageism, and the unique behavioral and mental health needs of older adults, and advocates for expanded funding and support for research on lifespan development, interventions to reduce ageism, and strategies to enhance the quality of life and health outcomes for aging populations.

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B.(11) Council voted to archive the following *2009 Resolution on the Psychological Needs of Children Exposed to Disasters*:

Resolution on The Psychological Needs of Children Exposed to Disasters

Whereas children are particularly vulnerable to the negative effects of disasters (abrupt, disruptive public events) through their dependence on adults for psychological and physical safety and day-to-day care and their widely varying stages of development;

Whereas disasters, both natural and human-made, often lead to devastating psychological effects on the populations impacted;

Whereas disasters are increasing sources of human dysfunction (Hurricane Andrew, Midwest floods), as urban areas grow in population and geographic area/spread, as rural areas fall further behind in access to resources, as technology expands the potential for accidents and negative side effects (Three-Mile Island), and as the rise in international terrorism increases the probability that U.S. sites will be targeted (1992 New York's World Trade Center);

Whereas formal policies and procedures directed to preventing and treating psychological dysfunction resulting from the impact of disasters on children are absent or minimal in the public and private organizations established to provide relief;

Whereas the APA currently has in place collaborative disaster training and intervention activities with some relief organizations (e.g., the Red Cross), and whereas these activities should specifically address children's psychological needs;

Whereas the federal government generally has been slow to provide adequate leadership in the development and application of knowledge about child victims of disaster;

Whereas disaster relief efforts have sometimes failed to ensure the physical and psychological safety of child disaster victims;

Whereas research on the prevention of negative psychological effects and on the treatment of disaster victims has been limited and of varying degrees of methodological soundness--e.g., lacking in control groups, standard instruments, before and after measures--and research on children's needs and responses in disasters is particularly scant;

Whereas emerging research establishes the acute short-term and serious long-term negative effects of disasters on children's behavior and mental health as well as on that of their families;

Whereas the positive impact of selected interventions with children and their families exposed to disasters is beginning to emerge through research;

Whereas available research suggests differences related to gender, disability, and family status in children's vulnerability and responses to disasters and many children find ways to cope successfully with a variety of negative situations;

Whereas the significance of race and ethnicity in the prevention and treatment of psychological dysfunction in child disaster victims has not been systematically studied;

Whereas emerging research suggests that children disadvantaged by known risk factors such as poverty, disability, and abuse may be at higher risk for dysfunctional outcomes as a result of exposure to disaster and may also be disproportionately represented among disaster victims;

Whereas the unique features that typify the effects of disasters on children and their families, and on the public institutions that deal with them, create needs for special training of psychologists and other professionals in assessing damage and initiating and evaluating prevention and treatment programs;

Whereas the development and application of knowledge about the impact of disasters on children and their families have been impeded by critical shortages of qualified researchers and mental health practitioners specializing in work on the topic;

Whereas Section I of APA's Division 12 has published an extensive review of the literature, in which they have (a) reviewed the scientific knowledge about (i) the prevention of negative psychological effects of disaster on children, (ii) treatment of disaster-exposed children, (iii) effects of interventions on disaster-exposed children and their families, (b) identified critical gaps in knowledge about the effects of disasters on children and their families, and (c) suggested initiatives to enhance the state of knowledge in this area;

Whereas psychologists have ethical duties to promote human dignity and welfare;

Resolved, that the Council of Representatives of the APA finds and declares that the development and implementation of a national strategy to prevent and treat the psychological dysfunction resulting from exposure of children and their families to disasters is a matter of the highest priority, and supports the establishment of policies to maintain their psychological well-being;

Therefore, be it resolved that the American Psychological Association:

1) authorizes the Association's Committee on Children, Youth, and Families to pursue collaborative efforts with Section I of Division 12, Division 16, the Psychology in the Schools Program in the Practice Directorate, and the Association's Disaster Response Network, in view of these groups' expertise and recent work in this area, and other interested, involved entities within the Association to:

- consider development of guidelines to (a) identify the needs of children and families exposed to disasters, (b) prevent and treat the negative psychological sequelae in children and their families exposed to disasters through interventions shown to be effective through research and clinical knowledge, (c) utilize other psychological experts, committees, divisions, and previously established APA guidelines (e.g., Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1990)) as references and resources, in the formulation of guidelines;
- explore proposals for other dissemination of psychological knowledge about child disaster victims' needs, as well as possible guidelines, to the organization's state associations, divisions, the membership at large, and national relief organizations (e.g., Red Cross, Salvation Army, FEMA); and to explore proposals for developing public relations campaigns, developed in collaboration with health and relief organizations, summarizing current research and clinical knowledge about the needs of children and families in disaster situations; such campaigns to be adaptable to specific disasters as they occur within local communities;
- encourage the development of research protocols for implementing empirical investigations of the impact of disasters on children and their families to understand successful coping mechanisms and individual characteristics which lead to excellent long term functioning and to encourage the evaluation of mental health intervention following disasters;
- explore possible sources for research funding to support such empirical investigations; and
- select current, quality psychological research and clinical knowledge to be used to explore proposals for a possible national public relations campaign as described herein.

2) Recognizing the interest in the Practice Directorate's Disaster Response Network shown by the Substance Abuse and Mental Health Services Administration--the federal agency that works with the Federal Emergency Management Administration (FEMA) to ensure that disaster mental health needs are met--will advocate, in consultation with the Practice

Directorate, for FEMA or other federal agencies to support the continuing efforts of the federal agencies to maintain their existing information data bank on disasters and encourages expansion to include available resources.

3) In all activities conducted pursuant to this act, due consideration shall be given to the need for cultural competence and appropriate psychological service delivery and research protocols to serve ethnic minority children and their families.

4) In all activities conducted pursuant to this act, due consideration shall be given to the relation of the needs of children exposed to disasters to other social issues, including the status of children, the status of women, the status of ethnic minorities, the status of lesbian and gay families, the status of refugee and immigrant families, the needs of children with disabilities and or experiencing handicapping conditions, the needs of children suffering from abuse and neglect, the effects of poverty, problems of substance abuse, the welfare of families, and cultural beliefs about violence (DeLeon, in press).

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Council also voted to adopt as APA policy the following 2025 *Resolution on the Psychological Needs of Children Exposed to Disasters*:

Resolution on Resolution on the Psychological Needs of Children Exposed to Disasters

Disasters are large-scale events that are often unexpected or come with little warning, affect multiple systems, and can cause death, trauma, and destruction of property (Neria et al., 2008). Disasters affect millions of people around the globe every year (Centre for Research on the Epidemiology of Disasters, 2023). Disasters include natural phenomena (e.g.,

hurricanes, fires, drought, earthquakes), human-made events (e.g., war, terrorism, population migrations, mass shootings), and some public health emergencies (e.g., COVID-19 pandemic, SARS, MERS). Disasters have become increasingly prevalent across the globe for numerous reasons, including climate change (APA, 2011; IPCC, 2023). Indeed, children born in 2020 are expected to experience a two- to seven-fold increase in extreme weather events compared to people born in 1960 (Thiery et al., 2021).

WHEREAS there are multiple trajectories of psychological outcomes post-disaster, with the most common being resilience or recovery, followed by risk for chronic impairment (Bonanno et al., 2010; La Greca et al., 2013; Masten & Narayan, 2012);

WHEREAS children are particularly psychologically vulnerable to the effects of disasters due to their limited coping skills, widely varying stages of development, and dependence on adults for emotional and physical safety (Grolnick et al., 2018; Masten & Osofsky, 2010);

WHEREAS most children and youth may display short-term, transient distress, particularly if adequate supports are provided, others may develop more chronic negative psychological effects, including grief and symptoms of posttraumatic stress disorder, anxiety, depression, and externalizing behavior (Furr et al., 2010; Lai et al. 2021; Masten et al., 2015; Rubens et al. 2018; Schonfeld et al., 2015);

WHEREAS children's long-term psychological outcomes may be further impacted by prolonged exposure to disasters or multiple disasters, and whether additional stressors, such as loss of homes and primary care providers, exist (Kessler et al., 2006; Schonfeld et al., 2015). Although recovery and resilience are common, up to 30% of youth may experience chronic impairment post-disaster (Bonnano et al., 2010). The stress of pre-disaster evacuation activities may also contribute to psychological distress and symptomatology (La Greca et al., 2022);

WHEREAS research indicates disproportional rates of preparedness for and exposure to disasters and negative outcomes for children from one or more traditionally under-resourced communities, such as racial and ethnic minoritized populations (Pumariaga et al., 2022), groups with disabilities (Chakraborty, 2021; Mann et al., 2021), those who identify as girls (Rahmani et al., 2023), who identify as LGBTQ+ (Goldsmith et al., 2022), or are from lower socio-economic backgrounds (Rohwerder et al., 2022);

WHEREAS children from underserved communities disproportionately affected by social, economic, or geographic disadvantage may have lower access to support and evidence-based resources that may exacerbate their increased vulnerability to negative psychological outcomes following exposure to disaster (Morello-Frosch & Obasogie, 2023);

WHEREAS despite the potential for disproportional effects of disasters on children from underserved communities that may be affected by social, economic, or geographic disadvantage, the prevention and treatment of psychological distress in such populations has not been systematically studied (Burkhart et al., 2023; Gibbs et al., 2021);

WHEREAS given the potentially negative impact of disasters on children it is crucial to offer and evaluate mental health interventions across the spectrum of prevention and early, and later interventions for children and families;

WHEREAS there is limited, though promising, data suggesting the efficacy of pre-disaster preparedness. There is some evidence that preparedness interventions may increase knowledge and practical skills when faced with disaster (Codreanu et al., 2014); however, it is not clear that such interventions affect children's mental health;

WHEREAS interventions delivered in the days or weeks after a disaster, such as Psychological First Aid (PFA; Brymer et al., 2006), seem to benefit adults (Everly & Lating, 2021), with a few exceptions (e.g., Ramirez, 2013), no controlled studies of PFA for children exist. There is some evidence that empirically supported trauma treatments typically delivered weeks or months after exposure to the disaster, such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2016) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2003), can improve depression and PTSD in youth post-disaster (e.g., Fu & Underwood, 2015; La Greca & Danzi, 2019). Further, empirically-supported interventions for parents as well as interventions focused on parent-child relationships, such as Respond with CARE (Child Adult Relationship Enhancement) (Gurwitch & Brymer, 2024), can help improve children's mental health functioning;

WHEREAS children's mental health post-disaster is inextricably linked to how their families, schools, and communities adapt post-disaster (Bonanno et al., 2010; Felix et al. 2013a, 2013b, 2020; Lai et al., 2024), these ecological contexts are important pathways of intervention and support to promote children's recovery and resilience post-disaster. Given their accessibility, schools have the potential to be critical and effective hubs for disaster response (Lai et al., 2024);

WHEREAS the unique features of disasters create the need for special training of psychologists and other professionals in current best practices (e.g. IASC, 2007 and Sendai, 2015) for supporting the resilience and recovery of children and families post-disaster. This includes evaluating prevention and treatment programs and engaging in these activities through a cultural lens. Psychologists affected by disaster may also need peer support to manage their own and their clients' needs;

WHEREAS the development and application of knowledge about the impact of disasters on children and their families have been impeded by critical shortages of qualified researchers and mental health practitioners specializing in work on the topic (Grolnick et al. 2018);

WHEREAS research on disasters and evaluation of post-disaster services requires specialized designs and funding mechanisms, given their unpredictable nature;

WHEREAS psychologists have ethical duties outlined within *APA's Ethical Principles of Psychologists and Code of Conduct* (APA, 2017a) to safeguard the welfare and rights of individuals as well as respect the dignity and worth of all people with particular attention to vulnerable persons or communities, including children and youth;

THEREFORE BE IT RESOLVED that the Council of Representatives of the APA declares that the development and implementation of a national strategy to prevent and treat the psychological sequelae of exposure of children and their families to disasters is a matter of the highest priority and supports the establishment of policies to maintain their psychological well-being.

THEREFORE BE IT RESOLVED that the American Psychological Association undertake the following activities:

- Encourage culturally informed research aligned with *APA's Multicultural Guidelines* (APA, 2017b) on the development, implementation, and evaluation of interventions to encourage resilience and mitigate the potential psychological effects of disasters on children and their families and promote effective coping strategies that lead to long-term enhanced functioning.
- Support efforts to increase research funding to engage in empirical investigations of preparedness interventions and multiple tiers of interventions post-disaster. This should include innovative delivery modalities (e.g., digital tools) and training of non-professional personnel (e.g., peers, paraprofessionals, community members) to deliver interventions. Encourage both private funding organizations and governmental agencies to make available to the extent possible rapid and accessible funding options for disaster relief and long-term recovery.
- Encourage the use of evidence-based mental health screeners and assessments to identify the psychological needs of children and families exposed to disasters in the settings they are most likely to access and receive support (e.g., school-based screenings). Advocate for increased funding for training of school staff to implement trauma-informed practices, conduct mental health screenings post-disaster, and coordinate evidence-based post-disaster interventions.
- Encourage increased governmental funding for disaster relief at the local, state, federal, and international levels that includes support for mental health screening, assessment and multiple tiers of intervention for youth and families. Prioritize funding that will reduce disparities in access to resources and interventions for under-resourced communities. Collaborate with relief organizations to identify a plan to disseminate evidence-based resources to under-served communities to assure health equity.
- Serve as a central resource to the public, communities, and those agencies that serve children and families in disseminating best practices and guidelines for supporting the mental health of children and families before and after disasters.
- Collaborate to disseminate evidence-based disaster planning materials and resources on mental health supports for disaster recovery efforts for children and families with international relief organizations (e.g., the International Federation of Red Cross and Red Crescent Societies, World Health Organization, CARE International), governmental partners (e.g., Administration for Strategic Preparedness and Response, Federal Emergency

Management Agency, Office of Victims Crime, Substance Abuse and Mental Health Services), national organizations (e.g., National Child Traumatic Stress Network, National Association of School Psychologists, Pediatric Disaster Centers of Excellence), state organizations (e.g., State, Provincial, and Territorial Psychological Associations), and other community health organizations.

- Encourage training programs in psychology to include education components on current best practices in disaster mental health services.
- In all activities conducted under this resolution, consideration should be given to the specific needs of under-served communities, including LGBTQ+ families, refugee and immigrant families, children with disabilities, and children facing abuse or neglect, poverty, or problems of substance use.

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- C.(12) Council voted to adopt as APA policy the following policy statement on *Disability Inclusion: Combating the Stigma and Discrimination of Ableism*:

Disability Inclusion: Combating the Stigma and Discrimination of Ableism

Combating the stigma and discrimination of ableism aligns with the American Psychological Association’s (APA) commitment to using psychological science to benefit society and improve lives. The APA upholds its ethical duty to challenge systemic injustices and advocate for policies that promote human welfare (APA, 2017, 2021, 2025a). Individuals with disabilities have historically been among the most marginalized and vulnerable groups in society. “Disability” encompasses physical, sensory, intellectual, developmental, psychiatric, and cognitive

conditions, as well as chronic illnesses and communication disabilities. Many of these may be invisible or fluctuating in nature (Bogart & Dunn, 2019). Disability is also a unique identity group and social position because any person can acquire a disability at any age. Today, over 1.3 billion people worldwide live with significant disabilities (World Health Organization [WHO], 2023), including more than one in four (28.7%) adults in the United States (Centers for Disease Control and Prevention [CDC], 2024). People with disabilities form the largest minority group globally when defined as a single, cross-cutting group with shared systemic barriers—despite the diversity within that group (WHO, 2022).

The greatest hardship for this group is often not the disability itself but the unscientific attitudes and systemic barriers that constitute ableism (Olkin, 1999, 2017; Patten, 2024). Ableism is defined as stereotyping, prejudice, discrimination, and social oppression toward people with disabilities (Bogart & Dunn, 2019), and contributes to health disparities and negatively impacts the mental health of people with disabilities (APA, 2025a). Ableism manifests in many ways, including inaccessibility, exclusion from participation, abuse, and neglect. Many people with disabilities experience both blatant and subtle discrimination in employment, housing, education, child-rearing, caregiving, marriage and partnership, and healthcare, including mental health services (APA, 2022). Ableism can profoundly affect well-being; when compounded by other forms of discrimination (e.g., racism, sexism, and ageism), its impact can be even more severe and enduring (Wang et al., 2024).

Inaccessibility of Environment (Physical, Auditory, & Digital) People with disabilities encounter substantial barriers in navigating physical environments in the United States and globally. Inaccessibility in the constructed environment, such as buildings, bathrooms, and pedestrian infrastructure, create obstacles for people with impairments (Hammel et al., 2015). People with disabilities also face problems of access, affordability, and reliability of public transportation services (Boadi-Kusi et al., 2023). These various challenges impact their ability to participate fully and be included in society. Despite the Americans with Disabilities Act (ADA), compliance and enforcement of this federal civil rights law and its regulations remain inconsistent (Nykiforuk et al., 2021).

Beyond physical inaccessibility, barriers in the auditory, linguistic, and visual environments exclude people with developmental disabilities and sensory processing disorders (SPDs), those who are blind or have low vision, and those who are deaf or hard-of-hearing (Jaiswal et al., 2018; Shadrack, 2020; Sousa et al., 2024). For example, during the COVID-19 pandemic, individuals who rely on lip reading, such as the deaf or those with hearing impairment were disproportionately affected by mask-wearing, creating significant barriers to effective communication. These barriers could have been avoided through inclusive practices like wearing transparent masks. In the digital space, people with disabilities also face disparities in internet access and digital literacy (Pacheco & Burgess, 2024), as well as exclusion due to lack of screen reader compatibility, inaccessible forms, and omission of image descriptions. Technological advancements, such as self-service interactive devices, are often inaccessible and unusable for many people with disabilities (Bin Noon et al., 2024). Taken together, these obstacles negatively impact the participation of individuals with disabilities in everyday activities like education, employment, civic engagement, and social life, correlating with reduced overall well-being (Aitken et al., 2022; Marom & McNeney, 2024; Murphy et al., 2024).

Reduced Healthcare Access

Individuals with disabilities frequently encounter barriers to healthcare access due to prejudicial beliefs embedded in some healthcare systems and held by other relevant stakeholders.

Individuals with disabilities often have holistic healthcare needs that remain unmet, receiving crucial diagnoses and treatments much later than non-disabled individuals (Meade et al., 2014; Patten, 2024). These disparities are exacerbated when intersecting marginalized identities are involved, notably in women with disabilities, people of color with disabilities, those who live in rural areas, LGBTQ+ people with disabilities, Medicaid beneficiaries, and immigrants with disabilities, who often report infrequent standard check-ups, reduced access to preventive care, and higher rates of life-threatening conditions (Apodaca et al., 2022; Ayahan et al., 2020; Bogenschutz, 2014; Horner-Johnson, 2021; Meade et al., 2014; Mulcahy et al., 2023; Ngondwe & Tefera, 2025).

Implicit ableist attitudes among healthcare workers also contribute to disparities. Studies show statistically significant preferences for working with non-disabled patients due to presumptions about the energy needed to meet the individual needs of patients with disabilities (Ames et al., 2024; VanPuymbrouck et al., 2020). Assumptions that people with disabilities have lower cognitive abilities and worse quality of life contribute to expectations that those individuals will not participate in healthcare decision making nor benefit from health services. This often leads to the cyclical nature of this group being viewed as “less than” or unknowledgeable about their own health needs, leading many to either fight to be heard or decline future healthcare services.

When considering reproductive health rights, people with disabilities have historically been overlooked and even denied access to services that non-disabled people often accessed freely. Despite perceptions of forced sterilization being an outdated eugenics practice, approximately 31 U.S. states still allow forced sterilization even in the 2020s (National Women’s Law Center, 2022). Lack of sex education and reproductive health services further undermine the bodily autonomy of people with disabilities, implying they should not have decision-making powers related to sexual activity and procreation (Ayhan, et. al., 2000). Moreover, invisible disabilities including olfactory and tactile conditions like chemical sensitivities and allergies which lead to medical consequences can easily be overlooked, further contributing to ableism.

Ableism can sometimes adopt a more benevolent-appearing form, involving well-intentioned attitudes that nonetheless perpetuate harmful stereotypes and unscientific assumptions about people with disabilities (Nario-Redmond et al., 2019). For example, out of a desire to protect a person with a disability, health care systems may favor care settings that are segregated from the general community for people with disabilities, even if the person with a disability is fully capable of participating in the general community with appropriate supports and services, which has the impact of undermining the person’s independence and sense of self-determination. The U.S. Supreme Court ruled in 1999 that such unjustified segregation constitutes a form of discrimination under the ADA; however, full enforcement of the ADA and *Olmstead v. L.C.* (1999) remains a challenge to this day.

Barriers to Educational and Vocational Inclusivity

Ableism can also exist in the full spectrum of educational settings from K-12 schools to graduate education programs. In an education context, ableism suggests that some abilities are “normal”

or “better”, in turn ranking some people’s relative worth based on these abilities (Oregon Department of Education, n.d.). Like in other settings, ableism can manifest in a variety of ways, both subtle and overt. For example, an educator may misattribute a symptom of a student’s disability (i.e., inability to focus due to a learning disability) to a behavioral problem or overall lack of discipline. This bias amplifies the risk of learning loss due to unfair disciplinary procedures in schools, and in fact, students with disabilities are overrepresented in disciplinary matters. Recent studies show that while only 17% of K-12 students have a disability, they account for 24% of in-school suspensions, 29% of out-of-school suspensions, 21% of expulsions (United States Department of Education, 2023), and nearly 30% of school arrests. This highlights how discrimination and lack of accommodations for young people with disabilities can have lifelong consequences since school arrests are strongly associated with future interactions with the criminal justice system as an adult, prematurely leaving school without a diploma, and depreciated earnings across the lifespan (Berry, 2024).

Attitudinal barriers also present significant challenges that begin before entering the workplace, often barring trainees from completing necessary educational requirements (Hassounah et al., 2024). These barriers persist in the workplace and vary in degree depending on whether the disability is visible or invisible (Serpas et al., 2024). Misunderstandings about the nature of disabilities and unawareness of workplace challenges often result in inadequate support and accommodations that would be necessary for fulfilling certain roles (Paniccia et al., 2019). An example of this is a sheltered workshop, an organization that provides employment for individuals with disabilities, but segregates disabled people from their non-disabled peers and often pays less than minimum wage.

There is a prevailing misperception that reasonable accommodations, which are designed to reduce barriers and allow employees to demonstrate their skill and productivity, impose an undue cost to the employer. However, most accommodations cost nothing or consist of a mere one-time fee (Job Accommodation Network [JAN], 2024). Such accommodations could include a flexible work schedule or access to existing accessible parking, building or office space. These accommodations significantly improve employee retention, workplace morale, and overall productivity, outweighing any associated costs (JAN, 2024), thereby dispelling misconceptions that accommodations are unprofitable for business.

People with disabilities also experience some of the highest levels of workplace discrimination, particularly regarding termination and reasonable accommodations (Graham et al., 2019). Evidence shows that salary progression for individuals with disabilities happens at a slower pace compared to that of their non-disabled counterparts due to perceived discrimination, making them less likely to participate in salary negotiations (Speech et al., 2023). Individuals with disabilities are more likely to accept lower salaries due to their feelings of undervaluation in negotiating, societal perceptions, and the fear of negative repercussions within society (Voermans et al., 2021).

Recommendations

Ableism continues to create widespread barriers undermining the health, autonomy, and inclusion of people with disabilities. The core issue is the pervasive stigma, discrimination, inaccessibility, and exclusion faced by individuals with disabilities rather than the disability itself.

The disability paradox—where individuals report a high quality of life despite societal assumptions to the contrary—highlights the impact of social attitudes on perceptions and experiences of impairment. Investing in accessibility efforts presents benefits for everyone, as illustrated by the curb-cut effect (Blackwell, 2016). Accommodations initially designed for individuals with disabilities, such as sidewalk ramps, improve usability and access for a much broader range of people. To combat ableism and to promote full participation in society for every person across the lifespan, psychology seeks to advance evidence-based attitudinal, structural, and policy changes that will support anti-discrimination practices and enhance disability inclusion.

To Reduce Physical, Communication, and Digital Barriers in the Environment, Psychologists will strive to:

- Support full compliance with the ADA, the Rehabilitation Act, and other relevant federal and state policy and legislation to:
 - a) identify and reduce barriers in city development and planning, so that physical and digital infrastructure like housing, schools, hospitals, parks, sidewalks, and transportation are accessible
 - b) ensure that digital platforms for commercial, educational, financial, healthcare, and transportation use are secure and accessible
 - c) monitor ride-sharing companies and transportation systems for wheelchair accessibility
 - d) invest resources to improve enforcement of federal anti-discrimination protections for people with disabilities;
- Promote inclusive and universal design principles (APA, 2019, 2024a);
- Model communication of psychological concepts and mental health in an accessible and inclusive manner (APA, 2023), encourage counter-stereotypical representation of people with disabilities in media to reduce stigma (Hammer & Stutts, 2025); and support large-scale public education campaigns to combat ableism at the societal/cultural level;
- Encourage the equal inclusion of people with disabilities in all aspects of research, including marketing research, by making recruitment and participation safe and accessible, as well as in leadership roles in research such as the roles of co-researchers, collaborators, and data analysts and;
- Support civic engagement to inform policy by making platforms for public commentary, surveys, phone systems, voting, and public office more accessible while also supporting training in advocacy and public policy for people with disabilities based on psychological science.

To Improve Healthcare Access and Inclusion, Psychologists will strive to:

- Encourage education and training for healthcare professionals by updating curricula with research, clinical, and policy implications of ableism, disability culture, and implicit bias;
- Advocate for equal representation in research, education, and healthcare policies that address the unique needs of people with disabilities who hold intersectional marginalized identities, including BIPOC, LGBTQ+, and other historically excluded communities;
- Support policy and legislation that promotes accessible healthcare management (e.g., single payer healthcare, Medicaid and Medicare expansion, mental health parity enforcement, telehealth expansion, strengthening the Affordable Care Act, etc.);
- Encourage ongoing research on physically and digitally accessible healthcare spaces that can be

adapted for people with physical, sensory, cognitive, and other disabilities, such as parking structures, waiting rooms, exam tables, surgical tools, call centers, and electronic patient portals to ensure equal access;

- Promote inclusive participation in social and family life by advocating for access to reproductive healthcare information for all, including people with disabilities to preserve their right to bodily autonomy and to protect against forced sterilization practices;
 - Support translation services for immigrants with disabilities to improve their understanding of and access to healthcare services;
 - Support programs, resources, and policies for caregivers with disabilities (APA, 2024b) as well as for family caregivers of children and adults with disabilities (APA, 2025b), and;
 - Support training of psychologists and other healthcare professionals in becoming familiar with research and clinical activities related to treatment of people with disabilities.
- To Promote Educational and Vocational Inclusion, Psychologists will strive to:
- Promote education, training, and mentoring to:
 - a) sensitize children and students to ableist practices and the ideology of disability as diversity by embracing a sociocultural model of disability to reduce social indifference (Dunn et al., 2013) and to reduce attitudinal barriers;
 - b) correct misunderstanding about the cost of reasonable accommodations and enhance transparency about the educational and work environment in internship and job requirements, and;
 - c) provide clear guidance to people with disabilities, educators, and employers on designing, implementing, and evaluating reasonable accommodation plans and fair and equitable pay negotiation (Graham et al., 2019);
 - Support policies that provide support for children with disabilities in school and educational settings (Individuals with Disabilities Education Act [IDEA], 2004; Lipkin et al., 2015), support for graduate students with disabilities to engage in teaching, research, accessible assessment training, and practice (Lund, 2023; Lund et al., 2023), and support for flexible school and work arrangements like expanding remote and hybrid options;
 - Promote recruitment, hiring, and retention of disabled students and workers by reducing discrimination, ableism, inaccessibility while enhancing healthcare resources and protection of disabled individuals in educational and vocational settings;
 - Encourage meaningful workforce participation by advocating for removing disincentives to work (e.g., subminimum wages for disabled workers), enforcing equal pay, strengthening; enforcement of anti-discrimination protections in hiring, wages, and promotions, and increasing tax incentives for employers to make physical spaces and essential job functions accessible and provide accommodations as needed;
 - Advocate for adequate resources for oversight and enforcement of federal antidiscrimination protections for students and workers with disabilities.

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D.(13) Council voted to adopt as APA policy the following statement on *Reconciling Traditional Wisdom and Psychological Science*:

Reconciling Traditional Wisdom and Psychological Science

Introduction

The mission of the American Psychological Association (APA) is to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives. This mission is advanced through a number of operating principles, including:

- Embrace cultural humility and reflexivity. Commit to organizational self-reflection while partnering with and learning from the people, communities, and systems with which APA interacts.
- Embrace a global perspective. Advance psychology through global engagement, association programs, and meaningful collaborations with psychological associations and other relevant groups from around the world.

APA recognizes that human behavior varies based on cultural norms and influences. Accordingly, this policy statement encourages the reconciliation of traditional wisdom (e.g., safe and restorative traditional healing practices supported by a body of knowledge) from around the world (e.g., spirituality among Native Americans, Confucian philosophy among some Asian cultures, Indigenous ways of knowing, and African traditional medicine) with knowledge derived from psychological research to enable a more inclusive, culturally relevant approach to understanding human behavior and wellbeing. Supporting the parity of traditional wisdom derived from non-dominant worldviews, (e.g., Blume, 2022), with dominant paradigms (typically drawn from Western, Educated, Industrialized, Rich, and Democratic population assumptions; Henrich et al., 2010) within psychological research would be a step toward fulfilling the commitment that APA has made to retire hierarchical and racist perspectives in psychology.

Historically, psychological science has been guided by positivism and empiricism without adequately recognizing the depth, validity, and contribution of traditional wisdom from around the world and committing “epistemological violence” that assumes the methods and interpretations of the dominant science are superior to traditional Indigenous wisdom (APA, 2021; APA Presidential Task Force on Psychology and Health Equity, 2023; Blume & Diop, in press; Teo, 2010). However, multiple epistemological frameworks, including Indigenous knowledge or traditional wisdom from other cultural-philosophical lineages, should complement and be respected alongside dominant knowledge (APA, 2023). It is necessary to integrate diverse ways of knowing to create a more inclusive and holistic understanding of human behavior and wellbeing (Kirmayer & Paul, 2009) and provide a richer toolkit for psychology.

Psychologists are subjected to colonial impacts, meaning that traditional wisdom has not been given equal power and weight as compared to mainstream epistemologies (Misra et al., 2025). Although historically some psychological theories were inspired by traditional wisdom, there

were no proper credits or acknowledgements in the discipline and concepts were often misinterpreted through reductionist lenses (Bear et al., 2022). For instance, the well-known theory of the hierarchical structure of needs, as outlined by the American psychologist Abraham Maslow, was found to have been a reference, without acknowledgement, of concepts from the Indigenous knowledge of communities from the Blackfeet nation (Michel, 2014).

It is necessary to critique the colonial legacy embedded in research, education, and professional structures which led to “self-colonization” an internalization of colonial ideologies and values which sometimes led to feelings of inferiority, self-hatred, and a preference for the colonizer's culture, often resulting in a rejection of one's own identity and culture (Gergen, 2007). Systems and power structures that stifle traditional wisdom should be addressed and traditional wisdom itself (e.g., language) should be protected and preserved whenever possible. It is necessary to implement systemic changes to eliminate self-colonization in psychological funding, accreditation, publications, and training.

Understanding diverse ways of knowing across cultures

APA encourages psychologists to reflect on positionality with cultural humility and reflexivity when attempting to understand traditional wisdom and dominant views within psychological research. Although some concepts overlap in both ways of knowing, historical ignorance and dismissal of traditional wisdom should be addressed with mutual reciprocity at the communal level (Adams et al., 2015; Sundararajan, 2020).

Supporting and promoting respect for and complementarity of Indigenous knowledge and other paradigms in the conduct of psychological research

APA recognizes multiple valid research methodologies, including practice-based evidence (Green, 2006) and Indigenous research methodologies (Smith, 2021). The research methods used in a particular research setting or context should be informed by and integrate the appropriate cultural knowledge. Moreover, it is necessary to provide institutional support and funding for collaborative, community-driven approaches when studying psychological topics involving Indigenous groups or other traditional wisdom holders (Blume & Diop, in press). The convergence of evidence from diverse methodologies will help to inform and advance the understanding of human behavior, health and mental health.

Addressing the colonial legacy on the language of psychological science and the accessibility of traditional wisdom

Language is crucial in shaping what is valued in psychology. Thus, English-based psychological literature can marginalize non-English users' perspectives. Concrete strategies such as multilingual publication and dissemination and the expansion of journal review boards to include experts in traditional knowledge would be beneficial.

Balancing global and regional considerations in psychological research

APA supports the fostering of global partnerships that respect and value local psychologies. This may be advanced by supporting and incentivizing global platforms for

traditional wisdom scholars to share knowledge, thereby increasing the representation of diverse traditional wisdom in mainstream psychological literature (Adams et al., 2015).

Recognizing pragmatic healing and holistic well-being in mental health services

APA recognizes that healing practices and the promotion of well-being vary across cultures, potentially incorporating spirituality (Mansouri & Pourghane, 2023), traditional healing, and relationality, and encourages the incorporation of diverse approaches into psychological practice and mental health interventions (Dudgeon et al., 2017). When possible, partnerships should be pursued with local communities (Koç & Kafa, 2018). It is vital to move beyond individualistic models of healing to incorporate Indigenous and community-based approaches (Ting et al., 2025a).

Decolonizing psychology

APA encourages educators to re-examine the pedagogical structure for colonial impacts in psychology, including curricula, staff and student recruitment, and measures of learning and success. Methods to measure the impact of scholarship can benefit by moving beyond citation to incorporate other outcomes, particularly related to social impact on traditionally marginalized groups (Teo, 2010). Indigenous and global psychologists deserve increased voice to ensure traditional wisdom is included in policymaking, accreditation, and training bodies. Developing guidelines for integrating traditional wisdom into psychological education and practice would be beneficial (Ting et al., 2025b). APA also has addressed issues related to promotion and tenure for faculty of color, highlighting systemic barriers for faculty in their pursuit of promotion and tenure, including financial constraints, workplace complexities, and issues of retention (<https://www.apa.org/pubs/reports/inequities-academic-tenure-promotion.pdf>).

Building on the commitments expressed in APA's 2023 *Offer of Apology to First Peoples in the United States*, this policy statement serves as a foundation for reconciling traditional wisdom and dominant knowledges within psychological science, nurturing a more inclusive and holistic understanding of human experience. Indigenous ways of knowing typically result from a relational kinship model that tends not to be dualistic or binary in interpretation but rather aligned with intersectional and equitable interpretations of the world (Blume & Diop, in press; Tynan, 2021). It remains necessary to critically examine the intersectional power dynamics embedded within each traditional knowledge system to ensure it affirms human rights and well-being (Bah & Barasa, 2022). Through acknowledging colonial impacts, diversifying psychological epistemologies, fostering global and community-based collaborations, broadening methodologies, and redefining measures of success, the integration of traditional wisdom from around the world with the conduct of psychological science can lead to a more equitable and culturally responsive discipline.

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E.(14) Council voted to adopt as APA policy the following *Policy Statement on the Benefits of Inclusivity to Psychology and Higher Education*:

Policy Statement on the Benefits of Inclusivity to Psychology and Higher Education

Consistent with the American Psychological Association’s mission to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives (APA, 2025), this Policy Statement supports APA’s commitment to justice, human rights, fairness, and dignity for all, recognizing these values as central to psychology. Recent policy changes and actions targeting institutions of higher education across the United States hinder psychologists’ abilities to provide care, deliver services, support educational advancement, and conduct research, particularly for underserved and vulnerable populations.

Psychological science consistently demonstrates the numerous benefits derived from integrating inclusivity into higher education curricula. Such integration enhances educational outcomes, fosters innovation, and prepares future psychologists to competently serve diverse populations (Jayakumar, 2008; Attari et al., 2023). As psychologists, we have an ethical obligation to prevent harm, challenge systemic injustices, and advocate for policies that promote human welfare (APA, 2017; APA, 2021). These values are essential for the advancement of both psychology and society.

Psychological and health research consistently underscores the importance of addressing disparities in healthcare. According to the National Academy of Medicine, systemic inequities significantly undermine population health, making it critical to sustain scientific and educational efforts aimed at reducing inequities through research and interventions (National Academy of Medicine, 2025). The National Institute on Minority Health and Health Disparities (NIMHD) further emphasizes that addressing social determinants of health, such as healthcare access, education, income and wealth gaps, and workplace conditions, is essential to improving mental and physical health outcomes (NIMHD, 2025; CDC, 2025). Advancing equitable and inclusive research supports

efforts to address health disparities. It also benefits clinical practice and mental health care, and teaching and training in psychology (Attari et al., 2023; Avery & Ruggs 2020; Jayakumar, 2008; Ruggs & Avery, 2025; Sue et al., 2022, Tipton et al., 2023).

Recommendations

BE IT RESOLVED we promote efforts to expand educational access and opportunity for all qualified students and to foster inclusive learning environments that support student success and professional growth in psychology and mental health.

BE IT RESOLVED we support increases in federal investments to public service loan forgiveness, financial aid, and other student loan programs that will provide greater access to higher education and incentivize more people to pursue behavioral health and mental health fields.

BE IT RESOLVED we support education, teaching, and training that promotes evidence-based practices in addressing complex social issues, while affirming our commitment to human rights, dignity, fairness, and justice for all.

BE IT RESOLVED we support academic freedom and believe in the shared commitment of colleges and universities and their faculty to serve open inquiry, the pursuit of truth, and the free exchange of ideas and opinions across a full range of viewpoints.

BE IT RESOLVED we advocate for increased federal investments in psychological science and increased funding for basic, clinical, and applied psychological research that investigates links between physical and mental health disparities, including cancer research, cardiovascular disease, diabetes, and many other health conditions that also impact mental and behavioral health.

BE IT RESOLVED we support efforts to strengthen psychological science and research that explores the various facets of human experience and perspectives.

BE IT RESOLVED we support fair policies and practices to attract qualified individuals of all backgrounds to meet the urgent need to increase the behavioral health workforce.

BE IT RESOLVED we support policies to incentivize those with higher education degrees to provide clinical practice and mental health care in low resource settings, such as rural areas, and to meet the unique mental health needs of veterans, older Americans, and rural populations.

BE IT FURTHER RESOLVED, we support initiatives to address the increase higher education enrollment, better educate K–12 students about psychology, support transitions from 2-year to 4-year colleges and reduce financial barriers to pursuing psychology careers.

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F.(23) Council was provided with an update on the new business in progress item, APA Resolution on Developing Mechanisms for Addressing Global Armed Conflict (NBI #19C/February 2025)

G.(24) Council was provided with an update on the new business in progress item, APA Resolution on Identifying Resources to Support Inclusion and Intra-group Dialogue within Groups and Organizations (NBI #17D/August 2025).

XIV. INTERNATIONAL AFFAIRS

A.(20) Council received as information the 2024 annual report summarizing APA activities at the United Nations.

XVI. Financial Affairs

A.(21) Council received as information the 2024 audited financial statements.

On Monday evening, Council engaged in a group activity, following up on its February 2025 discussion, where it was asked to consider questions related to APA's joint strategic priorities.

On Wednesday afternoon, Division 18, Psychologists in Public Service, was awarded with presidential citation.
