

Council of Representatives

August 4 & 5, 2026

DRAFT MINUTES

I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its February 20 & 21, 2026, meeting.

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) Council voted to elect the 121 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.

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 *Guidelines on Psychological Practice with Transgender and Nonconforming People* and the *Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists* to December 31, 2028.

B.(4) Council voted to approve withdrawal of item, Council New Business Item #15E/Aug 2025, Creating a Centralized Digital Dashboard for Council Transparency and Efficiency.

C.(5) Council voted to refer item #5, APA Ethnic Psychological Association Affiliation with the Association of Jewish Psychologists (NBI #15A/Aug 2025), to the Racial, Equity and Diversity (RED) Task Force and that the groups participating in the referral shall meet with mediation overseen by the EDI office. Further, that this referral includes a time-certain report back to council on progress or presentation of a resolution and action item by the February 2027 Council Meeting.

D. Council voted to approve forwarding the following to the Membership for a vote to the APA Bylaws, Article IV, Section 3 (bracketed/strikethrough material to be deleted; underlined material to be added): Council shall publish its minutes and proceedings. ‘

If ~~[one-fourth]~~ a majority of the Representatives present so request, the minutes shall include a record of those Representatives voting for and against a motion. If ~~[one-fourth]~~ a majority of the Representatives present so request, the Recording Secretary shall record in the minutes a brief description of majority and minority positions on any given Council action. Meetings of Council, except those specifically designated as executive sessions, shall be open to Members of the

Association, but they may not speak or otherwise participate in the meeting unless specifically invited to do so by the President.

Additionally, the following Association Rule changes will take effect upon approval of Bylaws amendments by the Membership:
following amendments to Association Rule 30-2 to take effect, if and when, the Bylaws amendments are approved (bracketed/strikethrough material to be deleted; underlined material to be added):

30-2.1 An affirmative vote of ~~[25%]~~ a majority of the members attending a Council meeting is required to order a roll call vote on any issue and to require the publication in a designated location on APA's website of the votes on any motion before Council.

E.(7) That Council approves the following Association Rule changes (underlined material to be added; bracketed/strikethrough material to be deleted):

30-6.3 When indicated, motions/reports and new business items shall reflect the most appropriate and relevant scientific data and literature available. Reviews of the scientific literature must be fact-checked. The moving party (whether a board, committee, or individual member(s)) shall assume responsibility for conducting or obtaining the appropriate scientific review, including the identification of pros, cons, and limitations of the conclusions based on the science. Independent scientific merit review shall be the responsibility of the moving ~~[board or committee]~~ party. The lead board or committee reviewing will ensure that a scientific review was conducted as described in this Rule. The results of such review shall be made available as part of the supporting documentation.

Upon receipt of any substantive written feedback from boards or committees to which the item has been referred under Rule 30-4.1, the moving party shall provide a written response to Council acknowledging and responding to the substance of the feedback received, including an explanation of how the feedback was incorporated or, if not incorporated, the rationale for that decision. The movers may consult with the Boards and/or Committees regarding their feedback.

30-1.5 No matter may be properly placed before the Council for its votes that has not been disseminated to the members of Council, in its final form and with a response from the Council Leadership Team, at least two weeks prior and whenever possible 30 days prior to the meeting at which the matter is to be deliberated.

"Final form" shall mean that all sections of the agenda item are complete. Agenda item sections that must be complete include (1) a description of the issue, (2) a description of the implementation plan, (3) the fiscal implications of passing the main motion or any amended or substitute motion, (4) any substantive written feedback received from boards and committees and the moving party's written response required under Rule 30-6.3, (5) the exact wording of the main motion and any amended or substitute motion, and ~~(5-6)~~ the recommendations of the Council Leadership Team and any other board or committee that has reviewed the issue.

This rule shall not be interpreted to apply to supplemental materials such as exhibits, comments, or minutes that are not available at the time the agenda is finalized and posted.

F.(8) Council voted to amend the following Association Rules (bracketed/strikethrough material to be deleted; underlined material to be added):

120-2. ~~[COMMITTEE ON]~~ EDUCATION AND TRAINING AWARDS

120-2.1 The Board of Educational Affairs shall determine the titles, criteria and selection processes for APA's education and training awards and may convene subcommittees or expert panels as needed to carry out this work. The Board of Directors shall determine award amounts and has the authority to act on recommendations regarding award recipients.

~~[There shall be a Committee on Education and Training Awards consisting of six members, three to be elected annually for terms of two years. At least one member of the committee shall be an early career psychologist.~~

~~The committee shall announce the recipients of the awards after final approval is given by the APA Board of Directors, and it shall report other matters to Council through the Board of Educational Affairs.~~

120-2.2 ~~The APA may award annually two \$1000 awards, one for Distinguished Contributions to Education and Training in psychology and a second award for Distinguished Contributions to Applications of Psychology in Education.~~

~~The intent of the Distinguished Contributions to Education and Training Award is to recognize psychologists whose contributions enhance the effectiveness of psychology education and/or training in psychology.~~

~~The intent of the Distinguished Contribution for Applications of Psychology to Education is to recognize psychologists who contribute to effective teaching methods or the solution of learning problems in educational settings, including PreK-12 schools, through the use of research findings or evidence-based practices.~~

~~Career designation can be added to either award as determined by the committee.~~

120-2.3 ~~Ineligible for the awards are members serving currently on the committee, former recipients of the awards, and the current APA President and President-elect.~~

120-2.4 ~~Nominations for these awards shall be solicited in the broadest possible manner, including through announcements in appropriate publications. The committee may also nominate candidates as well as specify which nominees will be carried over to the following year. Additionally, the Committee shall systematically review promising nominations from previous years. Deadlines for receipt of nominations shall be established by the committee each year.~~

120-2.5 ~~Award recipients shall be invited to the annual convention to receive the awards and to address annual convention attendees in the year following the committee's decision.]~~

130-3. PROFESSIONAL AWARDS

130-3.1 The Board of Professional Affairs shall [announce its professional awards in a timely fashion in advance of the annual convention] determine the titles, criteria and selection processes for APA's professional awards and may convene subcommittees or expert panels as needed to carry out this work. The Board of Directors shall determine award amounts and has the authority to act on recommendations regarding award recipients.

~~**130-3.2** The APA may award annually up to three prizes of up to \$2,000 each for outstanding contributions to psychology as a profession. The Board of Professional Affairs shall select as recipients for the awards those who have made outstanding contributions to the knowledge base of professional psychology, in technical applications in the applied practice of psychological knowledge, or in the use of the knowledge base or the practice base in psychology for the betterment of the general public. These contributions should be seminal or innovative in ways that are judged to have improved or changed significantly the conceptual understanding of behavior or the applied practice of such conceptual understanding of behavior, or to have accrued significant benefit to the public.~~

~~1. The APA Award for Distinguished Professional Contributions to Applied Research. This award is given to a psychologist whose research has led to important discoveries or developments in the field of applied psychology. To be eligible, this research should have led to innovative applications in an area of psychological practice, including but not limited to assessment, consultation, instruction, or intervention (either direct or indirect). Research involving the original development of procedures, methodologies, or technical skills that significantly improve the application of psychological knowledge and provide direct and immediate solutions to practical problem areas will be considered, as will research that has informed psychologists on how better to observe, define, predict, or control behavior. Original integration of existing theories or knowledge is also eligible for consideration.~~

~~2. The APA Award for Distinguished Professional Contributions to Independent Practice. The award is intended to recognize outstanding independent practitioners in psychology. Nominations will be considered for psychologists working in any area of clinical specialization, health services provision, or consulting, and services provided to any patient population or professional clientele in an independent or institutional practice setting. Services provided to diverse client groups or patient populations, including but not limited to children/adolescents/adults/older adults; urban/rural/frontier populations; minority populations; and persons with serious mental illness, will be considered. Contributions can be judged distinguished by virtue of peer recognition, advancement of the public's recognition of psychology as a profession, relevant professional association honors, or other meritorious accomplishments denoting excellence as a practitioner including advancement of the profession.~~

~~3. The APA Award for Distinguished Professional Contributions to Institutional Practice. The award is intended to recognize outstanding practitioners in psychology. Nominations will be considered for psychologists working in a wide variety of institutional practice settings (e.g. schools, military, state hospital, Department of Veterans Affairs, etc.). Services provided to diverse client groups or patient populations, including but not limited to children/adolescents/adults/older adults; urban/rural/frontier populations; minority populations; and persons with serious mental illness, will be considered. Contributions can be judged distinguished by virtue of peer recognition, advancement of the public's recognition of psychology as a profession, relevant professional association honors, or other meritorious accomplishments denoting excellence as a practitioner including improvement of institutional service delivery systems or development of psychologically informed public policy.~~

~~**130-3.3** The Board of Professional Affairs shall seek diversity in selecting recipients, avoiding as far as possible the consecutive selection of more than one person representing a specialized topic, a specific material, a given method, a particular application, or a specific specialized service.~~

~~130-3.4~~ Ineligible for the awards are members serving currently on the Board of Professional Affairs and the current APA President and President elect. The following rules also apply: No person can receive a professional award in any two consecutive years; recipients are permitted to receive only one award in their lifetime per category of the professional awards; current members of the Board of Professional Affairs cannot vote for members of their own family; and those with a history of ethical violations at a state or national level or who have received disciplinary action from a state board of examiners in psychology are not eligible.

~~130-3.5~~ Nominations for these awards shall be solicited in the broadest possible manner, including announcements in appropriate publications. The category of the three awards in which the nomination is placed shall be based, insofar as possible, on a determination of the candidate's primary area of work. Deadlines for receipt of nominations shall be established by the Board of Professional Affairs each year. Nominators are responsible for providing the Board of Professional Affairs with an up-to-date resume and bibliography and a narrative statement detailing the nature of the contributions and focus of the nomination. Endorsements from other individuals and groups are also considered part of the record. All nominations are good for two years, after which nominators must reapply for another review. Nominators of the award recipients are also responsible for the wording of the awards' citation.

~~130-3.6~~ Award recipients shall be invited to be present at the annual convention to receive the awards and to address convention attendees in the year following the receipt of the awards.]

140. SCIENTIFIC AFFAIRS

140-3. [COMMITTEE ON] SCIENTIFIC AWARDS

140-3.1 The Board of Scientific Affairs shall determine the titles, criteria and selection processes for APA's scientific awards and may convene subcommittees or expert panels as needed to carry out this work. The Board of Directors shall determine award amounts and has the authority to act on recommendations regarding award recipients.

~~[There shall be a Committee on Scientific Awards consisting of six members, two of whom shall be elected each year for terms of three years. At least one member of the Committee shall be an early career psychologist. The Committee shall announce the recipients of the awards at the annual convention, and it shall report other matters to Council through the Board of Scientific Affairs.~~

~~140-3.2~~ The APA may award annually up to four prizes of up to \$2,000 each for outstanding contributions to the science of psychology. Three of these awards are to be known as the "APA Award for Distinguished Scientific Contributions." The Committee shall select recipients for the awards who, in its opinion, have made distinguished theoretical or empirical contributions to basic research in psychology. The fourth award in the amount of up to \$2,000 shall be known as the "APA Distinguished Scientific Award for the Applications of Psychology." The award is for distinguished theoretical or empirical advances leading to the understanding or amelioration of important practical problems. The Committee shall seek diversity in selecting recipients, avoiding so far as possible the selection of more than one person representing a specialized topic, a specific material, a given method, or a particular application.

There shall be an increase in the number of these senior scientific awards from four to seven per year for calendar years 1987, 1988, and 1989.

~~140-3.3~~ The APA may award five annual prizes of up to \$1,000 for important contributions to the science of psychology made by younger people early in their career. The award is known as the "APA Distinguished Scientific Awards for an Early Career Contribution to Psychology." It is expected that award will focus more on specific contributions rather than on continuing contributions.

~~140-3.4~~ Ineligible for the awards are members serving currently on the Committee, former recipients of the award in question, and the current APA President and President-elect.

~~140-3.5~~ Nominations for these awards shall be solicited in the broadest possible manner, including announcements in appropriate publications. Deadlines for receipt of nominations shall be established by the Committee each year. Additionally, the Committee shall systematically review promising nominations from previous years.

~~140-3.6~~ Award recipients are invited to the APA annual convention to receive the award and to address convention attendees in the year following the receipt of the award.]

150. PUBLIC INTEREST

150-3. [~~COMMITTEE ON~~] PSYCHOLOGY IN THE PUBLIC INTEREST AWARDS

150-3.1 The Board for the Advancement of Psychology in the Public Interest shall determine the titles, criteria and selection processes for APA's psychology in the public interest awards and may convene subcommittees or expert panels as needed to carry out this work. The Board of Directors shall determine award amounts and has the authority to act on recommendations regarding award recipients.

[There shall be a Committee on Psychology in the Public Interest Awards consisting of the current Chair of the Board for the Advancement of Psychology in the Public Interest, the two past Chairs, and two psychologists appointed by Board for the Advancement of Psychology in the Public Interest who are members of the Association but not members of the Board for the Advancement of Psychology in the Public Interest and who will reflect the diversity of public interest constituencies. At least one member of the Committee shall be an early career psychologist. The Committee shall announce the recipients of the awards at the annual convention, and it shall report other matters to Council through the Board for the Advancement of Psychology in the Public Interest.

~~150-3.2~~ The APA may award annually up to three prizes of up to \$2,000 each for outstanding contributions to psychology in the public interest and for outstanding contributions to research in public policy. Two of these awards are to be known as the "APA Award for Distinguished Contributions to Psychology in the Public Interest." The Committee shall select recipients whose single extraordinary achievement or a lifetime of outstanding contributions have met one or more of the following criteria: (a) courageous and distinctive contribution in the science or profession of psychology that makes a material contribution to the solution of one of the world's intransigent social problems; (b) distinctive and innovative contribution that makes the science and/or profession of psychology more accessible in a positive manner to a greater number of persons; and (c) an integration of the science and/or profession of psychology with social action in a manner beneficial to all.

~~150-3.3~~ The third award in the amount of up to \$2,000 shall be known as the "APA Award for Distinguished Contributions to Research in Public Policy." The award is for a distinguished empirical or theoretical contribution to research in public policy. This contribution may consist of: (a) sound research that leads others to view specific national policies differently; (b) research that provides evidence directly relevant to public policy alternatives; (c) research that demonstrates the importance of the application of psychological methods and theory to public policy; and (d) research that clarifies the ways in which scientific knowledge regarding human behavior informs public policy.

~~150-3.4~~ Ineligible for the awards are members serving on the Committee and on the Board for the Advancement of Psychology in the Public Interest, former recipients of the award, and the current APA President and President-elect.

~~150-3.5~~ Nominations for these awards shall be solicited in the broadest possible manner, including placement of announcements in appropriate publications. The Committee may also nominate candidates. Additionally, the Committee shall systematically review promising nominations from previous years. Deadlines for receipt of nominations shall be established by the Committee each year.

~~150-3.6~~ Award recipients shall be invited to the APA annual convention to receive the awards and to address convention attendees in the year following the receipt of the awards.]

G.(25) Council received as information an update on the Council Liaison Program.

H.(26) Council was provided with an update on a recent APA Leadership Profile & Insights Report.

VII. PUBLICATIONS AND COMMUNICATIONS

No items.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(9) Council voted to approve a one-year extension of recognition of 1) Addiction Psychology and Sport Psychology as proficiencies and 2) Couple and Family Psychology as a specialty in professional psychology to expire December 31, 2027.

B.(10) Council voted to approve the continued recognition Group Psychology and Group Psychotherapy as a specialty in professional psychology for a period of seven years to expire on December 31, 2033.

C.(11) Council voted to approve the continued recognition of Clinical Health Psychology as a specialty in professional psychology for a period of seven years to expire on December 31, 2033.

D.(12) Council voted to approve the revisions to the APA Commission on Accreditation (CoA) Implementing Regulations A.1.

E.(13) Council voted to postpone item #13, Amendments to APA Association Rule 120-5.1: Teachers of Psychology in Secondary Schools to its February 2027 meeting.

X. PROFESSIONAL AFFAIRS

A.(14) Council voted to approve the following position statement on the use of seclusion and restraint:

Policy and Position Statement on the Use of Seclusion and Restraint and Policy Initiatives for Adults: Avoiding Institutional Harm and Promoting Evidence-Based Practices

APA joins leading mental health disciplines in calling for local and national efforts to reduce the use of seclusion and restraints, due to its lack of evidence-based support, its likelihood to cause trauma, and/or death (and consequently physical and mental health diagnoses), and its disproportionate use among people of color. APA also calls for elevating the use of more humane, non-coercive, non-punitive, non-violent, and scientifically supported practices in de-escalating concerning behavior and promoting safety of those receiving care and the staff providing that care. Advance and support research that evaluates and identifies best practices for training medical and correctional facility staff in trauma-informed, preventive, and evidence-based approaches that reduce the use of seclusion and restraint.

With a guiding position statement on seclusion and restraint APA will engage in policy advocacy internally and at state and federal levels related to its position statement and report on the reduction of the use of S&R by:

Utilizing the APA Task Force on Serious Mental Illness to have a subcommittee to work in conjunction with the Advisory Council across the nation and internally within APA for policy advocacy (ACC) and change that will affect institutions that use S&R across the nation. Additionally, this subcommittee will collaborate with APA divisions 18, 27, 45, and 53, and the Ethnic Minority Affairs Office, ensuring the implementation of this work across APA.

Developing an Advisory Council of approximately 10 people to include interdisciplinary partners in this effort such as community housing supports, hospitals, nursing homes, the judicial system, forensic settings, schools, churches, spiritual communities, people who have been placed in S&R, and organizations developed by those in recovery such as the Alternatives Conference, among others to help guide all APA advocacy work with the goal of reducing/eliminating the use of S&R. This could be voluntary or paid work but is a vital part of informing the work. To be specific, this Advisory Council would meet monthly over a virtual platform initially for 1 hour to provide input into the work and over time can phase to quarterly meetings. An equitable pay for such work is about \$25-35/hour so at the price of \$30/hour that would be \$3,600 annually. The tasks of this group are to ensure that those with lived experience help inform with their unique perspectives and consult on the further advancement of this work. This is vital as the literature indicates that “there should be nothing for us without us” which is a movement that came out of the disability rights era (Charlton, 1998). Ensure that all APA led or developed work (advocacy, policy, etc.) includes people with lived mental health experience and those who are peer supports who incorporate a trauma-informed and recovery-oriented care perspective to reduce the use of S&R.

Educational Trainings: APA will advocate for the development of and assessment of training models for organizations and agencies on alternative interventions to S&R. These models should ideally strengthen staff capacity to recognize signs of trauma, de-escalate crises safely, and

implement human behavioral interventions. Efforts should emphasize institutional culture change, accountability, and measurable reductions in coercive practices promoting safer, recovery-oriented, and ethically grounded care environments for both staff and patients. APA will encourage agencies to identify mechanisms for extended funding and support to maintain such alterations in care over time. Such training is important in any setting in which staff are interacting with individuals experiencing serious mental illness/severe emotional disturbance and/or intellectual or developmental disabilities, in which the use of S&R is permitted, including emergency room departments, inpatient medical hospitals, psychiatric inpatient units, residential facilities, criminal justice settings (prisons, jails, and detention centers), forensic settings, schools, and nursing homes.

Promoting APA-led advocacy and partnering with other mental health stakeholder organizations (e.g., American Psychiatric Association, State, Provincial, and Territorial Psychological Associations, American Psychiatric Nursing Association, National Association of Mental Illness, Substance Abuse and Mental Health Services Administration, National Association of State Mental Health Program Directors, Department of Health and Human Services, unions and/or labor associations that represent mental health associates, The Joint Commission, etc.) on national and state efforts and development of policy for reducing the use of S&R with the encouraged goal of a set statistical reduction by experts in this area by 5-7 years and another higher statistical reduction, with increased alternatives to de-escalation, within 10-15 years.

Collaborate with stakeholder organizations like above in developing policy on a federal level that will be directive for states and also provide a national foundation for The Joint Commission, Centers for Medicaid/Medicare, and the National Database of Nursing Quality Indicators (DNQI) to increase the requirement for reporting S&R use, as well as the grounding for making such databases transparent to the public and requisite across all settings that utilize S&R. Similarly, the movers encourage collaboration with the National Association of State Mental Health Program Directors (NASMHPD) leadership to develop and implement consistent policy to be proposed and adopted by states that will require standardized data collection and reporting of S&R usage—including descriptive variables of patients, settings, and staff as well as benchmarks and (physical and mental health) outcomes from use of S&R from staff and patient report—for all inpatient psychiatric, medical hospitals, residential facilities, nursing homes, forensic settings, schools, criminal justice settings (including prisons, jails, and detention centers), and emergency room settings.

Specific Call for Reduction of Clinically Ordered S&R in Prisons, Jails, and Detention Centers:
Since individuals are allowed to be housed by Federal/State law in jails, prisons, and detention centers, there needs to be a distinction about a focused reduction on secluding individuals alone in cells, secondary to disciplinary processes as a result of behaviors and/or symptoms. Similarly, there needs to be a focus on reducing the use of restraints in such settings and a universal effort to address psychiatric needs, institute alternatives to S&R, and the utilization of evidence-based practices.

Collaborate with key stakeholders towards the idea of requests for grant funding to develop and pilot evidence-based interventions to eliminate the need for S&R; and provide trauma-informed and safety-oriented training requirements for staff in nursing homes, criminal justice settings (including prisons, jails, and detention centers), forensic settings, medical hospitals, inpatient psychiatric units, residential facilities, schools, and emergency departments that currently use S&R.

Website Development and Online Tools: The APA will work with other collaborators on developing a centralized website on this initiative and the roadmap for a national impact. The website will attend to all aspects of the multi-pronged initiatives proposed.

Resource Development & Dissemination: Further, resources that can support the above work that is vital to the livelihood and well-being of those who interface with settings that experience S&R are developed. APA will work with policymakers, oversight agencies, and legal and advocacy groups to establish policies aligned with this position statement and these policy initiatives, as well as disseminate information about legal rights, including those already supportive of legal rights, for all patients, such as the use of Psychiatric Advance Directives.

Families, Individuals and Advocacy Groups: Information on this APA Policy will be disseminated to families, individuals, and advocacy groups to empower and support the legal rights for patients who may be at risk for use of S&R.

Report to Support the Main Motion

Brief History on the Use of Seclusion and Restraint

Early U.S. mental health treatment (ca. 1800s) was informed by the S&R practices such as those found in European “madhouses” initiated in earlier centuries—chaining and shackling people living with mental illness in barren cells (Rojas-Velasquez, 2017; Scull, 2015)—as well as using straitjackets and other processes to fulfill their role of social control (Rojas-Velasquez, 2017). Early treatment was focused on warehousing people living with mental illness, compared to the treatment of animals, with increased use of confinement and control (Pascal, 2000). Progression occurred with Dorothea Dix’s moral movement of asylum creation, focusing on healing within large, peaceful gardens that also provided separation from society (Rojas-Velasquez, 2017). However, overcrowding and chronicity of conditions led to a return of restraints including in chains and with heavy irons, ties, nets, muffs, and straitjackets—often within prison-like conditions that traumatized and denigrated those living with mental illness (Beers, 1996; Haskell, 1869). These experiences were given more public attention by Kesey’s publication of *One Flew over the Cuckoo’s Nest* (1960) which explored such themes as restraining people living with mental illness who were disagreeable in different forms. As psychiatric drugs improved and antipsychotics came into fruition, they were also used to both help people living with mental illness get better. They were also used as a way to manage those who were counter culture and especially used against women, and feminists who were part of the suffrage movement and the Black Panthers, those who were fighting racism and its injustice (Mizock & Carr, 2021; Rojas-Velasquez, 2017). During such times, there were advertisements developed specifically targeting the role of the use of such medications to control and pharmacologically restrain individuals such as women, who were not themselves, outspoken, and not doing their household duties and Black men, where the text included, “assaultive and belligerent” (Haldol Advertisement, 1974). In awareness of race relations during these years schizophrenia was increasingly associated with Black men and they were prescribed antipsychotics for participating in civil rights protests, riots, and/or the civil rights movement (Metzl, 2011). This grounding in oppression with racism and sexism occurred in synchrony to the disparate use of S&R across race during that time, and to this day (Eswaran et al., 2023). Studies during that time also showed that Black people in the U.S. had a 65% higher rate of being diagnosed with schizophrenia than White people by the National Institute of Health and studies in the 1980s showed similar disparities; with the DSM-II tying schizophrenia itself to men who do not follow rules (American Psychiatric Association, 1968; Office of Surgeon General, 2001; Rojas-Velasquez,

2017). Structural racism and challenges within our mental health systems mimic this legacy of racism in diagnostics and social control with its still current day disparity in higher use of restraints among Black men (Eswaran et al., 2023).

Once antidepressant and antipsychotic medication were developed and spread in the 20th century—along with the promise of community care through deinstitutionalization—treatment seemed hopefully humanistic again, particularly for people with serious mental illnesses (SMI). Sadly, the promise did not hold with current estimates that more than 350,000 individuals with SMI are incarcerated in jails or prisons rather than in treatment settings (Lamb & Weinberger, 2013). Notably, even people who are in psychiatric treatment settings are subjected to the widespread use of S&R to manage behaviors which are considered “challenging”—from minor issues (e.g., yelling, not following rules, or evidencing anger) to more serious behavior such as harm to self or others. In a post-institutionalization society, psychiatric treatment settings across the globe continue to rely on S&R despite the dark history, lack of evidence-base, and availability of other interventions (Chieze et al., 2019; Cummings et al., 2010; Flammer et al., 2022; Hansen et al., 2020).

To this day, the yearly toll of people traumatized due to the continued use of S&R and the loss of lives due to its usage persists (Rankin, 2023; Weiss, 1998). In 2023, Mr. Irvo Ortieno, a 28 year-old Black man died in a Virginia state hospital while being restrained; he is only one of among the estimated 50-150 people that are likely to die from S&R methods annually within our inpatient psychiatric facilities in the U.S. and most are not named publicly in news media (Rankin, 2023; Weiss, 1998).

Current Definitions and Guidance on the Use of Seclusion and Restraint

Seclusion, as defined by the U.S. Department of Health and Human Services (DHHS) “...is the involuntary confinement of a [person] alone in a room or area from which [they are] prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.” (p.96) Restraint is defined as “[a]ny manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a [person] to move his or her arms, legs, body, or head freely...” (p.89) and as “[a] drug or medication when it is used as a restriction to manage [a person’s] behavior or restrict [a person’s] freedom of movement and is not a standard treatment or dosage for the patient’s condition” (p. 90) (Department of Health & Human Services, 2008). Relatedly, The Joint Commission (2025) put out a new revised definition of restraint to include physical holding as a restraint since it can also cause death, as noted by the research, and have incorporated this element into their definition of restraint. Their new definition is “Restraint is any method (chemical or physical) of restricting the freedom of movement of an individual served to manage their behavior. This includes any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of an individual to move their arms, legs, body, or head freely (or temporarily restricts freedom). It also includes any drug or medication when it is used as a restriction to manage the individual’s behavior or to restrict their freedom of movement and is not a standard treatment or dosage for their condition.” (pg. 1) (The Joint Commission, 2025). Guidance from DHHS notes that the use of either S&R must be discontinued at the earliest possible moment and within 1 hour of instigation. The use of either of these methods deems that the restrained person must be evaluated face-to-face by a physician, registered nurse, physician assistant, or other licensed independent practitioner, who has been able to meet the unique and specified requirements of training (Department of Health & Human Services, 2008).

Settings in which S&R can legally be used include inpatient psychiatric settings, forensic hospital facilities, in behavioral health care, schools, healthcare settings and emergency departments, as well as nursing homes (Knox et al., 2012; The Joint Commission, 2025). Seclusion and restraint are allowed in jail, detention, and prison settings (Code of Federal Regulations, 2025). They can also be used in schools though this is regulated by states (Vollmer et al., 2019) and this specific NBI is focusing on adult experience of S&R as there has been a recent NBI passed on the experience of children and their interface with S&R.

Data and the Use of Seclusion and Restraint in the U.S.

Although multiple data sources regarding S&R exist, no comprehensive U.S. national database is maintained that would allow transparency and evaluation of the incidence of S&R. While some states and facilities have made efforts to collect and report data, overall transparency and evaluation have been insufficient. This has hindered efforts to track progress and implement consistent standards across the country (Belayneh et al., 2024; Staggs, 2020). Despite the efforts by The Joint Commission to mandate reporting using Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measures beginning in 2011 and the establishment of the Center for Medicare and Medicaid Services' (CMS) Hospital Compare website reporting these HBIPS data, the accuracy and completeness of S&R data are uncertain (Staggs 2020). Hospitals that take Medicare and that do not meet all the program's reporting requirements do have their annual reimbursement rate reduced by 2.0% for the subsequent year (Center for Medicare Services, 2025). Other data sources on S&R, including historical data from the Joint Commission and the National Database of Nursing Quality Indicators (DNQI) also present difficulties of self-selection and fee-based (proprietary) access and submission of data (Staggs, 2015; Staggs, 2021). These serious concerns about data lead to a lack of benchmarks for accurate data interpretation, policy, and other guidance.

Despite the concerns with the nuances of the data on the use of S&R, researchers using the available data have underscored the concerns of the frequency of use of S&R and differences in setting and staffing. Studies have found many hospitals reporting very high rates of use of both S&R, with government and nonprofit hospitals reporting higher rates than for-profit facilities (Staggs, 2020), nonteaching hospitals reporting higher rates of restraint (Staggs, 2021), hospitals with high staff turnover rates having three times the use of S&R compared to those with lower turnover (Way & Banks 1990), and freestanding psychiatric facilities that are considered "Institutions for Mental Diseases" (IMD) reporting much higher rates of S&R and complaints than non-IMD facilities (Shields & Hollander, 2023). Studies have also shown a connection between S&R and staffing. Data from one study indicated that higher numbers of qualified nurses per shift was associated with heightened seclusion use while in this same study better attitudes toward difficult patients was associated with less seclusion use (Bowers et al., 2010). Bowers and colleagues (2010) share the recognition of the need to change organizational culture and provide education on seclusion use and alternative strategies to decrease its use. A systematic review indicated that shifts staffed by those with greater physical stature decreased the association with seclusion use (Doedens et al., 2020). Relatedly, newer studies are attempting to understand what are the factors for the unexplained variance in S&R use across different hospitals beyond and in addition to that of patient factors (Flammer et al., 2022). The data indicates there may be multiple complexities related to the use of S&R beyond that of the behavior of a patient; many variables are likely at play and related to the use of such methods. As the review of this data highlights gaps in research and brings up more questions there is a great need for more thorough data that is higher quality to guide changes in policy and practices within care settings that use S&R.

Outcomes Related to use of Seclusion and Restraint

Research indicates negative outcomes including greater risk of functional decline and mortality (Chou et al., 2023) as well as other injuries including restraint asphyxia (accounting for about 40% of fatalities), blunt trauma to chest, aspiration, thrombosis, cardiac arrest, and more all attributed, ultimately, to causes of death (Mohr et al, 2003). Estimates from the National Association of State Mental Health Program Directors (NASMHPD, 2014) indicate that approximately 150 people die yearly in psychiatric and residential mental health facilities in the United States. Due to the lack of transparency, uniform accounting measures, and access to data, both the true number of fatalities and the percentage attributed to S&R remain a mystery. Given these concerns for mortality this provides evidence that it is vital that staff are adequately staffed and trained on the safe use of S&R, if they are used as a last resort, and the legal specifications that dictate the use of these methods.

Other harm includes the development of an increasing aggression-coercion cycle between patients and staff (Goren et al., 1993), trauma and incidences of PTSD (Chieze et al., 2019; Finke, 2001; Frueh et al., 2005; Knowles et al., 2015; Lendemeijer & Shortridge-Bagget, 1997; Veltkamp et al., 2008), and triggering of prior trauma memories (Cano et al., 2011; Haw et. al, 2011), as well as related feelings of loss of autonomy and control impacting well-being (Spinzy et al., 2018). Evidence also indicates that the use of S&R can cause further deterioration of mental health (Brophy et al., 2016; Chieze et al., 2019; Mohr et al., 2003; Nunno et al., 2006; Spinzy et al., 2018) including feelings of isolation that can exacerbate mental health symptoms (Bonner et al., 2002; Gilmartin et al., 2013).

Qualitative studies of people who have experienced S&R support the findings of the quantitative studies described

above. Participants indicated S&R measures were experienced as a loss of their human rights, and evoked feelings of isolation, dehumanization, trauma, loss of control, being “othered”, and as incongruent with a mental health recovery

model of care (Brophy et al., 2016). Thus, S&R can be experienced as traumatic and life-changing in a deleterious way

for their mental health and well-being (Hoekstra et al., 2004; Moran, et al., 2009; Sørgaard, 2004).

Research also indicates that the use of S&R is counterproductive to the therapeutic alliance and impacts providers as well as people receiving care from them. A recent qualitative review study of both staff and patients’ experiences indicates a shared view of disruption in therapeutic relationships and disruption in care after the use of S&R (Hawsawi et al., 2020). Patients have also reported themes related to seclusion indicating a lack of communication within the therapeutic relationship in inpatient settings and a belief that this lack manifested violence against patients, as well as a general lack of psychological support (Allikmets et al, 2020). With respect to staff, involvement in administering restraints can trigger staff’s own past traumatic memories (Bonner et al., 2002). A qualitative study of nursing staff involved in physical restraints use led to emotional responses such as anxiety, anger, fear, anger, crying and distress for some—while others reported feeling ‘hardened’ to such use and ‘numbing’ to the process over time (Sequeira & Halstead, 2004). All of these impacts pose significant harm to the treatment of patients and the staff serving them.

Disparities and the use of Seclusion and Restraint

Race and ethnicity, presence of a mental health diagnosis, age, and other characteristics have been linked to variability in the use of S&R, engagement in healthcare, and therapeutic services.

Race and as ethnicity

Data from state hospitals indicate that being a Black male and younger is a predictor of a greater likelihood of experiencing S&R (Hendryx et al., 2010). Studies within inpatient psychiatric settings also indicate that Black or Multiracial patients, in comparison to White patients, are more likely to experience S&R and are subjected to longer duration of S&R (Singal et al., 2024). In a meta-analysis regarding restraint use in emergency rooms, Black patients were more likely to be restrained than White patients – Black patients were also more likely to be restrained than all non-Black patients (Eswaran et al., 2023). Furthermore, when controlling for homelessness, insurance, gender, prior violence history, age, and diagnosis (all having a correlation with heightened restraint use) people of color are still more likely to experience restraints (Schnitzer et al., 2020). There is a need for future research that addresses the intersection of race and as ethnicity with other marginalized identities surrounding gender, sexual orientation, socioeconomic status, housing status, physical disability, nationality, etc.

On another note, it is important to conceptualize that there may be unique needs in emergency rooms to effectively manage working with diverse people with diverse needs. Research indicates the utility of special education and even training and simulation of aggression to more effectively manage the intensity of emergency rooms with less use of S&R (Wong et al., 2015). Notably, there is some research about the ability to train emergency rooms to do just that with outcomes that show significant impact (Roppolo et al., 2020).

Findings concerning disparities in S&R applied to patients of different race and to ethnic groups are mixed. Some science has indicated that there is no greater correlation for those who identify as Hispanic and the experience of restraint measures within hospital settings (Valtis et al., 2022). However, a systematic review found that Hispanic/Latinx patients are at higher risk of restraint than Black patients, while another study reported the risk to be lower than Black or White non-Hispanic patients (Eswaran et al., 2023). The literature also discusses the great difficulty there may be that this finding may be limited and is understudied; some studies may have grouped people that identify as Hispanic in either a White or Other classification, not allowing the data to reflect possible greater disparities that may exist (Valtis et al., 2022). The complexities of the data with race and to ethnicity require more devotion in research methods and more of a comprehensive look at what empirical findings there maybe to help us understand disparities in health equity research better.

There are many limitations to our understanding of S&R disparities and what indicators, factors, variables, and/or characteristics are at play. For instance, analysis of several datasets have found that the greatest use of S&R occurred among patients for whom race and as ethnic identity data were not available (Singal et al., 2024; Valtis et al., 2022). This likely obscures our understanding of the true extent of disparities and may suggest that those who may be Multiracial could be at higher risk of experiencing S&R. In a multinational systematic review, being younger (18-25), male gender (sex designation), being Black (European based studies), Maori, non-European or Pasifika (New Zealand based studies) found a higher association with seclusion than for White patients (Pederson et al., 2023). Multiple studies have indicated being Asian is correlated with a lesser likelihood of S&R (Schnitzer et al., 2020). Again, studies that also include assessment of gender identity are requisite to understand our data better and the intersection of multiple identities that may experience oppression.

Both Valtis and colleagues (2022) and Eswaran and colleagues (2023), among other scientists (Schnitzer et al., 2020) note the confusing nature of the research for those that do not identify as Black or White and the need for more scientific rigor among those of racially and ethnically diverse backgrounds, as it is not captured well in most registrations for hospital records. For example, Eswaran and colleagues (2023) in their systematic review found only one study who reported data about Indigenous, Native Hawaiian, Alaska Native, and Native American race in emergency room settings in Massachusetts (Schnitzer et al., 2020) and though they were included there was not enough data to determine accurately any significance, thus noting the need for more scientific rigor among those of racially and as ethnically diverse backgrounds.

Mental Health Diagnosis

Studies also show significant relationships between diagnosis and use of S&R. A recent study shows that in an emergency room setting those with a psychotic disorder diagnosis or bipolar diagnosis had a nearly 10 times greater likelihood of being restrained than patients with any other psychiatric diagnoses and those with a substance use disorder were at an 8 times greater risk of being restrained (Schnitzer et al., 2020). The literature also indicates that adults with SMI and/or cognitive disorders are more likely to be placed in S&R (DeSantis et al., 2015; Hamers et al., 2004) while others show higher correlations for restraint use among those who have schizophrenia (Korkeila et al., 2002).

Intellectual and Developmental Disabilities

A review of studies on the prevalence of S&R among adults with intellectual and developmental disabilities ranged from 11-78% (Fitton & Jones, 2020). The experience of intellectual and developmental disabilities may overlap with SMI, but also be solely diagnosed. People who experience intellectual and developmental disabilities are a unique population at risk as many of the studies also situate the challenge with the use of such measures within the person, rather than due to external factors. Some concerning findings indicate restraint use is higher among those with intellectual and developmental disabilities who communicate via signs and have impaired speech (Lundstrom et al., 2011; Merineau-Cote & Morin, 2013). Additionally, there have been findings that those with lower activity of daily living and lower adaptive functioning scores experienced S&R at a higher and more severe rate (Lundstrom et al., 2011; Scheirs et al., 2012). Though much literature focuses on challenging behaviors such as physical aggression, antisocial behavior, destructive behavior, and hurting oneself (McGill et al., 2009; Merineau-Cote & Morin, 2013), Lundstrom and colleagues (2011) did not find that restraint use was associated with being at harm to others. There is also evidence that environmental factors may be at play with use of S&R such as the level of experience of staff and ratio of staff (Fitton & Jones, 2020).

Age, Poverty, Violence History

There are multiple studies that indicate being of younger age (i.e., 18-25) is a predictor of being more likely to experience S&R (Hendryx et al., 2010; Pederson et al. 2023). Yet, Wong and colleagues (2019) found a greater risk for older adults (e.g., median age of 64) to be put in restraints within emergency room settings in comparison to other adult age ranges. In addition, patients who are unhoused, those who are not insured (when compared to private insurance), and those with a documented history of violence have a greater likelihood of restraint use in emergency room settings and such settings may benefit from specialized training for emergency work (Schnitzer et al., 2020).

Seclusion and Restraint: Endorsing vs. Reducing Usage

Arguments Endorsing Use of Seclusion and Restraint

The primary justification for these interventions is rooted in their potential to prevent serious injury or fatalities in acute crisis situations. Proponents argue that this practice is typically reserved for scenarios where patients exhibit severe aggression, self-harm, or pose an imminent risk to others (Chieze et al., 2019). Research also divides S&R, as seclusion could be considered a “non-invasive” method that is less coercive than restraints. Proponents argue that seclusion can be administered in less of a coercive manner when providers are trained appropriately to deliver therapeutic interventions (Chieze et al., 2019). The application of these interventions are argued as necessary when all other de-escalation strategies have failed (Recupero et al., 2011). Some studies suggest that when used appropriately and as a last resort, S&R can effectively manage immediate threats and stabilize volatile situations (Chieze et al., 2020).

Staff working in settings where S&R are used often express fear of harm to themselves or others on the unit. This may relate to the reality that there are assaults in healthcare and in 2020 the U.S. Bureau of Labor Statistics found that 10.3 healthcare providers were assaulted per every 10,000 providers (US Bureau of Labor Statistics, 2020). Even though nurses indicate that they know and understand that S&R methods result in a likelihood for increased experience of trauma (Muir-Cochrane et al., 2018) many still fear the reduction of these measures may result in unsafe psychiatric settings. This is in light of the fact that research has indicated that efforts to reduce S&R have not led to an increase in assaults (Smith et al, 2015). Interestingly, another qualitative study of nurses involved with S&R episodes found themes that identified occupational hazards of their profession with such practices (Varpula et al., 2020). These findings found that such episodes were not just brought upon by patients but included themes of staff-induced, organization-induced, and environmental-induced aggression leading to use of S&R (Varpula et al., 2020). In this study, nurses also noted measures that could be instituted, such as increased regulations, enhanced training, and uniform rationales and measures of accountability, to reduce such occupational hazards and risk for staff and patients alike.

Current Efforts to Reduce Seclusion and Restraint Use

The use of S&R is not an evidence-based practice. In fact, little data shows that there is any benefit from the use of these measures other than containment (Chieze et al., 2019). In the last quarter century, there has been a focus on policy and treatment processes that are intended to reduce the use of S&R given the important amount of data showing harm from the use of these interventions. Many mental health organizations supporting disciplines, advocacy, policy, and funding have public statements regarding the use of S&R including the American Nurses Association (2020), the American Psychiatric Association (2022), the American Psychiatric Nurses Association, (2018), the International Society of Psychiatric-Mental Health Nurses (1999), the National Association of State Mental Health Program Directors (1999), the National Association on Mental Illness (2000), and the Substance Abuse and Mental Health Administration (2010). However, the perspectives of psychologists are largely absent from this work to date.

Efforts by NASMHPD & SAMHSA

Treatment processes, supported by policy and oversight, have been introduced to reduce the use of S&R in the U.S. One example is the National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC)’s development and implementation of Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint (NASMHPD, 2008) and incorporating prevention-based techniques effective at reducing the use of S&R (Azeem et al., 2011; Huckshorn, 2004; LeBel, 2011; SAMHSA, 2004). These strategies were implemented across 43 inpatient psychiatric facilities

supported by a grant by SAMHSA. Wieman and colleagues (2014), evaluated the use and found a reduction in seclusion use by 17%, reduction in seclusion hours by 19%, and reduction of proportion of people restrained by 30%. SAMHSA, overall, has led many initiatives and funded a plethora of grants, since its intensified focus on the problematic nature of S&R. In 2010 (SAMHSA), developed issue briefs that aimed at exploring the problematic nature of S&R usage, uncovered recent research such as trauma and deaths associated with their use, and enhanced collaboration with national partners across organizations to focus on reducing their use. SAMHSA also partnered with federal, state, and local government and organizations, consumers, and national advocacy organizations on developing research, best practices, calls to action, state incentive grant plans, national plans, and a roadmap to S&R free facilities. This included a trauma-informed care focus across the nation, among many other focused efforts. It has had much impact and success but realizing the idea of S&R free facilities is still far off the horizon instead of a reality. In summary, the efforts by NASMHPD & SAMHSA and their positive impact on reducing the use of S&R related directly to reducing the need for activating the use of S&R by integrating alternatives to S&R implementation and being proactive in settings of care. This is critical as we conceptualize how to be effective at reducing the use of S&R.

Human Rights Position and Alternatives to Seclusion and Restraint Use

Although research and advocacy about people who have been placed in S&R has led to a movement to decrease the use of S&R (Martin et al., 2008; SAMHSA, 2014), there is much to do. In 2024, there is still widespread use of S&R; still a lack of consistency in data; ongoing difficulty researching and reporting on use and effects of these interventions; a lack of uniform national standards, regulations, and reporting policies; and, arguably most importantly, a lack of requirements and policy to use other more preventive and effective intervention methods to address undesired behavior and prevent injury and death.

We argue that the continued use of seclusion and restraints raises ethical concerns as well as concerns for basic human rights, dignity, and the right to be free from cruel, inhuman, and/or degrading treatment. We ask that the voices of psychologists, through the APA, be added to the voices of nurses, psychiatrists, social workers, state mental health program directors, advocates, and people who have been placed in S&R to call for policy change at national, state, and organizational levels with the goal of, ultimately, advocacy to further reduce the use of seclusion and restraint—and adopting practices like those described below as alternative interventions.

Psychological and Behavioral Alternatives to Seclusion and Restraint

Given the enormity of scientific literature showing the problems associated with S&R, as well as calls from global human right groups to reduce these practices, efforts have been made to develop alternative methods for addressing aggressive behavior and self-harm. Alternative methods are inclusive of changes to institutional culture and environment (such as establishing a 'no-restraint' culture, higher staff-to-patient ratios, and increasing outdoor space/time for patients), as well as the development of psychosocial and behavioral interventions. The American Psychological Association is particularly suited towards advocating for increased research, training, and proliferation of alternative methods to S&R, given that many fall within the domain of psychological intervention. To this point the perspective of psychologists as an organizational body (the APA) has been largely absent on S&R, though psychologists in this area have advocated for such nationwide efforts for quite some time. This may be due to the reality

that APA has only enhanced its strategic planning and goals to include priorities that map so well on to this initiative in the past seven years and/or that it is only more recently that the APA has risen with its notoriety and capability to make significant national change as an organization. Regardless, APA seeks to be a leader and change maker in the field of mental health, as well as for societal issues, so this NBI is a suitable mechanism to embody the goals of APA's strategic planning. Psychologists have all the skillsets needed to lead change in this area such as the development, implementation, and assessment of evidence-based practices to reduce the use of S&R, as well as organizational change strategies, advocacy, and policy skills requisite. Psychologists are also uniquely trained in research and implementation science to make change happen in this vital area of the field.

Donat (2003, 2005) has argued that greater use of behavioral interventions can significantly reduce S&R, including the development of behavioral competence among nursing staff. Specialized training of staff has been shown to lead to reduced instances of restraint use, as well as less time spent under restraint for patients (Geoffrion et al, 2018). Given that there is now national data that indicates healthcare settings are among the most hazardous places to work in the U.S. and particularly given the literature related to significant trauma for staff in relation to S&R use this is another reason to enhance adoption of alternative interventions to reduce such measures and increase safety (Occupational Safety and Health Administration, 2005). Notably, as these practices are envisioned for implementation across the nation the field of implementation science should be explored to utilize best practices for effective implementation (Dixon & Patel, 2020). The following section describes some of the psychosocial and behavioral interventions developed to reduce S&R use, as well as their feasibility and evidence base.

Positive Behavioral Support

Positive Behavioral Support (PBS) is a behavioral intervention based on the principles applied behavioral analysis (ABA). PBS was originally developed to address the behavioral challenges of children with developmental disabilities within school settings. Core values in the development of the intervention include helping individuals build a life of meaning and avoidance of all coercive measures. Since its development, there has been a plethora of research illustrating the intervention's positive impact on the behavior of children with developmental disabilities and the reduction of S&R use in institutional settings (LaVigna & Willis, 2005). More recently, PBS has been adapted for use with adults within inpatient psychiatric settings, targeting on decreasing behaviors of concern and avoiding coercive measures such as S&R. As this adaptation is still relatively new, the evidence-base is currently being built. However, research shows promise that adapted PBS is a feasible and helpful intervention for adults with SMI within inpatient settings (Carr et al., 2024; Carr & Hillbrand, 2022; Donat, 2003, 2005; Hamlett et al., 2016; Sondick, 2016). PBS has been effective among a racial/ethnically diverse population and notably younger Black men who have been identified as being at risk of experiencing more S&R. PBS has also been effective with populations that experience housing insecurity, schizophrenia, older adults, those with intellectual and developmental disabilities, and lower socioeconomic status.

PBS seeks to understand why concerning behavior may be happening and what type of function a behavior may serve (e.g., communication of an unmet need, lack of skill, lack of skillful environment, etc.), thus leading a psychologist, or other similarly trained individuals, to conduct a functional analysis of behavior within the inpatient setting across shifts and staff. A functional analysis of behavior examines many elements of what may elicit concerning behavior or reinforce it; this includes many things such as setting events, timing, antecedents and triggers, interpersonal interactions, precursors, consequences, and reinforcers. This also includes analysis

of when the behaviors of concern are least likely to occur, giving invaluable information to the hypothesis of why the behavior occurs and what maintains it. The concepts of PBS are to develop person-centered behavioral plans that help build skill on the part of the individual, the environment, and the staff to render the maladaptive behavior unnecessarily (Carr et al., 2024). Included in this process is also a differential reinforcement of other prosocial behavior than the maladaptive behavior, thus rendering the maladaptive behavior obsolete over time.

An effective PBS plan can help reduce behaviors of concern within settings that have traditionally led to the use of S&R. Donat's research (2001) also demonstrated that with nursing staff's increased training and competence in behavioral methods meant to mitigate behaviors of concern within inpatient settings these methods are more likely to be reliably implemented. Relatedly, this process of teaching staff other measures of working with people makes them more confident to use these measures and have positive outcomes that help them mitigate the stressors of such settings. Therefore, the behavioral knowledge and training of nursing staff working closely with patients who have behaviors of concern is integral to seeking alternatives to coercive measures such as S&R.

Sensory Modulation

Throughout and across many studies the use of sensory modulation has been implemented to help reduce the use of S&R (Anderson et al., 2017; Champagne & Stromberg, 2004; Sutton & Nicholson, 2011; Vakiparta et al., 2019). The idea of sensory modulation (SM) fosters the self-regulation of both emotional and physiological arousal and can support the reduction of S&R (Anderson et al., 2017; Champagne & Stromberg, 2004). The use of SM has been deemed an efficacious treatment intervention for patients who are anxious, agitated, distressed, or potentially aggressive, and also as an alternative for coercive methods (Sutton & Nicholson, 2011).

Introducing a breadth of SM supplies on units has been identified as helpful strategies to increase prosocial behavior and decrease behaviors of concern, as well as decrease the use of S&R (Anderson et al., 2017; Carr et al., 2024; Chandler, 2012). SM supplies may include many things such as personally identified music, aromatherapy, a weighted blanket, therapy balls, or the ability to touch ice cubes, or take a warm and/or cold shower based on preference. Across studies, the use of SM has been encouraged and supported by staff and, initially evaluated via a sensory assessment; it can be different per person (Anderson et al., 2017; Chandler, 2012; Cummings et al., 2010; Sivak, 2012). Sensory modulation rooms have also been designed which are meant to be comfort rooms where a patient can get space and distance from the intensity of an inpatient setting and feel enhanced self-soothing and more emotion regulation (Anderson et al., 2017; Cummings et al., 2010; Sivak, 2012). These are different than seclusion as in these are not forced isolation or separation from other individuals on the unit and people are able to make the choice to use this intervention and come and go as they please. Sensory modulation rooms may include a calming mural on the wall, a comfortable chair, calming music, and/or other offered personally self-identified soothing strategies to use in a comfort room. An extensive review of the literature across nations also shows SM's positive impact across diverse cultures, across diverse race and for ethnic groups, among young, middle, and senior adults, and its positive outcome for those that may be at a disparate likelihood of experiencing S&R, such as those with schizophrenia and intellectual and developmental disorders (Kandlur et al., 2022). These positive outcomes were found in emergency room settings, inpatient psychiatric units, geriatric units, intensive care units and had positive outcomes for patients and staff. This review also indicated the value of cultural adaptations for diverse cultures and to honor individual

preferences, such as the use of individualized spiritual soothing materials such as a Koran, diverse forms of music, a performance of haka (war dance), m. teatea (traditional chant), and waiata-ringa (action song), yoga, spices, auditory training (e.g., listening to electronically modified music), and aromatherapy, among many other interventions.

Psychiatric Advance Directives

Psychiatric advance directives (PAD) are legal documents created by service-users to outline their preferences for mental health treatment in the event that they lose decisional capacity. PADs are typically drafted during a state of wellness and lucidity in order to prepare for potential future crisis situations. As a result, PADs are considered tools for self-empowerment and self-determination in allowing service-users ownership over their own health decisions.

A systematic review of PADs found that service-users often include specific and preferred personal methods for de-escalating crises (Srebnik, et al, 2005), such that service providers can read an individual's PAD to understand how best to soothe them in the event of escalating behavioral concerns, as a way to reduce resorting to S&R use. In a study that compared people with PADs from people without PADs, Swanson and colleagues (2009) found that amongst those with PADs, there were lower odds of being subject to coercive practices, including S&R use. Significant barriers exist to further research the impact of PADs on reduction of S&R use; for example, not all states have PAD statutes (National Resource Center on Psychiatric Advance Directives, 2023) and in states with PAD legislation, update and implementation by clinical staff is low (Shields, et. al., 2014). Therefore, advocating for PAD implementation across state lines and the promotion of large-scale research studies may be an important step towards understanding the potential role these documents may play in reducing S&R (from both patient and clinician/worker factors). A recent study across VHAs shows veterans with SMI have a low prevalence and/or implementation rate of a PAD (McBride et al., 2025) and a study across countries shows the value of these despite poor completion rates (Gallard et al., 2022). From a social justice perspective, in the U.S. there are racial/ethnic disparities in the use of PAD related to issues such as mistrust, which needs to be addressed but is not surprising (Hong et al., 2018).

Collaborative Problem Solving

Collaborative Problem Solving (CPS) is an evidence-based intervention (Graesser et al., 2018; Greene et. al., 2006; Martin et. al, 2008) initially used to reduce aggressive behavior in children and adolescents and it has also been used effectively with adults in reducing S&R (Pollastri et al., 2019). CPS is a manualized, cognitive-behavioral strategy that focuses on the prevention of behavioral outbursts, violent behavior, and self-harm. The intervention begins with developing a formulation of the psychological factors that contribute to aggression and self-harm, including deficits in one's capacity for emotion regulation, frustration tolerance, problem solving, social cognition/skills, and adaptability/flexibility skills (Greene et. al., 2006).

In a pilot study exploring the implementation and feasibility of incorporating CPS into a highly utilized inpatient psychiatric unit over the course of five years, the adoption of CPS was found to significantly reduce the use of restraints (Martin et. al., 2008). Another study exploring the adoption of CPS on a child and adolescent inpatient unit found that in the 9 months prior to adopting CPS, 281 episodes of restraint occurred. After the adoption of CPS, this number fell to only one episode in 15 months (Greene et. al., 2006). Importantly, physical injuries to both staff and patients also decreased during the post-implementation period; such that an average of 10.8 staff and patient injuries occurred each month prior to CPS with this number being reduced to 3.3 injuries per month after the implementation of CPS. This finding indicates that contrary to common perceptions, restraint use does not necessarily indicate a physically safer environment. Older adults may particularly

benefit from engagement in collaborative problem solving as there are indications that among adults such strategies may work more efficiently among older adults as they capitalize more efficiently on these methods (Strough et al., 2008). There are also now meta-analyses on CPS among adults and its capacity to foster critical thinking and positive attitudes, however, more research is needed among those with SMI and diverse populations (Xu et al., 2023).

Safewards

The Safewards Model, developed in the United Kingdom, was developed specifically for use on adult inpatient psychiatric units. The goals of the model are to reduce conflict, which the developers identify as aggression, self-harm, suicide, absconding, substance/alcohol use and medication refusal, and containment, inclusive of involuntary medication, coerced intramuscular medication, seclusion, manual restraint, special observation in order to promote safety on the ward (Bowers, 2014). The Model examines the interaction between multiple factors in the development of “flashpoint” or potentially unsafe situations (e.g., telling a patient information that may be upsetting), including in the domains of staff, environmental, patient characteristics (e.g., age, gender, personality), outside the hospital (e.g., family, friends outside the unit), patient community, and regulatory frameworks (i.e., hospital policies). Safewards explores these domains and identifies modifiable factors that may limit conflict and containment. Key aspects of the intervention include: clear mutual expectations, mutual help meetings, gentle communication techniques, verbal emotion regulation techniques (“talking down”), getting to know each other (e.g., staff sharing personal information as they feel comfortable about their hobbies and interests), public display of messages from patients’ recently discharged, and techniques for mitigating bad news. A complete list of interventions and skills can be found on www.safewards.net. Although a relatively newer intervention, a blind, randomized control trial of 31 wards, found significant difference between experimental and control wards, such that experimental wards showed a 14.6% decrease in conflict and a 23.6% decrease in containment (e.g., seclusion and restraint use) (Bowers et al., 2015), indicating the Safewards Model as a promising intervention for further study.

Trainings Across Diverse Settings

It is important to note that training across diverse settings may look very different as well. There are nuances and experiences that can be offered in some settings and staff may be under different pressures, expectations, and have different mechanisms for support as well. One important setting to note is emergency room departments which have been studied some, including developing innovative methods such as a simulation room of an aggressive event and helping train a specialized team to respond to escalation, with understanding that emergency rooms are already highly intense settings (Wong et al., 2015). Relatedly, Roppolo and colleagues (2020) have been able to elucidate some of the national best practices for de-escalation in emergency room settings, called Project BETA (Best Practices in the Evaluation and Treatment of Aggression) which includes a focus on verbal de-escalation as a first-line intervention, appropriate psychiatric evaluations and treatment of comorbid medical concerns, pharmacotherapy designed to target the etiology of the agitation and minimization of physical S&R. Training is also deeply impacted by available resources and there may be more challenges with implementation science in places where there is less funding. There is a need to advocate for funding that can support the generalization of research findings and implementation of such interventions across many settings.

In other inpatient psychiatric settings trainings may differ from training in the ED tremendously with a focus on many of the aforementioned alternatives. On another note, training in alternatives for settings like nursing homes may include many of the before mentioned

interventions but also have to focus on unique needs of older adults and the even greater risk of complications from experiences such as S&R and risk for death (Lee et al., 2021). Relatedly, the training has to also focus on the high prevalence of different forms of restraint in nursing homes and how teams can best meet the unique needs of older adults.

Advances to Research & Stakeholder & Cross-institution Collaboration

It is imperative that as APA works towards an effort to reduce S&R that multiple things occur. First, as they work towards such efforts it is evident that many stakeholders who have already worked on this topic in terms of education, research, advocacy, and clinical implementation are involved. Such stakeholders would include, but are not limited to: SAMHSA, NASMHPD, the American Nursing Association (ANA), the American Psychiatric Nursing Association (APNA), the American Psychiatric Association, The Joint Commission, Centers for Medicare/Medicaid, and Department of Health and Human Services. The APA already has connections with some of these partners that we could foster as we work on this and there are many diverse ways we could foster collaborations with agencies vested in this work such as connecting with specific boards and committees that specialize in this advocacy work and create an integrated network across organizations and disciplines. There are many such organizations that would and are ready to collaborate, as evidenced by the feedback from this NBI development from organizations and outreach by other leaders in vested organizations. The initial year of this work would likely center on developing such stakeholder collaboration.

Relatedly, as APA seeks to help promote the use of alternatives for S&R nationally, it will be important to also advocate for more research on how effective such approaches are within systems of care as transparency and databases for collection of S&R data are further curated and heightened. Similarly, as advocacy can advance and more transparency can occur for the public the data can inform more direction about the needs of the nation in areas of the country that have unique or disparate growth needs, as the data is better able to capture what we know about the rates of S&R, the impact of alternatives, and an increased accountability for use. As an example, in one state, there is a set time limit on how long an adult and a child can be in restraint and this threshold itself may differentiate restraint use and length of restraint in that state versus other areas just because of this accountability measure at a legal level (Disability Rights Texas, 2025).

B.(15) Council voted to adopt as APA policy the *Guidelines for Education and Training Competencies for Doctoral-Level Psychology Practice in Primary Care* approved December 31, 2036 as the expiration date for the guidelines.

C.(16) Council voted to adopt as APA policy the *Guidelines for Diagnosis of Intellectual Disability* and approved December 31, 2036 as the expiration date for the guidelines.

D.(17) Council voted to receive the *Clinical Care Report: APA Presidential Task Force Report on Women's Health and Well-Being During Midlife and Menopause: The Imperative to Improve Access to and Quality of Medical and Mental Health Care*.

Additionally, Council voted to receive the *Research Report: APA Presidential Task Force Report on Women's Health and Well-Being During Midlife and Menopause: Research Gaps and Recommendations*.

E.(27) 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 2027.

F.(28) Council was provided as information an update on plans to revise APA's Model Act for State Licensure of Psychology Professionals.

XI. SCIENTIFIC AFFAIRS

A.(18) Council voted to refer item #18, Endorsement of the Psychological Specialty in Industrial-Organizational Psychology Certification to the Board of Professional Affairs, Board of Educational Affairs and the Committee for the Recognition of Specialties and Subspecialties in Professional Psychology.

XII. PUBLIC INTEREST

A.(19) Council voted to archive the following 2011 *Resolution on Family Caregivers*:

Whereas 65.7 million Americans, in 31 percent of all U.S. households, provide family caregiving during the course of any given year for ill or disabled family members across the lifespan, including 48.9 million who have cared for only adult recipients, 3.9 million who have cared for only child recipients, and 12.9 million who have cared for both child and adult recipients (National Alliance for Caregiving, 2009);

Whereas 16.8 million family caregivers have provided care to a child under the age of 18 with special needs (National Alliance of Caregiving, 2009), 9.9 million family caregivers have provided care for a person with Alzheimer's disease or other dementia (Alzheimer's Association, 2009), 8 million U.S. families include at least one parent that has a disability (Parents with Disabilities Online, 2010), 2.4 million family caregivers are primary caregivers for their grandchildren (U.S. Census Bureau, 2006), and 1.3 to 1.4 million children and teens serve as caregivers for sick siblings, parents or aging relatives (National Alliance for Caregiving, 2005);

Whereas the number of family caregivers is expected to increase due to the aging of the population, and an escalating rate of chronic, debilitating health conditions (Crimmins, 2010) and fully two-thirds of the U.S. public expects to be caregivers in the future (Opinion Research Corporation, 2005);

Whereas the majority of family caregivers are women (National Alliance for Caregiving, 2009) including over two-thirds of grandparent caregivers (Butts, 2005), and there is evidence that women take on more caregiving tasks, report more care recipient problems, and experience more distress due to caregiving than male caregivers (Pinquart & Sorensen, 2006a; Yee & Schulz, 2000);

Whereas the percentage of males who are primary caregivers has increased 50% from 1984 to 1994 (Spillman & Pezzin, 2000);

Whereas many spousal caregivers of individuals aged 65 and older are older themselves – most spouses who provide care to their disabled spouse are aged 65 and older, with 44% of spouse caregivers in their 70s and about one quarter in their 80s (Johnson & Weimer. 2006);

Whereas almost half -- 46 percent -- of lesbian, gay, bisexual and transgendered elders provide care to families of origin or families of choice (National Gay and Lesbian Task Force Policy Institute, 2005);

Whereas children and adolescents who serve as caregivers are at risk for less than optimal developmental, social, emotional, and/or behavioral outcomes, specialized services targeting this population are needed (National Alliance for Caregiving, 2005);

Whereas family caregivers are essential in providing care and facilitating community re-integration for service members and Veterans, many of whom are unprepared to cope with chronic illnesses exacerbated by age, and/or polytraumas such as brain injury, chronic pain, amputations or post-traumatic stress disorder (PTSD), and other mental health disorders that have been reported by a majority of active, reserve and retired service members of Operation Iraqi Freedom/Operation Enduring Freedom (President's Commission on Care for America's Returning Wounded Warriors, 2007);

Whereas family members of those with severe mental illness may need to assume supportive caregiving functions at times, especially during periods of acute exacerbation of illness, because of the scarcity of community-based housing alternatives and mental health services (Kaufman, et al, 2010; Lefley, 2009);

Whereas end-of-life caregiving presents a number of particular challenges, including the necessity of making life and death decisions about matters such as whether to utilize life-sustaining treatments and hospice care, intense care demands, and witnessing pain and suffering in loved ones (Stajduhar et al., 2010);

Whereas 1 in 10 working-age adults between 19 and 64 years of age are caregivers for a sick or disabled family member, and these working-age family caregivers are more likely to miss days of work, lack health insurance coverage, and live in households with incomes that are less than twice the federal poverty level, compared to non-caregivers (The Commonwealth Fund, 2005);

Whereas the nature and outcomes of family caregiving, and family structures and roles are different for various sub-groups, depending on such factors as age, gender, cultural and ethnic diversity and traditions, disability, sexual orientation, language, values and beliefs, socioeconomic status, degrees of acculturation and assimilation, interpersonal life experiences, religious affiliation, and geographic location (APA, 2010);

Whereas family caregivers may experience considerable burden, stress, and disruption of their own well-being, employment, educational and social pursuits (National Alliance on Caregiving, 2005), and are at increased risk for psychological and physical health problems, including premature mortality (Pinquart & Sorensen, 2003; Schulz & Beach, 1999), and increased mortality, coronary heart disease and stroke, particularly under conditions of high strain (Haley, et al., 2010; Lee, Colditz, Berkman, & Kawachi, 2003);

Whereas caregiving has significant consequences on the mental and behavioral health of family caregivers, including higher levels of stress and distress, depression, emotional problems, and cognitive problems than their non-caregiving counterparts (Brehaut et al., 2004; Douglas & Daly, 2003), and estimates suggest that between 40 to 70 percent of caregivers have clinically significant symptoms of depression, with approximately one-fourth to one-half of these caregivers meeting the diagnostic criteria for major depression (Zarit, 2006);

Whereas despite their important function in carrying out the in-home care plans prescribed by health care and social service systems, and a sense of fulfilling one's family obligations and

responsibilities, family caregivers frequently operate without adequate training, preparation, or ongoing support from these systems (Shewchuk & Elliott, 2000);

Whereas APA has historically supported efforts to enhance the health and well-being of family caregivers as exemplified in its 2010 Presidential Initiative on Caregivers and its product, The Family Caregiver Briefcase for Psychologists, the adoption of Blueprint for Change: Achieving Integrated Health Care for an Aging Population (2007) that highlights the role of family caregivers in integrated care models, and its membership in coalitions to encourage increased services and research to support the needs of family caregivers, including the National Alliance for Caregiving, Lifespan Respite Task Force, National Quality Caregiving Coalition, and the Consortium for Citizens with Disabilities;

Whereas psychologists have been major contributors to research on family caregiving beginning with its emergence as an important area of psychological research in the 1980s (Zarit, Reever & Bach-Peterson, 1980), and flourishing since in a variety of areas, cutting across age groups, health and disability conditions, and diverse sub-populations (APA, 2010);

Whereas family caregiving is an area of psychological research that has inspired both basic scholarly research (e.g., on the impact of different kinds of social support on caregiver well-being) and applied research (e.g., evaluating the efficacy of specific caregiver interventions) (APA, 2010);

Whereas psychological research has documented that caregiver interventions including cognitive behavioral therapy, psychoeducational interventions, psychotherapy, and culturally appropriate multicomponent interventions have proven effective in decreasing burden and depression while improving well-being, ability/knowledge, care recipient symptoms, and delaying nursing home placement (Gallagher-Thompson & Coon, 2007; Mittelman et al., 2006; Pinquart & Sorensen, 2006);

Whereas for over 20 years Psychologists have taken a leadership role in creating, implementing, evaluating and disseminating evidence-based interventions for reducing distress, and improving well-being of family caregivers and care recipients, and will increasingly be called upon to do so as the population ages and becomes increasingly diverse (APA, 2010);

Whereas APA has promulgated guidelines on practice with culturally diverse populations which hold relevance for psychological practice with caregivers including Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (2002), Guidelines for Psychological Practice with Older Adults (2003), Guidelines for Psychological Practice with Girls and Women (2007), Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (2011), Guidelines for Assessment of and Intervention with Persons with Disabilities (2011), and the Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change (2011);

Whereas there is inadequate access to, availability of, and financing for culturally sensitive, evidence-based interventions and services for family caregivers;

Whereas there is an increased need for assessment and diagnosis of family caregivers' mental health problems and strengths in the context of their culture, family, and community;

Whereas there is a need for increased research-practice collaboration for the translation of evidence-based practices into community-based, culturally appropriate, family caregiver interventions and services;

Therefore be it resolved that the American Psychological Association:

Continues to serve as a leader in raising awareness about the critical role that family caregivers play in our society, and to inform and advocate for psychological research, interventions, services, and supports that promote optimal health, well-being, and quality of life for family caregivers and their care recipients.

Encourages psychologists to use the APA Family Caregivers Briefcase for Psychologists as a resource for considering how they might assist the diverse group of family caregivers and care recipients through individual and organizational practice, research, teaching and community service.

Encourages its Offices, Boards, Committees, Divisions and State and Territorial Psychological Associations to educate their colleagues about the availability and utility of the APA Family Caregivers Briefcase for Psychologists with particular attention to individuals across the lifespan with disabilities and/or chronic health conditions, including mental health and addictive disorders and HIV/AIDS; culturally diverse groups; those near end-of-life; intergenerational families; gay, lesbian, bisexual and transgender persons; service members and Veterans; and those of low socioeconomic status.

Disseminates APA Family Caregivers Briefcase for Psychologists to diverse media outlets, including both majority and minority media outlets, and those with audiences across the socioeconomic spectrum.

Considers inclusion of messages within existing and future APA Public Education campaigns on the key issues described in the APA Family Caregivers Briefcase for Psychologists.

Promotes and facilitate psychologists' acquisition of competencies with respect to caregiving practice and research, including promoting opportunities for psychologists to study, research, and obtain skills for intervening with caregivers.

Supports interdisciplinary efforts to increase the competency of psychologists and other health care professionals in identifying and collaborating to address caregiving issues.

Supports the development and replication of culturally competent, developmentally appropriate, family-oriented, evidence-based, high-quality services for family caregivers that are in accessible settings.

Promotes the latest evidence-based psychological treatments/interventions with family caregivers with increased emphasis on community-based treatment approaches, as well as approaches suited to health care settings.

Fosters increased research-practice collaboration for the translation of evidence-based practices into community-based, culturally appropriate, family caregiver interventions and services.

Encourages basic and translational research on caregiver issues aimed at reducing caregiver health risks and improving the quality of life of caregivers and care recipients.

Encourages research on a) how factors of diversity, including age, race/ethnicity, gender, sexual orientation, disability, socioeconomic status, family structure, and immigration status affect the caregiving experience, b) on the best mechanism to translate findings into effective services and c) on how to evaluate services that are developed at the community level.

Acknowledges that we have a responsibility to inform professionals, the public, and policymakers - in language that is accessible for the targeted audience - about the importance of promoting the psychological well-being of caregivers across the life span. Supports public policies to increase caregiver research and prevention and intervention efforts, including innovative models for engaging caregivers in the interdisciplinary health teams caring for the care recipient.

Advocates for access to and appropriate reimbursement for, mental and behavioral health services and psychosocial supports for family caregivers individually and with their care recipient.

Continues to train psychologists as policy advocates and facilitates opportunities for them to advocate for public policies that support family caregivers at the local, state, and federal level.

Encourages APA to work with government agencies and private funding sources to promote research and prevention and intervention efforts to improve the health and well-being of family caregivers.

References

- American Psychological Association. (2002) Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. Retrieved April 26, 2011, from <https://www.apa.org/pi/oema/resources/policy/multicultural-guidelines>
- American Psychological Association. (2003). Guidelines for Psychological Practice with Older Adults. Retrieved April 26, 2011, from <https://www.apa.org/practice/guidelines/older-adults.pdf>
- American Psychological Association. (2007). Guidelines for Psychological Practice with Girls and Women. Washington, D.C.: Author. Retrieved April 26, 2011, from <https://www.apa.org/about/division/girlsandwomen.pdf>
- American Psychological Association, Presidential Task Force on Integrated Health Care for an Aging Population. (2008). Blueprint for change: Achieving integrated health care for an aging population. Retrieved April 26, 2011, from <https://www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf>
- American Psychological Association, Presidential Task Force on Caregivers (2010). APA Family Caregiver Briefcase for Psychologists. Retrieved April 26, 2011, from <https://www.apa.org/pi/about/publications/caregivers/index>
- American Psychological Association. (2011). Guidelines for the Assessment of Dementia and Age-related Cognitive Decline. Retrieved April 26, 2011, from <https://www.apa.org/pi/aging/resources/dementia-guidelines.pdf>
- American Psychological Association. (2011). Guidelines for Assessment of and Intervention with Persons with Disabilities. Retrieved April 26, 2011, from <https://www.apa.org/pi/disability/resources/assessment-disabilities>

- American Psychological Association. (2011). Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients. Retrieved April 26, 2011, from <https://www.apa.org/pi/lgbt/resources/guidelines>
- Alzheimer's Association (2009). Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia*, 5, (3).
- Brehaut, J.C., Kohen, D. E., Raina, P., Walter, S.D., Russell, D.J., Swinton, M., O'Donnell, M., Rosenbaum, P. (2004) The health of primary caregivers of children with cerebral palsy: how does it compare with that of other Canadian caregivers? *Pediatrics*, 114, e182–e191. doi: 10.1542/peds.114.2.3182
- Butts, D. M. (2005). *Kinship Care: Supporting Those Who Raise our Children*. Baltimore, MD: Annie E. Casey Foundation. Retrieved April 26, 2011, from <https://www.aecf.org/initiatives/mc/readingroom/documents/Kincare.pdf>.
- Crimmins, E. M. & Beltrán-Sánchez, H. (2010). Mortality and morbidity trends: Is there compression of morbidity? *Journal of Gerontology: Social Sciences*, 66B, 1, 75–86. doi: 10.1093/geronb/gb1088
- Douglas S.L., & Daly B.J. (2003). Caregivers of long term ventilator patients: Physical and psychological outcomes. *Chest*, 123 (4), 1073-1081. doi: 10.1378/chest.123.4.1073
- Easterseals & the National Alliance for Caregiving (2007). *Caregiving in Rural America*. Retrieved April 26, 2011, from <https://www.easterseals.com>
- Family Caregiver Alliance (2001). *Selected Caregiver Statistics (Fact Sheet)*. San Francisco, CA: Author.
- National Alliance for Caregiving (2009). *Caregiving in the U.S.* Retrieved April 26, 2011, from https://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf
- Gallagher-Thompson, D., & Coon, D. W. (2007). Evidence-based psychological treatments for distress in family caregivers of older adults. *Psychology and Aging*, 22, 37-51. doi: 10.1037/0882-7974.22.1.37
- Haley, W. E., Roth, D. L., Howard, G., & Stafford, M. M. (2010). Caregiving strain estimated risk for stroke and coronary heart disease among spouse caregivers: Differential effects by race and sex. *Stroke*, 41, 331-336. doi: 10.1161/STROKEAHA.109.568279
- Johnson, R.W & Weimer, J.M. (2006). *A Profile of Frail Older Americans and Their Caregivers*. Retrieved April 26, 2011, from <https://www.urban.org/publications/311284.html>
- Kaufman A.V., Scogin F., MacNeil G., Leeper J., Wimberly J.(2010). Helping aging parents of adult children with serious mental illness. *Social Service Research* 36, 445-459. doi: 10.1080/01488376.2010.510949
- Lee, S., Colditz, G., Berkman, L., & Kawachi, I. (2003). Caregiving and risk of coronary heart disease in U.S. women: A prospective study. *American Journal of Preventive Medicine*, 24(2), 113–119. doi: 10.1016/S0749-3797(02)00582-2
- Lefley, H. P. (2009). *Family psychoeducation for serious mental illness*. New York, Oxford University Press. doi: 10.1093/acprof:oso/9780195340495.003.0002
- Mittelman, M. S., Haley, W. E., Clay, O. J., & Roth, D. L. (2006). Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. *Neurology*, 67, 1592-1599. doi: 10.1212/01.wnl.0000242727.81172.91
- National Alliance for Caregiving (2009). *Caregiving in the U.S.* Retrieved April 26, 2011, from https://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf
- National Alliance for Caregiving.(2005). *Young Caregivers in the U.S.* Retrieved April 26, 2011, from <https://www.caregiving.org/data/youngcaregivers.pdf>
- National Alliance for Caregiving (2004). *Caregiving in the U.S.* Washington, DC: Author.
- National Gay and Lesbian Task Force Policy Institute (2005) *Selling Us Short: How Social Security Privatization Will Affect Lesbian, Gay, Bisexual, and Transgender* Retrieved April 26, 2011, from <https://thetaskforce.org/downloads/reports/reports/SellingUsShort.pdf>

- Opinion Research Corporation (2005). Attitudes and Beliefs about Caregiving in the United States: Findings of a national opinion survey. Opinion Research Corporation.
- Parents with Disabilities Online (2010). Retrieved April 26, 2011, from <https://www.disabledparents.net>
- Pinquart, M., & Sorensen, S. (2006). Gender differences in caregiver stressors, social resources, and health: An updated meta-analysis. *Journal of Gerontology: Psychological Sciences*, 61B, P33-P45.
- Pinquart, M., & Sörensen, S. (2006). Helping caregivers of persons with dementia: Which interventions work and how large are their effects? *International Psychogeriatrics*, 18, 577-595. doi: 10.1017/S1041610206003462
- Pinquart, M., & Sorensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: a meta-analysis. *Psychology and Aging*. 18, 250 – 267. doi: 10.1037/0882-7974.18.2.250
- President's Commission on Care for America's Returning Wounded Warriors (2007). *Serve Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors*. Retrieved April 26, 2011, from <https://www.veteransforamerica.org/wp-content/uploads/2008/12/presidents-commission-on-care-for-americas-returning-wounded-warriors-report-july-2007.pdf>
- Schulz, R., & Beach, S.R. (1999). Caregiving as a risk factor for mortality: The Caregiver Health Effects Study. *Journal of the American Medical Association*, 15, 2215–2219. doi: 10.1001/jama.282.23.2215
- Shewchuk, R., & Elliott, T. (2000). Family caregiving in chronic disease and disability: implications for rehabilitation psychology. In R. G. Frank, & T. Elliott (Eds.), *Handbook of rehabilitation psychology* (pp. 553–563). Washington, DC: American Psychological Association Press. doi: 10.1037/10361-026
- Spillman, B.C., & Pezzin, L.E. (2000). Potential and Active Family Caregivers: Changing Networks and the 'Sandwich Generation.' *The Millbank Quarterly*, 78, 3, 347-374. doi: 10.1111/1468-0009.00177
- Stajduhar, K. I., Funk, L., Toye, C., Grande, G. E., Aoun, S., & Todd, C. J. (2010). Part 1: Home-based family caregiving at the end of life: a comprehensive review of published quantitative research (1998-2008). *Palliative Medicine*, 24, 573-593. doi: 10.1177/0269216310371412
- The Commonwealth Fund (2005). *Issue Brief: A Look at Working-Age Caregivers' Roles, Health Concerns, and Need for Support*. Retrieved April 26, 2011, from <https://www.commonwealthfund.org>
- United States Census Bureau, (2006). 2005 American Community Survey: Tables S1001 and S1002. Washington D.C.: U.S. Census Bureau.
- Yee, J.,L & Schulz, R (2000). Gender differences in psychiatric morbidity among family caregivers: a review and analysis. *Gerontologist*, 40, 2, 147–164.
- Zarit, S.H., Reever, K.E., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *Gerontologist*, 20, 6, 649-55

Additionally, Council voted to adopt as APA policy the following 2026 *Resolution on Caregivers*:

2026 Resolution on Family Caregivers

Introduction

Family caregiving is an essential and growing focus in psychology. Psychologists have been major contributors to family caregiving science and practice since the publication of one of the first

psychologically-oriented empirical articles on caregiving burden (Zarit et al., 1980). This 2026 Resolution updates the 2011 APA Resolution on Family Caregivers (American Psychological Association [APA], 2011) incorporating contemporary psychological research, practice, education, and advocacy sought to meet the needs of today's family caregivers across their lifespan and various care settings.

Throughout this Resolution, the term family caregiver (FCG) is used to describe an unpaid "family member or other individual who has a significant relationship with and who provides a broad range of assistance to an individual with a chronic or other health condition, disability or functional limitation" (Administration of Community Living [ACL], 2022, p.7). These relationships are inclusive of FCG who provide care to families of origin as well as families of choice across diverse caregiving contexts. Consistent with other APA documents and the family caregiving landscape, the scope of this Resolution includes FCGs who provide support to children and adults with various medical or mental health conditions (e.g., intellectual and developmental disabilities [ID/DD], serious psychological and substance use disorders, acute illness and injury, chronic conditions such as diabetes, and progressive and/or life-limiting illnesses, such as neurocognitive disorders and cancer). This Resolution also includes FCGs who are primary caregivers to their grandchildren who may have a medical or mental health condition (ACL, 2022; APA, 2011).

The annual cost to the economy of family caregiving is \$522B in the US according to the latest estimates (ACL, 2024). Although FCGs are, by definition, unpaid, some may receive a stipend through the Centers for Medicare & Medicaid Services (CMS) or the Veterans Health Administration (VA). However, such minimal financial support is not sufficient to meet the needs of all FCGs or those who receive their care. Financial impact, access to support programs (e.g., stipend) also vary by state or type of caregivers (AARP and National Alliance for Caregiving, 2025b). The number of, and demands on, FCGs are increasing exponentially due to the rising cost of care. In addition, FCG experience indirect but adverse financial impacts due to out-of-pocket expenses incurred when delivering care.

Complicating the financial situation is the fact that there is a growing shortage of paid caregivers and direct care workers in institutional settings due to burnout, health risks, and career changes since the COVID19 pandemic (ACL, 2024), as well as recent changes in immigration policy and enforcement in the US (Chidambaram & Pillai, 2025). Globally, demands on care systems are increasing, although care work continues to disproportionately fall on women and especially older women (United Nations, 2024). Additional factors include the greater emphasis on managing serious illnesses in outpatient settings, partly reflecting the desire among older adults to "age in place." The time commitments of caregiving can force FCGs, especially women, to reduce their employment or leave the workforce completely to care for their family members, potentially leading to absenteeism, reduced productivity, employment instability, and career disruption. This is particularly true when FCGs lack employer support, do not have flexible schedules, have limited workplace benefits, especially as hourly workers (AARP & NAC, 2025b), or work in an environment where there may be stigma and discrimination towards one's caregiver status.

Limited time and financial resources can become barriers to FCGs' equitable access to and engagement in their own self-care, especially among caregivers with intersecting, marginalized identities (Cohen et al., 2022; Longacre et al., 2021). FCGs may forego both leisure opportunities and preventive medical care, which can have long-term implications for their own health. Older FCGs may experience their own serious medical issues or even death, disrupting the caregiving

fabric and placing the care recipient in a vulnerable situation. Finally, it is common to have a network of FCGs that may have positive experiences as they share caregiving responsibilities and offset some caregiver burden. However, FCG networks may also lead to increased interpersonal stress as they communicate their own expectations, negotiate responsibilities, and deal with difficult family dynamics that may predate the caregiving context, sometimes resulting in complications with care coordination and care fragmentation (Tingey et al., 2020).

It is therefore crucial for psychologists to maintain an ongoing role in family caregiving research, practice, education, and advocacy to address the evolving stress, mental health concerns, and potentially unmet needs of FCGs, such as by supporting the US National Strategy to Support Family Caregivers (2022).

Nature and Context of Family Caregiving

In 2025, there were an estimated 63 million Americans, or 24% of the U.S. population, serving as FCGs (AARP & NAC, 2025a). The average age of FCGs is 51 years, and the average age of the care recipient is 69.8 years. An estimated 22% of FCGs are aged 65 years and older and 61% are women. Among FCGs, 65 percent identify as non-Hispanic White; ten percent reported being lesbian, gay, bisexual, and/or transgender. While intended to be nationally representative, these data are limited by the underrepresentation of different racial/ethnic minority groups, as well as the lack of disaggregation of Asian, Native Hawaiian, and Pacific Islander groups. Furthermore, these surveys were conducted in English, thereby limiting the likelihood of capturing of the experiences of non-English speakers.

According to the same report, FCGs provide care to a wide variety of family members, including parents, children (both under 18 and adult), spouses/partners, siblings, grandparents, and “chosen families” including friends or other kinship groups. Approximately 24% of FCGs care for more than one family member. Half of all FCGs care for a parent (40%) or parent-in-law (7%), and 5.7% care for a child with an illness, injury, disability, or mental health problem. A substantial percentage also care for a spouse (15%), grandparent or grandparent-in-law (8%) or non-relative (11%).

FCGs provide emotional support, help with activities of daily living (e.g., bathing and toileting), instrumental activities of daily living (e.g., managing finances and medications), self-management support (e.g., managing medications, preventive care), and coordination of healthcare and social services. FCGs are often responsible for communicating with medical and mental health professionals to coordinate care across care transitions (e.g., from hospital to nursing home), understand and advocate for the needs of the care recipient. Although family caregiving usually takes place at the care recipient’s home in the community, it may also involve other healthcare and residential care settings (e.g., hospital ICU, skilled nursing facilities, hospice). FCGs may therefore be required to assist in coordinating the provision of services, including those provided by paid caregivers such as home-health nurses. Evolving responsibilities include digital health management (e.g., electronic medical records) and telehealth navigation.

The nature of caregiving varies substantially depending on the underlying condition. Caregiving in the context of serious mental illness (SMI) often involves managing symptom relapse, medication adherence, crisis episodes, and stigma, with caregivers frequently serving as informal care coordinators within fragmented systems (Perlick et al., 2016). In substance use disorders (SUD), families may navigate repeated relapse cycles, overdose risk, financial and legal

stressors, and complex boundary-setting, with recent research emphasizing the psychological toll on caregivers and the importance of family-inclusive interventions (Osilla et al., 2025). Caregivers of individuals with intellectual and developmental disabilities (ID/DD) often provide lifelong support that includes advocacy, service coordination, and future planning, particularly as parents age (Lindahl et al., 2019; Seltzer et al., 2011). In contrast, dementia caregiving is typically characterized by progressive decline, increasing supervision needs, behavioral symptoms, and anticipatory grief, with well-documented risks for caregiver burden, depression, and health decline (Greene et al., 2026; Pinquart & Sörensen, 2003, 2005; Schulz & Sherwood, 2008). Across conditions, differences in predictability, crisis intensity, duration, and system navigation demands shape caregivers' emotional experiences and support needs.

Psychological research illustrates that the nature and history of the relationship between the FCG and recipient serve as key influences on the caregiving experience. FCGs may receive support from adult children, siblings, or even other relatives and chosen families (Mulcahy Symmons et al., 2023; Opsomer et al., 2022; Phillips et al., 2023; Wiegelmann et al., 2021). For spouses/partners who serve as FCGs, there may be both higher positive and negative impacts of caregiving, compared to non-spousal/partner caregivers (Dang et al., 2022). The negative effects are especially pronounced for care recipients when caregiving is intensive, such as when the recipient has dementia (Lai et al., 2024). Research suggests that adult children caring for a parent, including Millennial caregivers and those who are middle-aged and older, may have different resources and needs based on their developmental stage (e.g., childcare needs, work advancement), which could result in having dual roles and added pressures; yet, they may also report greater satisfaction due to role enhancement. A narrative review of literature from 2004 to 2019 cited the ongoing stress faced by custodial grandparents, including complex family relationships and the need for parent training (Hayslip et al., 2019). Thus, there are important historical and generational influences on caregiving (Aaron et al., 2023; Brady et al., 2024).

Family and paid caregivers increasingly function as an intertwined workforce, and about one third of FCGs support someone who also receives paid home care from a direct care worker. Many paid workers first entered the field as unpaid family or friend caregivers themselves (PHI and NAC, 2024). As with FCG, paid caregivers report intensive physical and emotional labor. However, unlike FCG, they struggle with unique challenges of role ambiguity, feelings of disrespect, and low wages, contributing to high turnover that can affect FCGs (Sterling et al., 2021). Since immigrants comprise 28-32 percent of the direct care workforce, the current enforcement-oriented immigration policy and the rollback of protections for health facilities are expected to further destabilize staffing. These policies impact both paid caregivers and FCG, who must absorb gaps in paid care coverage and navigate even more under-resourced care teams (Center for Medicare Advocacy, 2025).

To provide optimal support to FCGs, psychologists need to be familiar with the range of circumstances and challenges that face this large and growing segment of the population.

Identity, Intersectionality, and Family Caregiving

The family caregiving experience is further shaped by the FCG's various identities, including age, gender, sexual orientation, race and ethnicity, health and disability status, education, and socioeconomic status. Of course, no two FCGs from a demographic group will have identical caregiving needs, experiences, and supports due to other demographic (e.g., age, disability), cultural (e.g., racial/ethnic minority, indigenous identity, immigration status), and geographic (e.g., rurality, natural disasters, geographic isolation on reservations) factors. Historically,

empirical evidence has reflected the experiences of FCGs who are non-Hispanic White, heterosexual, and are part of nuclear families.

In most cultures, gender norms dictate that women are caregivers. As noted earlier, 61% of all FCGs in the United States are women, and research indicates that women are more likely than men to provide intensive care, emotional support, and longer-term care, thereby reducing their time in the workforce and even leaving it completely to become a FCG (Huertas-Domingo et al., 2023). Such decisions have a significant impact on the economic well-being and security of many women FCGs. Because gender norms also intersect with race, women of color FCGs may experience additional expectations to provide care while getting limited financial support. This may be particularly challenging for Black women FCGs who are dealing with their own perinatal health issues as the maternal mortality crisis disproportionately affects Black women (Hoyert, 2025).

Age is another characteristic that has been studied extensively in family caregiving research. An estimated 42% of all FCGs are age 65 or older (AARP & NAC, 2025a). Older spousal/partner caregivers are more likely to be solo caregivers with a disability or illness (Ornstein et al., 2019). Although no research to date has examined FCGs with disabilities, caregivers with disabilities may experience greater access issues when they and their care recipients both need varying types of accommodations and support (e.g., a Deaf FCG needs ASL interpreter services at the hospital where their adult child who is in a coma after a stroke; when a FCG who needs to use a wheelchair is flying with a spouse living with dementia and related behaviors). In addition, disabled parents may experience stigma and discrimination across the lifespan (APA, 2024b). In communities that are impacted by massive incarceration and/or substance use, including Black families, it is more likely for grandparents or older siblings to care for, or become foster or adoptive parents to grandchildren and younger siblings (e.g., Turner et al., 2025; Xu et al., 2025). Although grandparents are generally resilient, they also experience notable financial stress, chronic physical health and psychological concerns, social isolation, stigma about their family circumstance, and difficulties accessing services and support (Hayslip et al., 2019).

There is growing attention to youth caregivers (i.e., FCGs who are under the age of 18 years old). Over 5.4 million children under age 18 provide care for older, ill, or disabled adult family members, with Latinx and Black youth providing higher levels of family caregiving due to systemic inequities and not only cultural factors. Adolescents and youths who care for a parent diagnosed with young-onset dementia may experience interruptions to their educational goals and other developmental needs (Sobers et al., 2025). Youth caregivers experience more emotional challenges, peer difficulties, lower school grades; and there are also poorer health habits among older youths and among White non-Latinx youth caregivers (Armstrong-Carter et al., 2025). Very young children aged six and younger are more likely to provide caregiving (e.g., assisting with household tasks, providing social contact, translating) in households of lower socioeconomic status. According to reports by parents, very young children experience fulfillment in their role as a family caregiver, however, they also experience lost sleep, increased emotional distress, and interference with school and social life.

Over the past few decades, there has been growing attention devoted to understanding the caregiving experiences of different minoritized communities. Minoritized FCGs share commonalities such as more intensive caregiving, juggling multiple caregiving roles, greater economic, educational, legal, and healthcare barriers; less access to caregiving resources; greater discrimination, marginalization, and stigma (e.g. Mage et al., 2024). For example, historical context (e.g., slavery, Jim Crow, medical experimentation), as well as generational,

historical, and contemporary trauma (e.g., the Holocaust, internment camps, genocide, forced assimilation and boarding schools, involvement with the criminal justice system, law enforcement-related violence) may influence caregiving patterns, help-seeking behaviors, and needs in Black, Indigenous, and other minoritized families because these experiences may impact trust in healthcare, mental health care, and other social systems. Immigration and migration history may further impact FCGs' caregiving resources and stress, namely language barriers, unfamiliarity with different healthcare systems, increased uncertainties about their legal status considering recent immigration policy changes, and potential for work exploitation. Furthermore, for FCGs who also work in long-term care settings (Chidambaram & Pillai, 2025), there may be "double caregiving burden" as unpaid caregivers at home. In addition, racial/ethnic minoritized groups often espouse collectivism compared to the individualism prevalent among non-Hispanic white groups, with a focus on familism, filial piety, and filial obligations (Knight & Sayegh, 2010). This may result in a reluctance to seek support outside of the family.

Sexual/gender minoritized groups continue to experience limited support in their caregiving experience. In the 2025 Caregiving in the US study, LGBTQ+ caregivers were less likely to have paid or unpaid assistance, more likely to face negative financial consequences, more likely to be working while caregiving, experiencing more isolation and poorer health, and being less likely to be included in care conversations when their care recipient is in the hospital (AARP & National Alliance for Caregiving, 2025). Research on LGBTQ+ older adult dementia caregivers suggested that minority stress intersected with caregiver stress to impact health, highlighting the importance of considering LGBTQ+ FCGs with intersecting identities, namely those from racial and ethnic minority groups (Lampe et al., 2025). FCG who identify as LGBTQ+ have also historically experienced barriers to social and legal recognition of their relationship status, amplifying the stress on these FCG while also making the act of caregiving uniquely challenging.

As this field continues to evolve, contemporary and future areas for psychological research about FCGs should examine more carefully intersectionality as a conceptual framework to better appreciate the nuances of family caregiving (Brady et al., 2024; Hepburn et al., 2025). In addition, there is an urgent need to improve the data infrastructure to capture the diverse experiences of FCG who have historically not been adequately studied, including but not limited to FCGs in rural communities, FCGs from racial/ethnic minority groups, households with multiple FCGs, FCGs who also work as professional caregivers, and non-English speaking FCGs.

Stress in Family Caregiving

The impact of family caregiving is multidimensional, complex, and variable and can be influenced by demographic variables and health status of the FCG, the intensity of care provided, relationship to the care recipient, diagnosis or condition of the care recipient, symptom severity of the care recipient, and personal and cultural characteristics (Larkin et al., 2019; Schulz et al., 2020; Spiers et al., 2021; van den Kieboom et al., 2024; Walbaum et al., 2024).

Captured by the term "caregiver burden," there is a long history on the combination of challenges faced by FCGs, including caregiving stress, depression and anxiety, quality of life, limited educational opportunities, financial strain, social isolation, and cognitive decline (Al Maqbali et al., 2025; Allen et al., 2017; Daley et al., 2019; Ervin et al., 2022; Haley et al., 2020; Kaddour & Kishita, 2020; King et al., 2024; Larkin et al., 2019; Walbaum et al., 2024). Family caregiving has been found to be associated with increased depressive symptoms (Gallagher &

Wetherell, 2020; Liu et al., n.d.). FCGs of people with dementia are more likely to experience symptoms of depression and anxiety than non-dementia caregivers (Huang, 2022; Sheehan et al., 2021). A heightened risk of depression among FCGs is influenced by various factors, such as caregiver guilt (Han et al., 2025), individual coping mechanisms, hours spent in caregiving, and the caregiving context (Walbaum et al., 2024). Anxiety has also been found to be a prevalent difficulty experienced by dementia FCGs (Kaddour & Kishita, 2020), with caregivers of individuals with Alzheimer's disease reporting higher anxiety and depression scores compared to those assisting with care for persons with other types of dementia (Deli et al., 2024).

The FCG's physical health can also be influenced by substantial and sustained caregiving (Haley et al., 2020). For example, caregiving is associated with higher risk of diseases of the spine, hypertension, diabetes, and reduced quality of life (Janson et al., 2022). FCGs are also found to experience higher rates of dementia risk factors such as excess alcohol consumption, obesity, smoking, depression, social isolation, physical inactivity, air pollution, and LDL cholesterol. FCGs are also less likely than non-FCGs to have health coverage, and have increased risk of inadequate health care coverage, often due to cost (Kilmer, 2024; Tingey et al., 2020). Psychologists, researchers, and those who provide services to FCGs should be aware of the potential strains associated with family caregiving and the impact these can have on mental and physical health. Routine screening of FCG for burden, stress, and depressive symptoms has been shown to be clinically feasible in waiting rooms (Suresh et al., 2023) and primary care (Riffin et al., 2019, 2020, 2021). Conceptualizing caregiving as a chronic stressor should be used to advocate for routine measurement of stress-related physical and physiological measurements.

Resilience in Family Caregiving

Early psychological research on caregiving emphasized caregiver burden and stress rather than the positive benefits of caregiving, such as personal growth and positive affect. However, psychological science on stress and coping (Lawton et al., 1989; Lazarus & Folkman, 20) has facilitated a paradigm shift in caregiving research since the early 2000s, moving the focus from reducing caregiver stress and burden to optimizing positive family caregiving experiences. A concept analysis of the term "resilience" revealed key aspects including acceptance, coping strategies, social support, self-appraisal, and spirituality (Poe et al., 2023).

Research supports the existence of resilience and its conceptual convergence among a variety of caregiving contexts including FCGs caring for those with neurocognitive disorders (Lee & Li, 2022; McKenna et al., 2022) including dementia (Poe et al., 2023; Quinn & Toms, 2019; Yu et al., 2018a), as well as those in palliative care settings (Palacio et al., 2020). A systematic review of 41 published studies identified four key domains of resilience: a sense of personal accomplishment, a sense of mutuality, an increase in family cohesion and functionality, and derivation of meaning and a sense of purpose (Yu et al., 2018b). A narrative synthesis of dementia caregiving across 53 studies found that FCGs' identification of positive aspects of family caregiving was associated with lower self-reported symptoms of depression and burden, better mental health, greater life satisfaction and quality of life, and greater self-efficacy (Quinn & Toms, 2019).

In the only English-published study that has examined older adult FCGs of autistic adults, researchers found that this population is at risk for chronic stress, poor mental health, and decreased quality of life. However, despite such challenges, these FCGs also show evidence of resilience, particularly as facilitated by positive social support, self-efficacy, and problem- and meaning-focused coping styles (Chakurian & Popejoy, 2024).

Resilience also exists among grandparents who serve as FCGs of young children, although there is a need for more evidence on how this is shaped by cultural, socio-interpersonal and policy-related considerations (Hayslip et al., 2019). Resilience also fosters improved mental health in caregivers of persons with late-stage dementia who are using hospice or other palliative care services (Han et al., 2025). Community support and spirituality function as resilience factors in Black FCGs (Idorenyin Imoh & Charity, 2023).

Given the extensive evidence supporting the existence of resilience among FCGs, a reframing of caregiver well-being is needed to foster a more balanced view of the caregiving experience and to provide a basis for interventions (Marino et al., 2017). Although many FCGs from racial, ethnic, sexual, and gender minority groups demonstrate remarkable resilience, clinicians, researchers, and advocates shall strive to dispel stereotypes (e.g., Strong Black Woman schema; Thomas et al., 2022) that may delay efforts to address systemic barriers and to advocate for better caregiver resources, as resilience may co-exist with suffering. Advances in psychological science and practice will rely on incorporating culturally grounded resilience models that include collectivism, spirituality, community coping strategies, while also focusing on positive caregiver outcomes, such as meaning making, advocacy skills development, and post-traumatic growth.

Family Caregiving Interventions

Psychological research on family caregiving cuts across age groups from children and adolescents as caregivers (Armstrong-Carter et al., 2025) to older FCGs caring for adult children with disabilities (Chakurian & Popejoy, 2024). Such information helps inform and tailor the delivery of psychological interventions for other family caregiving relationships. While much of the intervention research has focused on FCGs of people living with dementia, there is a growing evidence base of behavioral interventions that support FCGs of other chronic conditions such as cancer, diabetes, and heart failure (Applebaum et al., 2024; Dionne-Odom et al., 2022; Piette, 2009; Rosland et al., 2022; Trivedi et al., 2023) as well as interventions to support FCGs of those with serious mental illnesses and substance use disorders (Osilla et al., 2025).

Psychologists have taken a leadership role in creating, implementing, evaluating, and disseminating evidence-based interventions in applied research to reduce distress and improve the well-being of FCGs and care recipients, including individual psychotherapy, self-care and relaxation training, skills training (e.g. behavioral management strategies and interventions), psychoeducation (e.g. education about the disease, stress management, resources), support groups, and caregiver family therapy (Burgio & Wynn, 2021; Cheng et al., 2022; Qualls, 2016; Schulz et al., 2020). Cognitive behavioral therapy (CBT), Acceptance and Commitment Therapy (ACT), and mindfulness-based interventions for parents caring for children with serious illness and disabilities, stroke caregivers, and dementia caregivers across racial, ethnic, and cultural groups have demonstrated efficacy and effectiveness (Atefi et al., 2023; Han, 2021; Holmberg Bergman et al., 2023; Risch et al., 2025). A recent clinical handbook summarizes assessment and intervention tools for clinical psychologists treating patients with FCG distress (Gallagher-Thompson et al., 2023).

Psychoeducational programs for family caregivers are widely used to reduce caregiver strain by combining information (e.g., what to expect as the illness progresses, how to interpret behavioral symptoms) with skills training (e.g., problem-solving, communication strategies, behavior management, risk assessment, stress management, and self-care planning), often paired with coaching or peer support. Reviews focused on dementia (Cheng et al., 2022), advanced cancer (Chow et al., 2010), and schizophrenia (Okafor & Monahan, 2023) showed that

these interventions have small-to-moderate benefits for key caregiver outcomes, including reductions in depressive symptoms, caregiver burden, and distress, and improvements in coping and confidence in handling behavior concerns (e.g., Amin Abdelhalim et al., 2025; Burgio & Wynn, 2021; Sikora Kessler et al., 2021) particularly when programs are structured, multi-component, skills-based, and include active practice rather than information only (Meyer et al., 2018; Rouch et al., 2021; Schulz et al., 2003, 2009; Yu et al., 2018b). Efficacious multi-component interventions also improve FCG's knowledge, reduce care recipient symptoms, and delay long-term care placement of care recipients (Cheng et al., 2022; Cheng & Zhang, 2020; Chow et al., 2010; Khiewchaum & Chase, 2021; Pinquart & Sörensen, 2005; Shin et al., 2026; Wiegelmann et al., 2021). For example, REACH II was a large, randomized trial of 642 diverse dementia family caregivers that tested a 12-session skills-based intervention (Belle et al., 2006). The program reduced depressive symptoms across all racial/ethnic groups and improved quality of life for Hispanic and White caregivers. Adaptations have been made by community-based agencies (e.g., 4-session REACH OUT), the US Department of Veterans Affairs (REACH VA; Nichols et al., 2016), cultural adaptations to American Indian and Alaska Native Tribal communities, and the on-line Caregiver TLC: Thrive, Learn, Connect (Montoro-Rodriguez et al., 2025).

Family caregivers frequently experience multiple forms of grief across the caregiving trajectory. Anticipatory grief may arise as caregivers confront progressive changes in a loved one's health, functioning, or identity. Recent studies confirm that higher caregiver burden, illness uncertainty, lack of informativeness, and income level is significantly associated with greater anticipatory grief, and that resilience and strong family functioning can help mitigate these effects (e.g., Li, C., et al., 2023; Li, J., et al., 2022; Wang et al., 2022). Prolonged caregiving stress also places caregivers at risk for compassion fatigue and psychological distress, with research showing links between chronic caregiving demands, emotional exhaustion, and mental health outcomes such as anxiety and depressive symptoms (Applebaum & Sannes, 2025). Some caregivers, particularly those navigating repeated medical crises or crisis care situations, may experience emotional distress and trauma responses, underscoring the value of trauma-informed care approaches that prioritize safety, empowerment, validation, collaboration, empowerment, and holistic support (Meng et al., 2025). Grief-informed and trauma-informed support, including psychoeducation, peer groups, counseling, and respite services, are therefore critical to sustaining caregiver well-being across both caregiving and bereavement phases.

Recent research supported the usefulness of telehealth in improving the mental wellbeing of FCGs of children with neurodevelopmental disorders (Kelson & Dorstyn, 2025) and dementia FCGs whose care recipient transitioned to long-term care settings (Gaugler et al., 2024). Web-based programs, often with facilitator support, can reduce caregiver distress and improve quality-of-life-related outcomes. WHO's iSupport is a prominent example with growing trial evidence in multiple settings (Brijnath & Antoniadis, 2025; Windle et al., 2025; Zhao et al., 2019). In addition, online health communities may support FCGs to flexibly access information and support based on their own schedule, and overcome barriers of distance, mobility, or travel costs (Kamalpour et al., 2021). Interventions with a virtual component, either live or through study-specific software, have been found to be efficacious and effective in specific clinical population such as depression (Aikens, Trivedi, Heapy, et al., 2015), cancer (Badr et al., 2016), diabetes (Aikens, Trivedi, Aron, et al., 2015; Rosland et al., 2015), heart failure (Piette, 2009), as well as for patient-caregiver dyads managing multiple conditions (Trivedi et al., 2023). However, FCGs from marginalized and minoritized groups such as racial and ethnic minority FCGs and FCGs in rural communities may not have reliable access to broadband internet infrastructure often necessary to access these interventions (Wang et al., 2025).

Despite psychology's contributions in basic and applied caregiving research, there is insufficient research-practice collaboration to translate evidence-based practices into community-based, culturally appropriate family caregiver interventions and services (National Academies of State Health Policy, 2022). There is a strong need to either culturally adapt evidence-based programs or co-design programs in collaboration with cultural groups to ensure that the programs meet the needs of the community. Faith-based communities with Black churches are a strong example of such programs (Epps et al., 2022). Accumulating evidence shows that for Black dementia caregivers, programs embedded in faith settings and championed by faith leaders improve caregiving outcomes such as increased knowledge of dementia and improved coping skills (Fields et al., 2025). In general, FCGs may lack equitable access to and engagement in interventions, due in part to the extensive demands of their caregiving responsibilities, particularly FCGs with significant work obligations, regional variability in caregiving resources, limited time, and limited financial resources (Cohen et al., 2022; Longacre et al., 2021). More research is needed to maximize the potential contributions of these interventions in reducing caregiver burden and maximizing resilience.

Education, Training and Advocacy

APA has developed guidelines and resolutions on practice with diverse populations that hold relevance for psychological practice with FCGs, including *Guidelines for Psychological Practice with Older Adults* (APA, 2024a), *Guidelines for Assessment of and Intervention with Persons with Disabilities* (APA, 2022), *Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* (APA, 2021), and the *Resolution on Parents With Disabilities* (APA, 2024b). Currently, there are no professional guidelines for working with FCGs. More information is needed for psychologists and caregivers to increase knowledge and skills in this area beyond static online material. In addition, there are few culturally relevant and personalized education and training opportunities based on variations in preferences, needs, and experiences among FCGs across different disease/caregiving contexts.

To support FCGs, APA continues to train psychologists and facilitate opportunities to advocate for policies supporting FCGs at the local, state, and federal levels. For example, APA encourages the use of the Recognize, Include, Support, and Engage [RAISE] Act (ACL, n.d.) to support FCGs of older adults, as well as grandparents who are caregivers. Additionally, APA supports the mission of the National Institute on Aging to provide vital funding support for caregiving research and training programs across disease contexts. Even when policies are enacted, they may be inequitably implemented in diverse and minoritized groups due to structural barriers, systemic racism, and inequitable distribution of resources.

APA can support all FCG communities by engaging with a variety of policy and advocacy groups, including those that focus on the needs of cultural/minority groups, including but not limited to Diverse Elders Coalition, National Caucus & Center on Black Aging, and Services and Advocacy for GLBT Elders (SAGE). APA supports efforts to enhance the health and well-being of family caregivers as exemplified by updates to the 2010 *Family Caregiver Briefcase for Psychologists* (updated in 2015; 2020; 2026 pending) and the adoption of the 2011 *Resolution on Family Caregivers*, as well as partnerships with the National Alliance for Caregiving and others to advocate for the rights of and support for FCGs. In addition, APA submitted written comments to the Administration for Community Living regarding the National Strategy to Support Family Caregivers (2022), to the US Congress's Special Committee on Aging regarding the mental health impact of family caregiving (2024) and published a *Caregiving Policy Statement* (2025) to inform

policy at the federal level.

Consistent with APA's commitment to promote a global perspective in psychology, it is important to amplify models of family caregiving around the world, especially for family-centered care (FCC) to be supported across the lifespan (Kokorelias et al., 2019). In the World Health Organization (WHO)'s various guidelines and policy recommendations (e.g., *Integrated Care for Older People*; *Supporting Informal Long-term Caregivers for Older People*; *Caregiving Interventions for Early Child Development*), accessible training and support programs for FCGs are key. Countries such as Australia, Germany, and the United Kingdom have implemented more comprehensive caregiver support systems, including caregiver allowances, statutory rights to assessment, and integration of caregiver needs into healthcare planning. Some of these strategies are already part of the US National Strategy to Support Family Caregivers (2022). However, without a strong commitment to providing financial and social support to FCGs, caregiver support may remain inadequate, and adherence to FCC principles may be difficult to achieve. At its worst, this could result in FCGs being involved in hospital care only as unpaid labor when hospital staff is unavailable (Gwaza & Msiska, 2022).

In Summary

WHEREAS psychologists are key in advancing the science and practice to promote resilience across the scope of chronic illness trajectories through their involvement in content development in education and training to healthcare professionals and family caregivers, and refinement of psychological assessment tools of burden, resilience, abuse/neglect, and capacity;

WHEREAS the FCG empirical evidence has been historically defined based on single identities such as gender, age, race/ethnicity, health and disability status, and sexual and gender identity;

WHEREAS much of the scientific bases of our insights into FCGs and caregiver intervention is based on family caregiving experiences of non-Hispanic White communities and the experiences of women;

WHEREAS caregiving expectations and experiences of racial/ethnic, LGBTQ+, and other minoritized communities are often influenced by cultural mores, generational trauma, and the historical exploitation of women of color as caregivers; such communities also usually face the specific challenges related to structural racism, implicit bias in healthcare, and economic disparities;

WHEREAS psychologists have significantly contributed to the design and implementation of evidence-based interventions for FCGs, delivered both in person, virtually, over the phone, and asynchronously;

WHEREAS existing evidence-based approaches to support FCGs are disease specific and/or age-specific, typically focused on dementia, cancer, other chronic health conditions, and children with ID/DD; and have varying degree of cultural relevance and ease of engagement;

WHEREAS family caregiving is a rich and complex experience involving uplifts and resilience, but also caregiver burden, physical, and economic strain;

WHEREAS APA has developed relevant practice guidelines for working with older adults, people with disabilities, people with cognitive disorders, and disabled parents but not with FCGs;

WHEREAS online health communities may be powerful tools in support of FCG resilience as a space to share and receive social support, and experience self and moral empowerment by promoting self-care, independence, altruism, and connectedness;

WHEREAS the number of FCGs in the United States continues to rise with the aging population while resources and support remain limited;

WHEREAS FCGs' needs vary based on the nature, intensity, duration, stage, and setting of caregiving, including being caregivers to multiple people simultaneously or in long-term care and/or palliative and end-of-life care settings;

WHEREAS FCGs' needs vary by characteristics of the care recipient including diagnoses, functional abilities, availability of home and community supports, geographical proximity to care recipient, and there is limited research on specific populations such as older adults caring for autistic adult children, and caregivers of adults with ID/DD;

WHEREAS FCGs' experiences and well-being may vary based on the type of relationship with the care recipient; quality of that relationship; and social mores and norms;

WHEREAS nationally there has been limited recognition and implementation of the National Strategy to Support Family Caregivers, the RAISE Family Caregivers Act, the CARE Act, and other programs that provide direct financial and social support to FCGs compared to other countries; and there are laws that are actionable to protect against workplace discrimination based on caregiver status;

WHEREAS APA continues to train psychologists and facilitate opportunities to advocate for policies supporting FCGs at the local, state, and federal levels.

THEREFORE BE IT RESOLVED that the APA supports the use of psychological science to further develop, identify, and incorporate meaningful and accessible caregiving outcome measures in research and practice to facilitate ongoing funding and coverage of needed services for family caregivers.

THEREFORE BE IT FURTHER RESOLVED that the APA supports FCG research that involves culturally-diverse caregiving experiences by increasing recruitment and retention of racial/ethnic minorities, rural contexts, non-English speakers, and those who live in households with multiple caregiving relationships.

THEREFORE BE IT FURTHER RESOLVED that the APA supports FCG research that involves patient-FCG dyads, the wider caregiver network, and the complex dynamics between patient, FCGs, and healthcare teams across the lifespan through an intersectional lens that consider the unique needs of FCGs across the lifespan.

THEREFORE BE IT FURTHER RESOLVED that the APA supports improvement in data infrastructure to capture cross-sectional and longitudinal experiences of FCG who have historically been excluded in caregiving science, including developing national epidemiological datasets that can be used to monitor caregiving as a measure of public health.

THEREFORE BE IT FURTHER RESOLVED that the APA supports the exploration of design and

implementation of evidence-based interventions for caregivers that take into consideration their individual preferences, needs, experiences, and the accessibility, feasibility, and sustainability of such interventions, including psychological interventions such as individual, dyadic, and group psychotherapy, integration of I/O psychology principles and artificial intelligence to improve caregiving-related products and care delivery (e.g., smart homes).

THEREFORE BE IT FURTHER RESOLVED that the APA encourages the development of a training curriculum to ensure competency-based and trauma-informed caregiver training in doctoral-level, master's level, and continuing education programs and expand ethical guidance for psychologists treating caregivers and care recipients concurrently.

THEREFORE BE IT FURTHER RESOLVED that the APA encourages psychologists to familiarize themselves with evidence-based practice and educational content on different FCGs and their needs, the various dynamics and nuances of relationships with care-recipients, impact of caregiving, types of programs/supports, types of illness or disability that call for family caregiving, and strategies to address the impact of racism and other structural inequities on FCGs.

THEREFORE BE IT FURTHER RESOLVED that the APA supports the promotion of theoretically and culturally grounded conceptual and operational definitions of resilience among FCGs across the lifespan and all care settings.

THEREFORE BE IT FURTHER RESOLVED that the APA explores the development of APA Guidelines for Psychological Practice with FCGs, the development of which could include establishing a taskforce of psychologists or inter-professional workgroups to advance family caregiving research and practice.

THEREFORE BE IT FURTHER RESOLVED that the APA supports culturally adapting evidence-based programs, including those that address design, implementation, and evaluation of interventions in partnership with caregivers from racial/ethnic minority groups, rural communities, LGBTQ+ communities, male caregivers, and other groups that may be underrepresented in research.

THEREFORE BE IT FURTHER RESOLVED that the APA supports the development of 24/7 online health communities and caregiver learning and support platforms, especially for those who experience barriers to accessing in-person programs such as those with mobility, financial, geographical, and time constraints.

THEREFORE BE IT FURTHER RESOLVED that the APA supports the development of alternate modes of program delivery beyond telehealth to address the needs of FCGs, including from racial/ethnic minority groups and those living in rural areas, who may have limited access to broadband internet.

THEREFORE BE IT FURTHER RESOLVED that the APA supports the provision of emotional and psychological support to family caregivers through different types of best practices, including individual psychotherapy, dyadic or family therapy, support groups, as well as to educate the public (including the media) about the need for reducing caregiver burden, improving stress management, promoting self-care, maintaining positive caregiver-care recipient relationships, and supporting resilience.

THEREFORE BE IT FURTHER RESOLVED that the APA calls on psychologists to routinely monitor

and assess in-person and through telehealth key indicators of psychological and physical well-being and resilience among FCGs and their care recipients, such as meaning in life, self-efficacy, compassion satisfaction, traumatic growth, and positive aspects of caregiving in addition to anxiety, depression, compassion fatigue, cognitive function, social isolation and loneliness, grief, physical health and health behaviors, abuse, and neglect.

THEREFORE BE IT FURTHER RESOLVED that the APA encourages psychologists to maintain active engagement with community organizations, such as local Area Agencies on Aging, to facilitate family caregivers' access to resources like caregiver education, respite care, and transportation assistance, home health and other care navigation, as well as legal, medical, financial, and insurance assistance.

THEREFORE BE IT FURTHER RESOLVED that the APA encourages clinical and educational programs to promote culturally responsive care and personalized approaches based on individual needs.

THEREFORE BE IT FURTHER RESOLVED that the APA contributes to policy changes that support family caregivers across the lifespan and address root causes of disparities in healthcare access to caregivers, such as enhancing economic and employment policies to make the process to request paid leave and caregiver allowance or stipend less burdensome and more accessible; enacting policy to protect caregivers from workplace discrimination; and enhancing caregiver programs especially in rural communities, for disabled caregivers, and youth caregivers in schools.

References

- Aaron, S. P., Waters, A., Tolentino, A., Rascon, A., Phan, C., Chen, E., Travers, J., Jones, M. G., Kent-Marvick, J., & Thomas Hebdon, M. (2023). Complex identities, intersectionality and research approaches in millennial family caregivers in the United States. *Journal of Advanced Nursing*, 79(5), 1724–1734. <https://doi.org/10.1111/jan.15452>
- AARP & National Alliance for Caregiving. (2025a). *Caregiving in the US 2025*. AARP. <https://doi.org/10.26419/ppi.00373.001>
- AARP and National Alliance for Caregiving. (2025b). *Caregiving in the US 2025: Caring Across States*. <https://www.aarp.org/content/dam/aarp/ppi/topics/ltss/family-caregiving/cgus-2025-caring-across-states/caregiving-in-the-us-2025-caring-across-states.doi.10.26419-2fppi.00383.001.pdf>
- Administration of Community Living. (n.d.). *Supporting Grandparents Raising Grandchildren*. National Strategy to Support Family Caregivers. Retrieved <https://acl.gov/programs/support-caregivers/supporting-grandparents-raising-grandchildren-0>
- Administration of Community Living. (2022). *National strategy to support family caregivers*. Administration of Community Living. <https://acl.gov/CaregiverStrategy>
- Administration of Community Living. (2024). *2024 report to congress progress report: Federal implementation of the 2022 national strategy to support family caregivers*. https://acl.gov/sites/default/files/2024ProgressReport_StrategyToSupportCaregivers.pdf
- Aikens, J. E., Trivedi, R., Aron, D. C., & Piette, J. D. (2015). Integrating support persons into diabetes telemonitoring to improve self-management and medication adherence. *Journal of General Internal Medicine*, 30(3), 319–326.
- Aikens, J. E., Trivedi, R., Heapy, A., Pfeiffer, P. N., & Piette, J. D. (2015). Potential impact of incorporating a patient-selected support person into mHealth for depression. *Journal of General Internal Medicine*, 30(6), 797–803. <https://doi.org/10.1007/s11606-015-3208-7>

- Al Maqbali, A., Al Omari, O., Abu Sharour, L., Al-Naamani, Z., Al Khatiri, M., Sanad, H. M., Al Hashmi, I., Alkhawaldeh, A., Al Qadire, M., & Al Omari, D. (2025). The perceived levels of stress, anxiety and depression among family caregivers of patients undergoing haemodialysis and their association with quality of life. *BJPsych Open*, 11(3), e100. <https://doi.org/10.1192/bjo.2025.44>
- Allen, A. P., Curran, E. A., Duggan, Á., Cryan, J. F., Chorcóráin, A. N., Dinan, T. G., Molloy, D. W., Kearney, P. M., & Clarke, G. (2017). A systematic review of the psychobiological burden of informal caregiving for patients with dementia: Focus on cognitive and biological markers of chronic stress. *Neuroscience & Biobehavioral Reviews*, 73, 123–164. <https://doi.org/10.1016/j.neubiorev.2016.12.006>
- American Psychological Association. (2011). *Resolution on Family Caregivers*. American Psychological Association. <https://www.apa.org/about/policy/family-caregivers>
- American Psychological Association. (2021). *APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change*. <https://www.apa.org/practice/guidelines/guidelines-dementia-age-related-cognitive-change.pdf>
- American Psychological Association. (2022). *Guidelines for Assessment and Intervention with Persons with Disabilities*. <https://www.apa.org/pi/disability/resources/assessment-disabilities>
- American Psychological Association. (2024a). *APA Guidelines for Psychological Practice With Older Adults*. <https://www.apa.org/practice/guidelines/guidelines-psychological-practice-older-adults.pdf>
- American Psychological Association. (2024b). *APA Resolution on Parents With Disabilities*. <https://www.apa.org/about/policy/parents-disabilities.pdf>
- Amin Abdelhalim, D. S., Ahmed, M. M., Hussein, H. A., Sarhan, M. D., & Khalaf, O. O. (2025). A Skill-Based multimodal intervention for dementia caregivers: Impact on burden and anxiety. *Aging Clinical and Experimental Research*, 37(1), 95. <https://doi.org/10.1007/s40520-025-02985-x>
- Applebaum, A. J., Kent, E. E., Ellington, L., Campbell, G., Donovan, H., Trivedi, R., Van Houtven, C., Gray, T. F., Gebert, R. R., Rosa, W. E., & Odom, J. N. (2024). Top Ten Tips Palliative Care Clinicians Should Know About Caring for Family Caregivers. *Journal of Palliative Medicine*, 27(7), 930–938. <https://doi.org/10.1089/jpm.2023.0640>
- Applebaum, A. J., & Sannes, T. S. (2025). The Importance of Honoring Family Caregiver Burden: Challenges in Mental Health Care Delivery. *Journal of Clinical Psychology in Medical Settings*, 32(2), 193–201. <https://doi.org/10.1007/s10880-024-10051-3>
- Armstrong-Carter, E., Liu, S., Obradović, J., & Fisher, P. (2025). Understanding households in which very young children are contributing to the family. *Children and Youth Services Review*, 175, 108323. <https://doi.org/10.1016/j.childyouth.2025.108323>
- Atefi, G. L., de Vugt, M. E., van Knippenberg, R. J. M., Levin, M. E., Verhey, F. R. J., & Bartels, S. L. (2023). The use of Acceptance and Commitment Therapy (ACT) in informal caregivers of people with dementia and other long-term or chronic conditions: A systematic review and conceptual integration. *Clinical Psychology Review*, 105, 102341. <https://doi.org/10.1016/j.cpr.2023.102341>
- Badr, H., Lipnick, D., Diefenbach, M. A., Posner, M., Kotz, T., Miles, B., & Genden, E. (2016). Development and usability testing of a web-based self-management intervention for oral cancer survivors and their family caregivers. *European Journal of Cancer Care*, 25(5), 806–821. <https://doi.org/10.1111/ecc.12396>
- Brady, S., Patskanick, T., & Coughlin, J. F. (2024). An Intersectional Approach to Understanding the Psychological Health Effects of Combining Work and Parental Caregiving. *The Journals of Gerontology: Series B*, 79(6), gbae042. <https://doi.org/10.1093/geronb/gbae042>
- Brijnath, B., & Antoniadis, J. (2025). WHO's iSupport model for dementia care: Why the mode

- and measures matter. *The Lancet Regional Health – Europe*, 48. <https://doi.org/10.1016/j.lanepe.2024.101144>
- Burgio, L., & Wynn, M. (2021). *The REACH OUT Caregiver Support Program: A Skills Training Program for Caregivers of Persons with Dementia, Clinician Guide*. *A Skills Training Program for Caregivers of Persons with Dementia, Clinician Guide*. <https://doi.org/10.1093/med-psych/9780190855949.001.0001>
- Center for Medicare Advocacy. (2025). *Immigration Policies Threaten Critical Nursing Home Workforce*. Center for Medicare Advocacy. <https://medicareadvocacy.org/immigration-policies-threaten-critical-nursing-home-workforce/>
- Chakurian, D., & Popejoy, L. (2024). A SYSTEMATIC REVIEW OF RESILIENCE IN FAMILY CAREGIVERS OF AUTISTIC ADULTS: IMPLICATIONS FOR RESEARCH AND PRACTICE. *Innovation in Aging*, 8(Supplement_1), 1179–1180. <https://doi.org/10.1093/geroni/igae098.3779>
- Cheng, S.-T., Li, K.-K., Or, P. P. L., & Losada, A. (2022). Do caregiver interventions improve outcomes in relatives with dementia and mild cognitive impairment? A comprehensive systematic review and meta-analysis. *Psychology and Aging*, 37(8), 929–953. <https://doi.org/10.1037/pag0000696>
- Cheng, S.-T., & Zhang, F. (2020). A comprehensive meta-review of systematic reviews and meta-analyses on nonpharmacological interventions for informal dementia caregivers. *BMC Geriatrics*, 20(1), 137. <https://doi.org/10.1186/s12877-020-01547-2>
- Chidambaram, Priya & Pillai, Drishti. (2025). *What Role Do Immigrants Play in The Direct Long-Term Care Workforce?* Kaiser Family Foundation. <https://www.kff.org/medicaid/what-role-do-immigrants-play-in-the-direct-long-term-care-workforce/>
- Chow, W., Law, S., Andermann, L., Yang, J., Leszcz, M., Wong, J., & Sadavoy, J. (2010). Multi-Family Psycho-Education Group for Assertive Community Treatment Clients and Families of Culturally Diverse Background: A Pilot Study. *Community Mental Health Journal*, 46(4), 364–371. <https://doi.org/10.1007/s10597-010-9305-5>
- Cohen, S. A., Ahmed, N., Brown, M. J., Meucci, M. R., & Greaney, M. L. (2022). Rural-urban differences in informal caregiving and health-related quality of life. *The Journal of Rural Health*, 38(2), 442–456. <https://doi.org/10.1111/jrh.12581>
- Daley, S., Murray, J., Farina, N., Page, T. E., Brown, A., Basset, T., Livingston, G., Bowling, A., Knapp, M., & Banerjee, S. (2019). Understanding the quality of life of family carers of people with dementia: Development of a new conceptual framework. *International Journal of Geriatric Psychiatry*, 34(1), 79–86. <https://doi.org/10.1002/gps.4990>
- Dang, S., Looijmans, A., Ferraris, G., Lamura, G., & Hagedoorn, M. (2022). Exploring the Needs of Spousal, Adult Child, and Adult Sibling Informal Caregivers: A Mixed-Method Systematic Review. *Frontiers in Psychology*, 13. <https://doi.org/10.3389/fpsyg.2022.832974>
- Deli, D., Tsouvelas, G., Roukas, D., & Mentis, M. (2024). A systematic review of depressive and anxiety symptoms in caregivers of dementia patients. *Psychiatriki*. <https://doi.org/10.22365/jpsych.2024.023>
- Dionne-Odom, J. N., Azuero, A., Taylor, R. A., Dosse, C., Bechthold, A. C., Currie, E., Reed, R. D., Harrell, E. R., Engler, S., Ejem, D. B., Ivankova, N. V., Martin, M. Y., Rocque, G. B., Williams, G. R., & Bakitas, M. A. (2022). A lay navigator-led, early palliative care intervention for African American and rural family caregivers of individuals with advanced cancer (Project Cornerstone): Results of a pilot randomized trial. *Cancer*, 128(6), 1321–1330. <https://doi.org/10.1002/cncr.34044>
- Epps, F., Moore, M., Chester, M., Gore, J., Sainz, M., Adkins, A., Clevenger, C., & Aycock, D. (2022). The Alter Program: A Nurse-Led, Dementia-Friendly Program for African American Faith Communities and Families Living With Dementia. *Nursing Administration Quarterly*, 46(1), 72–80. <https://doi.org/10.1097/NAQ.0000000000000506>
- Ervin, J., Taouk, Y., Alfonzo, L. F., Peasgood, T., & King, T. (2022). Longitudinal association

- between informal unpaid caregiving and mental health amongst working age adults in high-income OECD countries: A systematic review. *eClinicalMedicine*, 53.
<https://doi.org/10.1016/j.eclim.2022.101711>
- Fields, S., Arthur, K., Philip, S. R., Smallman, R., Kalra, V., Yehl, K., Lee, F., & Kerr, D. (2025). Diabetes and Wellness Smartphone Applications for Self-Management Among Adults With Diabetes in the United States. *Journal of Diabetes Science and Technology*, 19(5), 1230–1238. <https://doi.org/10.1177/19322968251322189>
- Gallagher, S., & Wetherell, M. A. (2020). Risk of depression in family caregivers: Unintended consequence of COVID-19. *BJPsych Open*, 6(6), e119. <https://doi.org/10.1192/bjo.2020.99>
- Gallagher-Thompson, D., Bilbrey, A. C., Qualls, S. H., Ghatak, R., Trivedi, R., & Waelde, L. C. (2023). *Family Caregiver Distress*. Hogrefe.
- Gaugler, J. E., Birkeland, R. W., Albers, E. A., Peterson, C. M., Louwagie, K., Baker, Z., Mittelman, M. S., Hepburn, K., & Roth, D. L. (2024). Efficacy of the residential care transition module: A telehealth intervention for dementia family caregivers of relatives living in residential long-term care settings. *Psychology and Aging*, 39(5), 565–577.
<https://doi.org/10.1037/pag0000820>
- Greene, L., Brain, J., Watkins, P., Kafadar, A. H., Sabatini, S., Blundell, B., Bothe, E., Harper, K., Hersh, D., Morrisby, C., Myers, B., Stafford, A., Tang, E. Y. H., Stephan, B. C. M., & Burton, E. (2026). Mind the gap: A systematic review of barriers, facilitators, and experiences of care transitions for people living with dementia and their informal caregivers. *The Gerontologist*, 66(1), gnaf275. <https://doi.org/10.1093/geront/gnaf275>
- Gwaza, E., & Msiska, G. (2022). Family Involvement in Caring for Inpatients in Acute Care Hospital Settings: A Systematic Review of Literature. *Sage Open Nursing*, 8, 23779608221089541. <https://doi.org/10.1177/23779608221089541>
- Haley, W. E., Roth, D. L., Sheehan, O. C., Rhodes, J. D., Huang, J., Blinka, M. D., & Howard, V. J. (2020). Effects of Transitions to Family Caregiving on Well-Being: A Longitudinal Population-Based Study. *Journal of the American Geriatrics Society*, 68(12), 2839–2846.
<https://doi.org/10.1111/jgs.16778>
- Han, A. (2021). Mindfulness- and Acceptance-Based Interventions for Stroke Survivors: A Systematic Review and Meta-Analysis. *Sage Journals*. (Sage CA: Los Angeles, CA).
<https://doi.org/10.1177/00343552211043257>
- Han, A., Hong, I., Yuen, H. K., Hawkins, J., Lee, H. K., Montoro-Rodriguez, J., Lim, Y., Lee, H. Y., & Delzell, E. S. (2025). Relationships Among Caregiver Burden, Psychological Flexibility Processes, and Depressive Symptoms in Family Caregivers of People with Dementia: Path Analyses. *Journal of Applied Gerontology: The Official Journal of the Southern Gerontological Society*, 44(11), 1751–1761. <https://doi.org/10.1177/07334648251315991>
- Hayslip, B., Fruhauf, C. A., & Dolbin-MacNab, M. L. (2019). Grandparents Raising Grandchildren: What Have We Learned Over the Past Decade? *The Gerontologist*, 59(3), e152–e163.
<https://doi.org/10.1093/geront/gnx106>
- Hepburn, K., Gaugler, J., Roberto, K., Van Houtven, C., Chula, R., Resendez, J., & Thomas, C. (2025). Support for Care Partners and Caregivers: 2023 Summit Session 5. *Alzheimer's & Dementia*, 21(6), e70389. <https://doi.org/10.1002/alz.70389>
- Holmberg Bergman, T., Renhorn, E., Berg, B., Lappalainen, P., Ghaderi, A., & Hirvikoski, T. (2023). Acceptance and Commitment Therapy Group Intervention for Parents of Children with Disabilities (Navigator ACT): An Open Feasibility Trial. *Journal of Autism and Developmental Disorders*, 53(5), 1834–1849. <https://doi.org/10.1007/s10803-022-05490-6>
- Hoyert, D. (2025). *Maternal Mortality, 2023*. National Center for Health Statistics (U.S.).
<https://doi.org/10.15620/cdc/174577>
- Huang, S.-S. (2022). Depression among caregivers of patients with dementia: Associative factors and management approaches. *World Journal of Psychiatry*, 12(1), 59–76.

- <https://doi.org/10.5498/wjp.v12.i1.59>
- Huertas-Domingo, C., Losada-Baltar, A., Romero-Moreno, R., Gallego-Alberto, L., & Márquez-González, M. (2023). Sociocultural factors, guilt and depression in family caregivers of people with dementia. Kinship differences. *Aging & Mental Health*, 27(9), 1655–1665. <https://doi.org/10.1080/13607863.2023.2195821>
- Idorenyin Imoh, U., & Charity, T. (2023). Cultural and Social Factors in Care Delivery Among African American Caregivers of Persons With Dementia: A Scoping Review. *Gerontology and Geriatric Medicine*, 9, 23337214231152002. <https://doi.org/10.1177/23337214231152002>
- Janson, P., Willeke, K., Zaibert, L., Budnick, A., Berghöfer, A., Kittel-Schneider, S., Heuschmann, P. U., Zapf, A., Wildner, M., Stupp, C., & Keil, T. (2022). Mortality, Morbidity and Health-Related Outcomes in Informal Caregivers Compared to Non-Caregivers: A Systematic Review. *International Journal of Environmental Research and Public Health*, 19(10). <https://doi.org/10.3390/ijerph19105864>
- Kaddour, L., & Kishita, N. (2020). Anxiety in Informal Dementia Carers: A Meta-Analysis of Prevalence. *Journal of Geriatric Psychiatry and Neurology*, 33(3), 161–172. <https://doi.org/10.1177/0891988719868313>
- Kamalpour, M., Rezaei Aghdam, A., Watson, J., Tariq, A., Buys, L., Eden, R., & Rehan, S. (2021). Online health communities, contributions to caregivers and resilience of older adults. *Health & Social Care in the Community*, 29(2), 328–343. <https://doi.org/10.1111/hsc.13247>
- Kelson, E., & Dorstyn, D. (2025). Telehealth as a Psychological Intervention for Caregivers of Children with Neurodevelopmental Disorders: A Systematic Review with Effect Sizes. *Journal of Autism and Developmental Disorders*, 55(1), 43–58. <https://doi.org/10.1007/s10803-023-06185-2>
- Khiewchaum, R., & Chase, J.-A. D. (2021). Interventions to Improve Health and Well-Being Among Family Caregivers of Older Adults With Chronic Illnesses: A Scoping Review. *Journal of Gerontological Nursing*, 47(5), 45–51. <https://doi.org/10.3928/00989134-20210408-02>
- Kilmer, G. (2024). Changes in Health Indicators Among Caregivers—United States, 2015–2016 to 2021–2022. *MMWR. Morbidity and Mortality Weekly Report*, 73. <https://doi.org/10.15585/mmwr.mm7334a2>
- King, T. L., Vitaliano, P. P., Maheen, H., & Taouk, Y. (2024). Impact of informal caregiving on depressive symptoms among a national cohort of men. *Journal of Epidemiology and Community Health*, 78(7), 431–436. <https://doi.org/10.1136/jech-2023-221814>
- Knight, B. G., & Sayegh, P. (2010). Cultural Values and Caregiving: The Updated Sociocultural Stress and Coping Model. *The Journals of Gerontology: Series B*, 65B(1), 5–13. <https://doi.org/10.1093/geronb/gbp096>
- Kokorelias, K. M., Gignac, M. A. M., Naglie, G., & Cameron, J. I. (2019). Towards a universal model of family centered care: A scoping review. *BMC Health Services Research*, 19(1), 564. <https://doi.org/10.1186/s12913-019-4394-5>
- Lai, A., Griffith, L. E., Kuspinar, A., Turchyn, J.-S., & Richardson, J. (2024). Impact of Care-Recipient Relationship Type on Quality of Life in Community-Dwelling Older Adults With Dementia Over Time. *Journal of Geriatric Psychiatry and Neurology*, 37(4), 294–306. <https://doi.org/10.1177/08919887231215044>
- Lampe, N. M., Money, V. L., Clark, K. A., & McKay, T. (2025). Minority Stress, Discrimination, and Health Outcomes Among LGBTQ+ Older Adult Dementia Caregivers. *American Journal of Alzheimer's Disease and Other Dementias*, 40, 15333175251398999. <https://doi.org/10.1177/15333175251398999>
- Larkin, M., Henwood, M., & Milne, A. (2019). Carer-related research and knowledge: Findings from a scoping review. *Health & Social Care in the Community*, 27(1), 55–67. <https://doi.org/10.1111/hsc.12586>
- Lawton, M. P., Kleban, M. H., Moss, M., Rovine, M., & Glicksman, A. (1989). Measuring

- caregiving appraisal. *Journal of Gerontology*, 44(3), P61-71.
<https://doi.org/10.1093/geronj/44.3.p61>
- Lazarus, R. S., & Folkman, S. (20). *Stress, Appraisal, and Coping*. Springer Publishing Company.
- Lee, Y., & Li, L. (2022). Evaluating the Positive Experience of Caregiving: A Systematic Review of the Positive Aspects of Caregiving Scale. *The Gerontologist*, 62(9), e493–e507.
<https://doi.org/10.1093/geront/gnab092>
- Li, C., Tang, N., Yang, L., Zeng, Q., Yu, T., Pu, X., Wang, J., & Zhang, H. (2023). Effect of caregiver burden on anticipatory grief among caregivers of elderly cancer patients: Chain mediation role of family functioning and resilience. *Frontiers in Psychology*, 13, 1020517.
<https://doi.org/10.3389/fpsyg.2022.1020517>
- Li, J., Sun, D., Zhang, X., Zhao, L., Zhang, Y., Wang, H., Ni, N., & Jiang, G. (2022). The relationship between anticipatory grief and illness uncertainty among Chinese family caregivers of patients with advanced lung cancer: A cross-sectional study. *BMC Palliative Care*, 21(1), 30.
<https://doi.org/10.1186/s12904-022-00925-4>
- Lindahl, J., Stollon, N., Wu, K., Liang, A., Changolkar, S., Steinway, C., Trachtenberg, S., Coccia, A., Devaney, M., & Jan, S. (2019). Domains of planning for future long-term care of adults with intellectual and developmental disabilities: Parent and sibling perspectives. *Journal of Applied Research in Intellectual Disabilities*, 32(5), 1103–1115.
<https://doi.org/10.1111/jar.12600>
- Liu, C., Badana, A. N. S., Burgdorf, J., Fabius, C. D., Roth, D. L., & Haley, W. E. (n.d.). Systematic Review and Meta-Analysis of Racial and Ethnic Differences in Dementia Caregivers' Well-Being. *The Gerontologist*. <https://doi.org/10.1093/geront/gnaa028>
- Longacre, M. L., Miller, M. F., & Fang, C. Y. (2021). Racial and ethnic variations in caregiving-related physical, emotional, and financial strain during COVID-19 among those caring for adult cancer patients. *Supportive Care in Cancer: Official Journal of the Multinational Association of Supportive Care in Cancer*, 29(7), 4137–4146.
<https://doi.org/10.1007/s00520-020-05933-9>
- Mage, S., Benton, D., Gonzalez, A., Zaragoza, G., Wilber, K., Tucker-Seeley, R., & Meyer, K. (2024). "I Lay Awake at Night": Latino Family Caregivers' Experiences Covering Out-of-Pocket Costs When Caring for Someone Living With Dementia. *The Gerontologist*, 64(1), gnad011. <https://doi.org/10.1093/geront/gnad011>
- Marino, V. R., Haley, W. E., & Roth, D. L. (2017). Beyond hedonia: A theoretical reframing of caregiver well-being. *Translational Issues in Psychological Science*, 3(4), 400–409.
<https://doi.org/10.1037/tps0000134>
- McKenna, O., Fakolade, A., Cardwell, K., Langlois, N., Jiang, K., & Pilutti, L. A. (2022). Towards conceptual convergence: A systematic review of psychological resilience in family caregivers of persons living with chronic neurological conditions. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 25(1), 4–37.
<https://doi.org/10.1111/hex.13374>
- Meng, C., Lachapelle, S., Adekoya, A., Kervin, L., Seetharaman, K., Basu Khan, K., & Baumbusch, J. (2025). Using a Trauma-Informed Care Approach to Understand Family Caregivers' Experiences of Accessing Formal Supports in Dementia Care. *Journal of Family Nursing*, 31(1), 3–15. <https://doi.org/10.1177/10748407251314549>
- Meyer, O. L., Liu, X. L., Tancredi, D., Ramirez, A. S., Schulz, R., & Hinton, L. (2018). Acculturation level and caregiver outcomes from a randomized intervention trial to enhance caregivers' health: Evidence from REACH II. *Aging & Mental Health*, 22(6), 730–737.
<https://doi.org/10.1080/13607863.2017.1317330>
- Montoro-Rodriguez, J., Reeve, C. L., Gallagher-Thompson, D., Ramsey, J., Choryan Bilbrey, A., & Kajiyama, B. (2025). Modeling Pathways by Which the Caregiver TLC Psychoeducational Program Affects Psychological Health of Caregivers. *The Gerontologist*, 65(4), gnaf020.

- <https://doi.org/10.1093/geront/gnaf020>
- Mulcahy Symmons, S., Ryan, K., Aoun, S. M., Selman, L. E., Davies, A. N., Cornally, N., Lombard, J., McQuillan, R., Guerin, S., O'Leary, N., Connolly, M., Rabbitte, M., Mockler, D., & Foley, G. (2023). Decision-making in palliative care: Patient and family caregiver concordance and discordance-systematic review and narrative synthesis. *BMJ Supportive & Palliative Care*, 13(4), 374–385. <https://doi.org/10.1136/bmjspcare-2022-003525>
- National Academies of State Health Policy. (2022). *RAISE Act State Policy Roadmap for Family Caregivers: RAISE Act State Policy Roadmap Engagement of Family Caregivers for Family Caregivers: The Direct in Health Care Systems*. https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2022/12/NASHP_Report_2-1.pdf
- Nichols, L. O., Martindale-Adams, J., Burns, R., Zuber, J., & Graney, M. J. (2016). REACH VA: Moving from Translation to System Implementation. *The Gerontologist*, 56(1), 135–144. <https://doi.org/10.1093/geront/gnu112>
- Okafor, A. J., & Monahan, M. (2023). Effectiveness of Psychoeducation on Burden among Family Caregivers of Adults with Schizophrenia: A Systematic Review and Meta-Analysis. *Nursing Research and Practice*, 2023(1), 2167096. <https://doi.org/10.1155/2023/2167096>
- Opsomer, S., Lauwerier, E., De Lepeleire, J., & Pype, P. (2022). Resilience in advanced cancer caregiving. A systematic review and meta-synthesis. *Palliative Medicine*, 36(1), 44–58. <https://doi.org/10.1177/02692163211057749>
- Ornstein, K. A., Wolff, J. L., Bollens-Lund, E., Rahman, O.-K., & Kelley, A. S. (2019). Spousal Caregivers Are Caregiving Alone In The Last Years Of Life. *Health Affairs (Project Hope)*, 38(6), 964–972. <https://doi.org/10.1377/hlthaff.2019.00087>
- Osilla, K. C., Lean, M., Gallagher-Thompson, D., Atherton, D., & Watkins, K. E. (2025). Supporting family caregivers: Variations in caregiving among families managing chronic health conditions. *The American Psychologist*, 80(9), 1499–1519. <https://doi.org/10.1037/amp0001663>
- Palacio G, C., Krikorian, A., Gómez-Romero, M. J., & Limonero, J. T. (2020). Resilience in Caregivers: A Systematic Review. *The American Journal of Hospice & Palliative Care*, 37(8), 648–658. <https://doi.org/10.1177/1049909119893977>
- Perlick, D. A., Berk, L., Kaczynski, R., Gonzalez, J., Link, B., Dixon, L., Grier, S., & Miklowitz, D. J. (2016). Caregiver burden as a predictor of depression among family and friends who provide care for persons with bipolar disorder. *Bipolar Disorders*, 18(2), 183–191. <https://doi.org/10.1111/bdi.12379>
- PHI and National Alliance of Caregiving. (2024). *Empowering Direct Care Workers and Family Caregivers to Meet Growing Demand for Care (Together in Care)* [Brief]. PHI and National Alliance of Caregiving.
- Phillips, R., Durkin, M., Engward, H., Cable, G., & Iancu, M. (2023). The impact of caring for family members with mental illnesses on the caregiver: A scoping review. *Health Promotion International*, 38(3), daac049. <https://doi.org/10.1093/heapro/daac049>
- Piette, J. D. (2009). *Enhancing Caregiver Support for Heart Failure Patients: The CarePartner Study*. Department of Veterans Affairs.
- Pinquart, M., & Sörensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. *Psychology and Aging*, 18(2), 250–267. <https://doi.org/10.1037/0882-7974.18.2.250>
- Pinquart, M., & Sörensen, S. (2005). Ethnic Differences in Stressors, Resources, and Psychological Outcomes of Family Caregiving: A Meta-Analysis. *The Gerontologist*, 45(1), 90–106. <https://doi.org/10.1093/geront/45.1.90>
- Poe, A. A., Vance, D. E., Patrician, P. A., Dick, T. K., & Puga, F. (2023). Resilience in the context of dementia family caregiver mental health: A concept analysis. *Archives of Psychiatric Nursing*, 45, 143–151. <https://doi.org/10.1016/j.apnu.2023.06.015>

- Qualls, S. H. (2016). Caregiving families within the long-term services and support system for older adults. *The American Psychologist*, 71(4), 283–293. <https://doi.org/10.1037/a0040252>
- Quinn, C., & Toms, G. (2019). Influence of Positive Aspects of Dementia Caregiving on Caregivers' Well-Being: A Systematic Review. *The Gerontologist*, 59(5), e584–e596. <https://doi.org/10.1093/geront/gny168>
- Riffin, C., Van Ness, P. H., Wolff, J. L., & Fried, T. (2019). Multifactorial Examination of Caregiver Burden in a National Sample of Family and Unpaid Caregivers. *Journal of the American Geriatrics Society*, 67(2), 277–283. <https://doi.org/10.1111/jgs.15664>
- Riffin, C., Wolff, J. L., Estill, M., Prabhu, S., & Pillemer, K. A. (2020). Caregiver Needs Assessment in Primary Care: Views of Clinicians, Staff, Patients, and Caregivers. *Journal of the American Geriatrics Society*, 68(6), 1262–1270. <https://doi.org/10.1111/jgs.16401>
- Riffin, C., Wolff, J. L., & Pillemer, K. A. (2021). Assessing and Addressing Family Caregivers' Needs and Risks in Primary Care. *Journal of the American Geriatrics Society*, 69(2), 432–440. <https://doi.org/10.1111/jgs.16945>
- Risch, A. K., Lechner-Meichsner, F., & Wilz, G. (2025). Telephone-Based Acceptance and Commitment Therapy for Caregivers of Persons with Dementia: Results of a Randomized Controlled Trial. *Clinical Gerontologist*, 48(4), 644–662. <https://doi.org/10.1080/07317115.2024.2393307>
- Rosland, A. M., Piette, J. D., Trivedi, R., Lee, A., Stoll, S., Youk, A., Obrosky, D. S., Deverts, D., Kerr, E. A., & Heisler, M. (2022). Effectiveness of a health coaching intervention for patient-family dyads to improve outcomes among adults with diabetes: A randomized clinical trial. *JAMA Network Open*, 5(11), e2237960.
- Rosland AM, Heisler ME, Trivedi R, Gaudioso S, Fennelly J, & Piette JD. (2015). Improving diabetes management by engaging family supporters in the patient-centered medical home: A pilot intervention study. *Journal of General Internal Medicine*, 30(2), S187. <https://doi.org/10.1007/s11606-015-3271-0>
- Rouch, S. A., Fields, B. E., Alibrahim, H. A., Rodakowski, J., & Leland, N. E. (2021). Evidence for the Effectiveness of Interventions for Caregivers of People With Chronic Conditions: A Systematic Review. *The American Journal of Occupational Therapy*, 75(4), 7504190030. <https://doi.org/10.5014/ajot.2021.042838>
- Schulz, R., Beach, S. R., Czaja, S. J., Martire, L. M., & Monin, J. K. (2020). Family Caregiving for Older Adults. *Annual Review of Psychology*, 71(1), 635–659. <https://doi.org/10.1146/annurev-psych-010419-050754>
- Schulz, R., Burgio, L., Burns, R., Eisdorfer, C., Gallagher-Thompson, D., Gitlin, L. N., & Mahoney, D. F. (2003). Resources for Enhancing Alzheimer's Caregiver Health (REACH): Overview, Site-Specific Outcomes, and Future Directions. *The Gerontologist*, 43(4), 514–520. <https://doi.org/10.1093/geront/43.4.514>
- Schulz, R., Czaja, S. J., Lustig, A., Zdaniuk, B., Martire, L. M., & Perdomo, D. (2009). Improving the quality of life of caregivers of persons with spinal cord injury: A randomized controlled trial. *Rehabilitation Psychology*, 54(1), 1–15. <https://doi.org/10.1037/a0014932>
- Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *The American Journal of Nursing*, 108(9 Suppl), 23–27; quiz 27. <https://doi.org/10.1097/01.NAJ.0000336406.45248.4c>
- Seltzer, M. M., Floyd, F., Song, J., Greenberg, J., & Hong, J. (2011). Midlife and aging parents of adults with intellectual and developmental disabilities: Impacts of lifelong parenting. *American Journal on Intellectual and Developmental Disabilities*, 116(6), 479–499. <https://doi.org/10.1352/1944-7558-116.6.479>
- Sheehan, O. C., Haley, W. E., Howard, V. J., Huang, J., Rhodes, J. D., & Roth, D. L. (2021). Stress, Burden, and Well-Being in Dementia and Nondementia Caregivers: Insights From the Caregiving Transitions Study. *The Gerontologist*, 61(5), 670–679.

- <https://doi.org/10.1093/geront/gnaa108>
- Shin, J. W., Tate, J. A., & Choi, J. (2026). Family Caregiver Psychological Experiences After an Intensive Care Unit Stay. *Critical Care Nursing Clinics of North America*, 38(1), 39–54. <https://doi.org/10.1016/j.cnc.2025.10.006>
- Sikora Kessler, A., Mock, G., Hendricks, D., Robbins, L., Kaur, H., Potter, J. F., & Burgio, L. D. (2021). Translating the REACH OUT dementia caregiver intervention into a primary care setting: A pilot study. *Aging & Mental Health*, 25(8), 1483–1492. <https://doi.org/10.1080/13607863.2020.1850638>
- Sobers, T., Wolverson, E., Gardner, H., Joddrell, P., Walpert, M., Pepper, A., & Harrison Denning, K. (2025). A Systematic Review of the Needs of Children and Young People of a Parent Diagnosed With Young-Onset-Dementia: Informing a Nursing Intervention. *Journal of Advanced Nursing*, jan.70205. <https://doi.org/10.1111/jan.70205>
- Spiers, G. F., Liddle, J., Kunonga, T. P., Whitehead, I. O., Beyer, F., Stow, D., Welsh, C., Ramsay, S. E., Craig, D., & Hanratty, B. (2021). What are the consequences of caring for older people and what interventions are effective for supporting unpaid carers? A rapid review of systematic reviews. *BMJ Open*, 11(9), e046187. <https://doi.org/10.1136/bmjopen-2020-046187>
- Sterling, M. R., Li, J., Cho, J., Ringel, J. B., & Silver, S. R. (2021). Prevalence and Predictors of Home Health Care Workers' General, Physical, and Mental Health: Findings From the 2014–2018 Behavioral Risk Factor Surveillance System. *American Journal of Public Health*, 111(12), 2239–2250. <https://doi.org/10.2105/AJPH.2021.306512>
- Suresh, M., Risbud, R., Patel, M. I., Lorenz, K. A., Schapira, L., Gallagher-Thompson, D., & Trivedi, R. (2023). Clinic-based Assessment and Support for Family Caregivers of Patients With Cancer: Results of a Feasibility Study. *Cancer Care Research Online*, 3(4), e047. <https://doi.org/10.1097/CR9.0000000000000047>
- Thomas, Z., Banks, J., Eaton, A. A., & Ward, L. M. (2022). 25 years of psychology research on the “strong black woman.” *Social and Personality Psychology Compass*, 16(9), e12705. <https://doi.org/10.1111/spc3.12705>
- Tingey, J. L., Lum, J., Morean, W., Franklin, R., & Bentley, J. A. (2020). Healthcare coverage and utilization among caregivers in the United States: Findings from the 2015 Behavioral Risk Factor Surveillance System. *Rehabilitation Psychology*, 65(1), 63–71. <https://doi.org/10.1037/rep0000307>
- Trivedi, R., Hirayama, S. K., Risbud, R., Suresh, M., Humber, M. B., Butler, K., Razze, A., Timko, C., Nelson, K., Zulman, D. M., Asch, S. M., Humphreys, K., & Piette, J. D. (2023). Adapting a Telephone-Based, Dyadic Self-management Program to Be Delivered Over the Web: Methodology and Usability Testing. *JMIR Formative Research*, 7, e43903. <https://doi.org/10.2196/43903>
- Turner, A., Pederson, C. A., Salgado, E., Dir, A., Adams, Z., Zapolski, T., Hulvershorn, L., & Aalsma, M. C. (2025). Characterizing caregivers of youth at risk for substance use and caregiver engagement in the youth legal system: A mixed methods approach. *Frontiers in Health Services*, 5, 1455111. <https://doi.org/10.3389/frhs.2025.1455111>
- United Nations. (2024). *Transforming Care Systems in the Context of the Sustainable Development Goals and Our Common Agenda*. [Resource]. United Nations.
- van den Kieboom, R., Snaphaan, L., Mark, R., van Assen, M., & Bongers, I. (2024). The Effects of Neuropsychiatric Symptom Clusters in People with Dementia on Family Caregiver Burden. *Journal of Alzheimer's Disease: JAD*, 100(4), 1289–1298. <https://doi.org/10.3233/JAD-230972>
- Walbaum, C., Philipp, R., Oechsle, K., Ullrich, A., & Vehling, S. (2024). Existential distress among family caregivers of patients with advanced cancer: A systematic review and meta-analysis. *Psycho-Oncology*, 33(1), e6239. <https://doi.org/10.1002/pon.6239>

- Wang, K., Dong, Y., Zeng, X., Johnson, C., Ruggiano, N., & Clay, O. J. (2025). From Disparity to Opportunity: Racial Differences in Internet Access and Health App Usage Among Older Informal Caregivers. *Journal of Applied Gerontology*, 07334648251383631. <https://doi.org/10.1177/07334648251383631>
- Wang, L., Zhou, Y., Fang, X., & Qu, G. (2022). Care burden on family caregivers of patients with dementia and affecting factors in China: A systematic review. *Frontiers in Psychiatry*, 13, 1004552. <https://doi.org/10.3389/fpsy.2022.1004552>
- Wiegelmann, H., Speller, S., Verhaert, L.-M., Schirra-Weirich, L., & Wolf-Ostermann, K. (2021). Psychosocial interventions to support the mental health of informal caregivers of persons living with dementia—A systematic literature review. *BMC Geriatrics*, 21(1), 94. <https://doi.org/10.1186/s12877-021-02020-4>
- Windle, G., Flynn, G., Hoare, Z., Goulden, N., Edwards, R. T., Anthony, B., Algar, P. M., Kurana, S., Spector, A., Hughes, G., Innes, R., Connaghan, J., Proctor, D., Ismail, F. A., Jackson, K., Egan, K., & Stott, J. (2025). Evaluating the effects of the World Health Organization’s online intervention ‘iSupport’ to reduce depression and distress in dementia carers: A multi-centre six-month randomised controlled trial in the UK. *The Lancet Regional Health – Europe*, 48. <https://doi.org/10.1016/j.lanepe.2024.101125>
- Xu, Y., Pei, F., Mendoza, N., & Harrison, T. M. (2025). Resilience Profiles Among Grandparents Raising Grandchildren in the United States: White and Black Differences. *The Gerontologist*, 65(4), gnaf032. <https://doi.org/10.1093/geront/gnaf032>
- Yu, D. S. F., Cheng, S.-T., & Wang, J. (2018a). Unravelling positive aspects of caregiving in dementia: An integrative review of research literature. *International Journal of Nursing Studies*, 79, 1–26. <https://doi.org/10.1016/j.ijnurstu.2017.10.008>
- Yu, D. S. F., Cheng, S.-T., & Wang, J. (2018b). Unravelling positive aspects of caregiving in dementia: An integrative review of research literature. *International Journal of Nursing Studies*, 79, 1–26. <https://doi.org/10.1016/j.ijnurstu.2017.10.008>
- Zarit, S. H., Reever, K. E., & Bach-Peterson, J. (1980). Relatives of the Impaired Elderly: Correlates of Feelings of Burden. *The Gerontologist*, 20(6), 649–655. <https://doi.org/10.1093/geront/20.6.649>
- Zhao, Y., Feng, H., Hu, M., Hu, H., Li, H., Ning, H., Chen, H., Liao, L., & Peng, L. (2019). Web-Based Interventions to Improve Mental Health in Home Caregivers of People With Dementia: Meta-Analysis. *Journal of Medical Internet Research*, 21(5), e13415. <https://doi.org/10.2196/13415>

B.(20) Council voted to receive the *Report of the APA Task Force on Variations in Sex Characteristics*.

C.(21) Council voted to adopt as APA policy the following *Resolution on the Psychological Impact of Immigration-Related Enforcement, Detention, Forced Deportation, and Persecution*:

Resolution on the Psychological and Developmental Impacts of Immigration-Related Enforcement, Detention, and Forced Deportation

Consistent with the American Psychological Association (APA)’s mission to advance, communicate, and apply psychological science to benefit society and improve lives, this Resolution builds upon the APA Presidential Task Force on Immigration (2013)’s report [*Crossroads: The Psychology of Immigration in the New Century*](#), APA’s [*Immigration and Refugee Policy Statement*](#) (2019), [*APA Policy Statement on Immigrant Health*](#) (2024a), and APA (2024b)’s report on [*Psychological Science and Immigration Today*](#). Collectively, these documents recognize immigration experiences and policy environments as social and structural determinants of behavioral health.

Although this resolution focuses primarily on the United States, similar patterns are documented globally: restrictive border regimes, detention, deportation, and exclusion are associated with psychological harm (Côté-Olijnyk et al., 2024; Filges et al., 2024; Martinez et al., 2015; Sherif et al., 2025; Steel et al., 2011; von Werthern, 2018). Communities also mobilize within and across borders to withstand, resist, and transform harmful conditions while advancing healing and collective well-being (Esposito et al., 2024; Siim & Meret, 2021; Society for Community Research and Action, 2021).

Research documents that chronic exposure to threat, uncertainty, detention, deportation, and forced family separation is associated with sustained stress responses, anxiety, depression, posttraumatic stress symptoms, and disruptions in cognitive, relational, and developmental functioning (Brabeck & Xu, 2010; Danese & McEwen, 2012; Dreby, 2012; Hainmueller et al., 2017; Rojas-Flores et al., 2017; Shonkoff & Garner, 2012; Torres et al., 2018; Verhulsdonk et al., 2021; Wood, 2018). Thus, immigration has been globally recognized as a social determinant of health (Castaneda et al., 2015). Studies also report elevated posttraumatic distress among asylum-seeking families navigating U.S. immigration processes (Mercado et al., 2024; Robjant et al., 2009).

Socioecological and population health frameworks recognize immigration enforcement intensity, policy environments, and community climate as structural factors affecting directly targeted individuals, mixed-status families, U.S.-citizen children, and broader community networks. Fear of detention or deportation is associated with decreased healthcare access, educational disruption, increased psychological distress, reduced safety for survivors of gender-based violence, and reduced trust in healthcare providers, schools, and other institutions (APA, 2024b; Bettinger-Lopez et al., 2020; Brabeck & Xu, 2010; Klein & von dem Knesebeck, 2018; López-Cevallos et al., 2026; Martinez et al., 2015; Rabin et al., 2022; SCRA, 2018, 2021). These dynamics underscore the importance of trauma-informed and culturally responsive approaches across clinical, educational, and community settings.

This Resolution applies established psychological science to contemporary immigration contexts and reaffirms APA's commitment to evidence-based, developmentally informed, and ethically grounded approaches that promote human well-being and reduce preventable psychological harm.

Psychological Science on Stress, Trauma, and Development

Research consistently shows that prolonged stress and trauma related to threat, unpredictability, and social exclusion are associated with elevated risk for psychological and developmental disruption across the lifespan (APA, 2019; APA, 2024b; Conti & Heckman, 2012; Felitti et al., 2019).

Immigrant populations may experience adversity before, during, and after migration, including political violence, organized crime, poverty, forced displacement, discrimination, fear of deportation, family separation, and restricted access to services. These experiences are often shaped by broader structural conditions, including legacies of colonization, armed conflict, and social marginalization in countries of origin (Cerdeña et al., 2021; Valdez et al., 2024). Emerging scholarship further suggests that restrictive immigration policies, enforcement practices, chronic fear of detention or deportation, family separation, and related structural marginalization may function as community-level adverse childhood experiences (ACEs) that shape child

development and long-term health outcomes (Barajas-Gonzalez et al., 2021; Ertanir et al., 2023; Valdez et al., 2023; Warner et al., 2023).

Across the migration process, these adversities are associated with poorer physical and emotional well-being, increased psychological distress, developmental risk, and complex distress related to family separation and reunification (APA, 2012; APA, 2019; APA, 2024a, 2024b; Heeren, et al., 2014; Lindert et al., 2009; Lustig et al., 2004; Martinez et al., 2017; Patel et al., 2021; von Werthern et al., 2018). Further, youth experience distress and retraumatization related to family separation and subsequent reunification during and after the migration process that is complex and multifaceted (Patel et al., 2021).

These conditions may also disrupt identity development and sense of belonging. Identity formation is shaped by migration as well as receiving-community conditions, including discrimination, exclusion, legal precarity, and barriers to participation (APA, 2012, 2024b, 2025b). Persistent marginalization and uncertainty about belonging are associated with acculturative stress and identity conflict, including disconnection from both country of origin and receiving society (Berry, 2006; Bhugra & Becker, 2005; Phinney et al., 2001; Schwartz et al., 2010; Verkuyten, 2018).

Immigration Trends and Demographic Shifts

U.S. Census Bureau estimates indicate a sharp decline in net international migration to the U.S., between 2024 and 2025, decreasing from approximately 2.7 million to 1.3 million persons during a period of intensified enforcement (U.S. Census Bureau, 2026). This decline in migration is thought to reflect both a decrease in immigration to the U.S. and increase in emigration out of the U.S. Pew Research Center analyses similarly report that the total U.S. immigrant population declined in 2025 for the first time in more than five decades (Pew Research Center, 2025). Although these trends provide contemporary context, the resolution is intended to address the psychological and developmental impacts of immigration enforcement conditions across administrations and policy environments.

Enforcement Trends and Detention Patterns

Empirical data from 2025–2026 show substantial increases in U.S. immigration enforcement actions, including ICE arrests reaching their highest daily levels in the past decade while the proportion of arrests involving individuals with criminal convictions fell to a near-historic low (East et al., 2026).

The U.S. Department of Homeland Security (DHS) reported more than 605,000 deportations in 2025, with analyses indicating that deportations following ICE detention rose more than fourfold compared with late 2024 (Blair & Hausman, 2026; U.S. DHS, 2025). ICE detention populations exceeded 70,000 individuals in early 2026 (Stateline, 2026), a more than 75% increase from early 2025, including a substantial rise in detainees without criminal convictions (American Immigration Council, 2026; East, 2026; Stateline, 2026; TRAC Reports, 2026).

Oversight reports and public records from 2025–2026 also document deaths in ICE custody and large-scale workplace enforcement operations detaining hundreds of workers, contributing to heightened uncertainty and fear in affected communities (Blair & Hausman, 2026; Santos et al., 2018). Historical federal records further show that the 2018 “zero tolerance” policy systematically separated thousands of children from parents, often without adequate systems for family tracking or reunification, contributing to significant trauma-related distress and overwhelming legal and detention systems (American Immigration Council, 2025). Such

separations are associated with anxiety, depression, posttraumatic stress symptoms, sleep disturbances, behavioral difficulties, and long-term psychological distress among children and caregivers (Hampton et al., 2021; Naseh et al., 2023; Wood, 2018).

Federal data also indicate a dramatic expansion in the number of children entering immigration custody. Before 2012, fewer than 8,000 unaccompanied children annually were placed in federal custody; in recent years, that number rose to nearly 100,000 or more annually, peaking at 128,904 in 2022 (U.S. Department of Health and Human Services, Office of Refugee Resettlement, 2026). One recent study found that over one third of Latinx adolescent immigrants were detained for at least four weeks, and nearly half witnessed or experienced a traumatic event during detention or after resettlement (Palacios et al., 2024).

Immigration-related family separation may also strain child welfare and behavioral health systems. Reliable data remain limited on U.S.-citizen children of deported parents in state and local child welfare tracking systems. Nationally, approximately 4.71 million U.S.-citizen children live with at least one undocumented parent, and about one-half could be left without a parent in the U.S. because of mass deportation efforts (Lisiecki et al., 2025). A recent analysis found that during the first seven months of enhanced deportation efforts, parents of more than 11,000 U.S.-citizen children had been detained by ICE (Ernsthausen et al., 2026). While enforcement patterns vary across federal administrations, the psychological concerns addressed in this resolution arise from enforcement actions and conditions themselves, including detention, deportation, family separation, community raids, legal uncertainty, and fear-related barriers to services.

Psychological and Educational Impacts on Children and Families

Public health and behavioral research documents psychological sequelae of immigration enforcement exposure among children and families, including increased anxiety, fear of separation, behavioral dysregulation, and educational disruption (Jordan et al., 2021; Patel et al., 2021). National educator surveys link recent enforcement actions to elevated anxiety and reduced attendance among students in immigrant families, while recent surges in immigration apprehensions have been associated with lower test scores among Spanish-speaking students, regardless of nativity (Education Week Research Center, 2025; Figlio & Özek, 2025; von Werthern et al., 2018).

National survey data also indicate rising worries about detention, deportation, and negative health impacts among immigrant communities, with substantial proportions reporting fear-related stress affecting daily functioning (Kaiser Family Foundation & The New York Times, 2025). Research further links fear and enforcement exposure to trauma and distress processes among children and families affected by detention and deportation (Bettinger-Lopez et al., 2020; Dreby, 2012; Gulbas & Zayas, 2017; Hainmueller et al., 2017; Rojas-Flores et al., 2017; Torres et al., 2018).

Health and Safety Conditions in Detention

Evidence indicates that individuals in immigration detention often face inadequate health care, including delayed or inappropriate care and limited response to medical crises. Documented deaths in U.S. immigration detention include medical emergencies and suicide, often among young men without significant preexisting conditions (Grassini et al., 2021; Inda, 2020; Marquez et al., 2021; New York Lawyers for the Public Interest, 2020).

Evidence also suggests that detained immigrants, including children, may face unsafe living conditions (Esposito et al., 2025; Homeland Security's Office for Civil Rights and Civil Liberties Inspection Reports, 2016–2019; Manek et al., 2024). Prolonged exposure to uncertainty, isolation, restricted communication, degradation, insufficient resources, and loss of autonomy in detention settings is associated with severe psychological suffering (Amnesty International, 2025; Bosworth, 2023; Cleveland et al., 2018; Coffey et al., 2010; Esposito et al., 2025; Filges, 2024; Inda, 2020; Jansen et al., 2018; Manek et al., 2024; Winters et al., 2023).

Immigration Enforcement as a Social and Structural Determinant of Health

Socioecological and population health frameworks recognize governance structures, policy environments, and law enforcement practices as social and structural determinants of behavioral health, including stress regulation, community cohesion, and access to culturally responsive care (APA, 2024a, 2024b; Wallace et al., 2018).

Immigration enforcement can undermine trust in healthcare systems, schools, and community institutions and reduce use of healthcare, mental health, preventive, and other essential services. These dynamics contribute to reduced institutional engagement and worsening psychological and developmental outcomes among immigrant families and communities (APA, 2024a; APA Services, Inc., 2025b; Brabeck & Xu, 2010; Capps et al., 2015; Hacker et al., 2012; Hagan et al., 2010; Lopez, 2019; Lopez et al., 2017, 2019; Martinez et al., 2015; SCRA, 2018; Vargas, 2015).

These effects extend beyond directly targeted individuals, disrupting family functioning, community cohesion, institutional participation, civic engagement, and psychological well-being across broader communities, including mixed-status families and U.S.-citizen children (Buckingham & Angulo, 2022; Buckingham & Brodsky, 2020; Philbin et al., 2018; SCRA, 2018, 2021; Torres et al., 2018).

Healthcare systems, schools, and community organizations can serve as protective settings that support resilience, developmental stability, and mental health. Fear-related barriers to accessing these settings can exacerbate psychological harm and developmental risk (APA, 2024b; SCRA, 2021). Immigration policy climates, including enforcement activities, detention exposure, and legal uncertainty, shape stress exposure, access to care, developmental trajectories, and long-term psychological and community well-being, while also eroding community social capital by removing members who contribute social, economic, and civic resources (APA, 2024a, 2024b; Castañeda et al., 2015; Ferreira van Leer et al., 2025; Garcini et al., 2023; Hall et al., 2025; Lebrón, 2023; Lopez et al., 2017; Philbin et al., 2018).

Community Resilience and Resistance During Immigration Enforcement

Psychological research identifies protective factors that may mitigate the psychosocial effects of immigration enforcement stress, including family cohesion, cultural identity, community solidarity, and access to supportive services (Alegría et al., 2017; The APA Presidential Task Force on Immigration, 2013). When enforcement policies create fear of accessing resources, immigrant community networks often provide emotional support, information sharing, and practical assistance that help people navigate legal uncertainty, maintain caregiving responsibilities, and sustain daily life despite risk (Abrego, 2019; Dreby, 2015; Lemon et al., 2025; Menjivar & Abrego, 2012; Negrete et al., 2025; SCRA, 2021; Suarez-Balcazar, 2025). Ethno-racial trauma frameworks further emphasize critical consciousness, collective resistance, and restored safety, dignity, and belonging as central to healing from systemic oppression (Chavez-Dueñas, 2019; Comas-Díaz et al., 2019).

Immigrant communities also demonstrate resilience through individual and relational strengths. Family cohesion, intergenerational caregiving, cultural identity, community belonging, meaning-making practices, and support from trusted community and faith networks can help individuals and families cope with fear, uncertainty, discrimination, legal precarity, and detention or deportation threats (Abrego, 2014; Alegría et al., 2017; Dreby, 2015; Garcini et al., 2020; Kaufman & Beltrán del Río, 2025; Menjívar & Abrego, 2012; Ornelas et al., 2020; Torres & Young, 2016). Similar protective processes have been documented among migrant and refugee populations across diverse international contexts, suggesting that resilience in the face of migration-related adversity is supported by comparable social, cultural, and community resources worldwide (Bhugra, 2004; Olcese et al., 2024; World Health Organization, 2023).

Community solidarity and shared sense of community can support collective action to improve conditions, resist harmful immigration policies, and promote well-being (Artero, 2025; Cadenas et al., 2025). However, mobilization of immigrants, allies, and broader community networks is shaped by contextual risks, fear, disempowerment, and relative privilege, including access to social resources and secure legal status (Brodsky et al., 2022; Buckingham & Brodsky, 2020; Cadenas et al., 2025). Community responses to enforcement may therefore range from mutual aid and informal support networks to collective organizing that protects well-being and challenges conditions that threaten health and safety.

The preceding evidence highlights the psychological and developmental implications of immigration enforcement environments. Consistent with APA policies (APA, 2019; 2024a), strategic plan (APA, 2024), human rights and population health frameworks (APA, 2021, 2022), and ethical commitments (APA, 2017), the following actions are recommended:

1. **Recognition of Enforcement-Related Stressors:** APA recognizes that intensified immigration enforcement, including detention exposure, forced deportation, community raids, and legal uncertainty, is associated with acute and chronic psychosocial stressors affecting emotional, developmental, cognitive, and relational functioning among immigrants, families, and communities.
2. **Social and Structural Determinants Awareness:** APA affirms that immigration enforcement climates function as social and structural determinants of behavioral health, shaping psychological outcomes, family stability, developmental trajectories, institutional engagement, and community well-being. APA supports incorporating this understanding into assessment, intervention, and research frameworks.
3. **Ethical Assessment and Treatment:** APA encourages psychologists to address immigration enforcement–related stressors in assessment, treatment, consultation, and forensic contexts of clients while avoiding over-pathologizing normative responses to threat. This includes attention to intersectional vulnerabilities, including sexual orientation and gender identity, when deportation threat may involve return to identity-based persecution or violence. Psychologists are also encouraged to remain knowledgeable about local community resources and services for immigrant populations.
4. **Trauma-Informed Integration:** APA supports trauma-informed, culturally responsive, and developmentally appropriate approaches across clinical, educational, medical, and legal settings serving immigrants and families exposed to immigration enforcement–related stressors.

5. **Developmentally Appropriate Practices:** APA promotes developmentally appropriate and culturally informed practices in educational and pediatric settings serving children and adolescents exposed to immigration enforcement–related stressors.
6. **Evidence-Based Public Communication and Policy Advocacy:** Consistent with APA’s human rights and population health frameworks, and in alignment with the WHO global action plan on promoting the health of refugees and migrants, APA supports communication of psychological science on immigration enforcement environments to promote human well-being, community health, and equitable access to psychological support.. APA encourages informed psychologists to participate in public dialogue and policy discussions, including advocacy for practices and policies that reduce psychological harm, protect family and community stability, and support humane, evidence-informed immigration governance.
7. **Ethical, Evidence-Based Guidance for Practice:** APA will continue to develop and disseminate ethical, evidence-based, and community-informed guidance to support culturally responsive services for individuals, families, and communities affected by immigration enforcement. This guidance should promote trauma-informed care, public trust in service settings, workforce capacity, and policies that reduce psychological harm.
8. **Workforce Support:** APA commits to providing resources and ethical guidance for practitioners, researchers, academics, and trainees working with populations affected by immigration enforcement. APA also encourages institutional resources and supervision structures that address secondary traumatic stress among professionals working in high-intensity immigration enforcement contexts.
9. **Professional Competency Training:** To promote the continuity and quality of mental health care for immigrants, APA supports graduate, continuing education, and professional training initiatives that equip psychologists and allied professionals to assess and address stress, trauma, family disruption, and contextual fear associated with immigration enforcement.
10. **Longitudinal and Causal Inference Research Funding:** APA supports increased investment in rigorous, longitudinal, causal inference, and community-based research on how immigration enforcement environments influence psychological well-being, resilience, educational outcomes, intergenerational impacts, and access to care. This includes ethically grounded research designs capable of clarifying the psychological and developmental effects of enforcement exposure while strengthening the evidence base and advancing global perspectives in psychology.
11. **Monitoring and Reporting Family Separation Trends:** APA encourages continued monitoring and periodic public reporting on family separation related to immigration enforcement and associated behavioral health trends to inform policy, resource allocation, prevention, and intervention.
12. **Scientific Dissemination:** APA supports dissemination and translation of psychological research on the behavioral health consequences of immigration enforcement, detention conditions, family instability, and public enforcement climates for practitioners, policymakers, educators, and community stakeholders.

13. Removal of Access Barriers: APA affirms that access to healthcare, education, and community-based services without fear-related barriers is essential to protecting lifespan psychological well-being, promoting early identification and intervention, and preventing escalation of behavioral health conditions among immigrant populations and their families.
14. Institutional Safety and Trust: APA affirms the critical role of healthcare systems, educational institutions, and community organizations as protective settings that support psychological well-being, resilience, and recovery. APA encourages practices that promote accessibility, safety, trust, confidentiality, and culturally responsive care, including protections for individuals with precarious immigration statuses and policies maintaining these settings as sensitive locations free from immigration enforcement.
15. Community Engagement and Partnership: APA supports community-engaged, strengths-based approaches that promote resilience, resistance, social connectedness, collective efficacy, and access to culturally responsive resources among immigrant communities. APA encourages psychologists to collaborate with community organizations, schools, faith-based institutions, advocacy groups, and local stakeholders to support community well-being, strengthen protective factors, facilitate access to services, and elevate the voices and leadership of affected immigrant communities.

References

- Abrego, L. J. (2014). *Sacrificing families: Navigating laws, labor, and love across borders*. Stanford University Press.
- Abrego, L. J. (2019). Relational legal consciousness of U.S. citizenship: Privilege, responsibility, guilt, and love in Latino mixed-status families. *Law & Society Review*, 53(3), 641–670.
- Alegría, M., Álvarez, K., & DiMarzio, K. (2017). Immigration and mental health. *Current Epidemiology Reports*, 4(2), 145-155.
- American Immigration Council. (2025). *A look back at the family separation policy*.
<https://www.americanimmigrationcouncil.org/report/family-separation-policy>
- American Immigration Council. (2026). *Immigration detention expansion in Trump's second term*. American Immigration Council.
<https://www.americanimmigrationcouncil.org/report/immigration-detention/>
- American Psychological Association. (2013). *Crossroads: The psychology of immigration in the new century*.
- American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. <https://www.apa.org/ethics/code>
- American Psychological Association. (2019). *Immigration and refugee policy statement*.
- American Psychological Association. (2021). *Resolution on APA, Psychology, and Human Rights*.
<https://www.apa.org/about/policy/resolution-psychology-human-rights>

- American Psychological Association. (2022). *Psychology's role in advancing population health*. <https://www.apa.org/about/policy/advancing-population-health>
- American Psychological Association & American Psychological Services, Inc. (2024). *APA/APASI Strategic Plan*. <https://www.apa.org/about/apa/strategic-plan>
- American Psychological Association. (2024a). *APA policy statement on immigrant health*.
- American Psychological Association. (2024b). *Psychological science and immigration today*.
- American Psychological Association Services, Inc. (2025a). *Public charge ground of inadmissibility: Comment letter*.
- American Psychological Association Services, Inc. (2025b). *What psychological science says about immigration and immigrant health*.
- Amnesty International (2025). *Torture and enforced disappearances in the 'Sunshine State': Human rights violations at "Alligator Alcatraz" and Krome in Florida*. Amnesty International USA/Report.
- Artero, M. (2025). Citizens here and there against the crisis: immigrant organizations' transnational solidarity during the COVID-19 pandemic. *Frontiers in Sociology: Migration & Society*, 10, 1519301. <https://doi.org/10.3389/fsoc.2025.1519301>
- Barajas-Gonzalez, R. G., Ayón, C., Brabeck, K., Rojas-Flores, L., & Valdez, C. R. (2021). An ecological expansion of the adverse childhood experiences (ACEs) framework to include threat and deprivation associated with US immigration policies and enforcement practices: An examination of the Latinx immigrant experience. *Social Science & Medicine*, 282, 114126. <https://doi.org/10.1016/j.socscimed.2021.114126>
- Berry, J. W. (2006). Acculturative stress. In P. T. P. Wong & L. C. J. Wong (Eds.), *Handbook of multicultural perspectives on stress and coping* (pp. 287–298). Springer. https://doi.org/10.1007/0-387-26238-5_12
- Bettinger-Lopez, C., Flomo, J., & Suarez, A. (2020). The effects of anti-immigration laws in the U.S. on victims of domestic violence, sexual assault, and human trafficking: a gender-based human rights analysis. *Harvard Latinx Law Review*, 23, 17-42.
- Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, 109, 243-258. <https://doi.org/10.1046/j.0001-690X.2003.00246.x>
- Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry*, 4(1), 18–24. <https://pmc.ncbi.nlm.nih.gov/articles/PMC1414713/>
- Blair, G., & Hausman, D. (2026, January 27). *Immigration enforcement in the first nine months of the second Trump administration*. Deportation Data Project.
- Bosworth, M. (2023). The politics of pain in immigration detention. *Punishment & Society*, 25(2), 307–323. <https://doi.org/10.1177/14624745211048811>

- Brabeck, K., & Xu, Q. (2010). The impact of detention and deportation on Latino immigrant children and families: A quantitative exploration. *Hispanic Journal of Behavioral Sciences*, 32(3), 341-361.
- Brodsky, A. E., Buckingham, S. L., Fedi, A., Rochira, A., Gattino, S., Altal, D., & Mannarini, T. (2022). Resilience and empowerment in immigrant experiences: A look through the Transconceptual Model of Empowerment and Resilience. *American Journal of Orthopsychiatry*, 92(5), 564–577. <https://doi.org/10.1037/ort0000634>
- Buckingham, S. L., & Angulo, A. (2022). The impact of public policies on acculturation: A mixed-method study of Latinx immigrants' experiences in four U.S. states. *Journal of Community Psychology*, 50(2), 627–652. <https://doi.org/10.1002/jcop.22639>
- Buckingham, S. L., & Brodsky, A. E. (2020). Relative privilege, risk, and sense of community: Understanding Latinx immigrants' empowerment and resilience processes across the United States. *American Journal of Community Psychology*, 67(3–4), 364–379. <https://doi.org/10.1002/ajcp.12486>
- Cadenas, G. A., Domenech Rodríguez, M. M., Garcini, L. M., Mendoza, J. G., Suro, B., Mercado, A., Rojas Perez, O. F., Venta, A., Galvan, T., Moreno, O., & Paris, M. (2025). Antiracist activism for immigrant rights and healthy coping: Initial evidence for a community-based framework. *American Journal of Community Psychology*, 75(3–4). <https://doi.org/10.1002/ajcp.12769>
- Capps, R., Koball, H., Campetella, A., Perreira, K., Hooker, S., & Pedroza, J. M. (2015). *Implications of immigration enforcement activities for the well-being of children in immigrant families*. Urban Institute.
- Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health*, 36, 375–392. <https://doi.org/10.1146/annurev-publhealth-032013-182419>
- Cerdeña, J. P., Rivera, L. M., & Spak, J. M. (2021). Intergenerational trauma in Latinxs: A scoping review. *Social Science & Medicine*, 270, 113662. <https://doi.org/10.1016/j.socscimed.2020.113662>
- Chavez-Dueñas, N. Y., Adames, H. Y., Perez-Chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist*, 74(1), 49. <https://doi.org/10.1037/amp0000289>
- Cleveland, J., Kronick, R., Gros, H., & Rousseau, C. (2018). Symbolic violence and disempowerment as factors in the adverse impact of immigration detention on adult asylum seekers' mental health. *International Journal of Public Health*, 63(8), 1001-1008. <https://doi.org/10.1007/s00038-018-1121-7>
- Coffey, G. J., Kaplan, I., Sampson, R. C., & Tucci, M. M. (2010). The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Social Science & Medicine*, 70(12), 2070-2079. <https://doi.org/10.1016/j.socscimed.2010.02.042>

- Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, 74(1), 1.
- Conti, G., & Heckman, J. J. (2012). *The developmental approach to child and adult health* (No. w18664). National Bureau of Economic Research.
- Côté-Olijnyk, M., Perry, J. C., Paré, M. È., & Kronick, R. (2024). The mental health of migrants living in limbo: A mixed-methods systematic review with meta-analysis. *Psychiatry Research*, 337, 115931. <https://doi.org/10.1016/j.psychres.2024.115931>
- Danese, A., & McEwen, B. S. (2012). Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiology & Behavior*, 106(1), 29–39.
- Dreby, J. (2012). The burden of deportation on children in Mexican immigrant families. *Journal of Marriage and Family*, 74(4), 829–845. <https://doi.org/10.1111/j.1741-3737.2012.00989.x>
- Dreby, J. (2015). *Everyday illegal: When policies undermine immigrant families*. University of California Press.
- East, C. N., Patler, C., & Cox, E. (2026). *ICE arrests across Trump's first and second terms: Variation in targeting, method, and geography* (NBER Working Paper No. 34794). National Bureau of Economic Research. <https://doi.org/10.3386/w34794>
- Education Week Research Center. (2025). *The widespread effects of immigration enforcement on schools*. <https://www.edweek.org/leadership/the-widespread-effects-of-immigration-enforcement-on-schools-in-charts/2025/11>
- Ernsthausen, J., Ariza, M., Funk, M., Rosenberg, M., & Sandoval, G. (2026, March 24). Trump has detained the parents of more than 11,000 U.S. citizen kids. *ProPublica*. <https://www.propublica.org/article/trump-family-deportations-ice-citizen-kids>
- Ertanir, B., Cobb, C. L., Unger, J. B., Celada-Dalton, T., West, A. E., Zeledon, I., Perazzo, P. A., Cano, M. Á., Des Rosiers, S. E., Duque, M. C., Ozer, S., Cruz, N., Scaramutti, C., Vos, S. R., Salas-Wright, C. P., Maldonado-Molina, M. M., Nehme, L., Martinez, C. R., Zayas, L. H., & Schwartz, S. J. (2023). Crisis migration adverse childhood events: A new category of youth adversity for crisis migrant children and adolescents. *Research on Child and Adolescent Psychopathology*, 51(12), 1871–1882. <https://doi.org/10.1007/s10802-022-01016-x>
- Esposito, F., de Lellis, F., De Cordova, F., & Briozzo, E. (2025). "Who's breaking the law ... not us, them!": Inside immigration detention in Portugal. *American Journal of Community Psychology*, 75(3-4), 371–385. <https://doi.org/10.1002/ajcp.12784>
- Esposito, F., Rebelo, D., Olanrewaju, M., Vine, M., Fernandes-Jesus, M., Bodden, D., Kalokoh, A., & Olson, B. (2024). A community psychology for migrant justice: Critically examining border violence and resistance during the COVID-19 syndemic. *American Journal of Community Psychology*, 73(1-2), 27–43. <https://doi.org/10.1002/ajcp.12669>

- FactCheck.org. (2026). *As ICE arrests increased, a higher portion had no U.S. criminal record.*
<https://www.factcheck.org/2026/01/as-ice-arrests-increased-a-higher-portion-had-no-u-s-criminal-record/>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine*, 56(6), 774–786.
<https://doi.org/10.1016/j.amepre.2019.04.001>
- Ferreira van Leer, K., Lombardi, C., Chazan-Cohen, R., Esquivel, V., Isais, P., & Berset, A. (2025). Implications of state policy context for the well-being of immigrant families with young children. *American Journal of Community Psychology*, 75(3-4), 332–345.
<https://doi.org/10.1002/ajcp.12783>
- Figlio, D. N., & Özek, U. (2025). *The Effects of Immigration Enforcement on Student Outcomes in a New Era of Immigration Policy in the United States* (No. w34452). National Bureau of Economic Research.
- Filges, T., Bengtsen, E., Montgomery, E., & Kildemoes, M. W. (2024). The impact of detention on the health of asylum seekers: An updated systematic review. *Campbell Systematic Reviews*, 20(3), e1420. <https://doi.org/10.1002/cl2.1420>
- Garcini, L. M., Domenech Rodríguez, M. M., Mercado, A., & Paris, M. (2020). A tale of two crises: The compounded effect of COVID-19 and anti-immigration policy in the United States. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(S1), S230–S232.
<https://doi.org/10.1037/tra0000775>
- Garcini, L. M., Domenech Rodríguez, M. M., Mercado, A., Silva, M., Cadenas, G., Galvan, T., & Paris, M. (2023). Anti-immigration policy and mental health: Risk of distress and trauma among deferred action for childhood arrivals recipients in the United States. *Psychological Trauma: Theory, Research, Practice, and Policy*, 15(7), 1067–1075.
<https://doi.org/10.1037/tra0001228>
- Grassini M, Terp S, Fischer B, et al. Characteristics of Deaths Among Individuals in U.S. Immigration and Customs Enforcement Detention Facilities, 2011-2018. *JAMA Netw Open*. 2021;4(7):e2116019. doi:10.1001/jamanetworkopen.2021.16019
- Gulbas, L. E., & Zayas, L. H. (2017). Exploring the effects of U.S. immigration enforcement on the well-being of citizen children in Mexican immigrant families. *The Russell Sage Foundation Journal of the Social Sciences*, 3(4), 53–69.
<https://doi.org/10.7758/RSF.2017.3.4.04>
- Hacker, K., Chu, J., Arsenault, L., & Marlin, R. P. (2012). Provider’s perspectives on the impact of Immigration and Customs Enforcement (ICE) activity on immigrant health. *Journal of Health Care for the Poor and Underserved*, 23(2), 651–665.
<https://doi.org/10.1353/hpu.2012.0052>

- Hagan, J., Castro, B., & Rodriguez, N. (2010). The effects of U.S. deportation policies on immigrant families and communities: Cross-border perspectives. *North Carolina Law Review*, 88(5), 1799–1824. <https://scholarship.law.unc.edu/nclr/vol88/iss5/12>
- Hagan, J., Leal, D., & Rodriguez, N. (2015). Deporting social capital: Implications for immigrant communities in the United States. *Migration Studies*, 3(3), 370–392. <https://doi.org/10.1093/migration/mnu054>
- Hainmueller, J., Lawrence, D., Martén, L., Black, B., Figueroa, L., Hotard, M., Jiménez, T. R., Mendoza, F., Rodriguez, M. I., Swartz, J. J., & Laitin, D. D. (2017). Protecting unauthorized immigrant mothers improves their children’s mental health. *Science*, 357(6355), 1041–1044. <https://doi.org/10.1126/science.aan5893>
- Hall, M., Olivero, G., & Gleeson, S. (2025). The impact of undocumented status in the United States: Empirical challenges and new frontiers. *Annual Review of Sociology*, 51(1), 291–309. <https://doi.org/10.1146/annurev-soc-031021-012330>
- Hampton, K., Raker, E., Habbach, H., Camaj Deda, L., Heisler, M., & Mishori, R. (2021). The psychological effects of forced family separation on asylum-seeking children and parents at the US-Mexico border: A qualitative analysis of medico-legal documents. *PLoS One*, 16(11), e0259576. <https://doi.org/10.1371/journal.pone.0259576>
- Heeren, M., Wittmann, L., Ehler, U., Schnyder, U., Maier, T., & Müller, J. (2014). Psychopathology and resident status—comparing asylum seekers, refugees, illegal migrants, labor migrants, and residents. *Comprehensive psychiatry*, 55(4), 818–825.
- Inda, J. X. (2020). Fatal prescriptions: Immigration detention, mismedication, and the necropolitics of uncare. *Death Studies*, 44(11), 699–708. <https://doi.org/10.1080/07481187.2020.1771852>
- Jansen, M., Tin, A. S., & Isaacs, D. (2018). Prolonged immigration detention, complicity and boycotts. *Journal of Medical Ethics*, 44(2), 138–142. <https://doi.org/10.1136/medethics-2016-104125>
- Jordan, L. S., Walsdorf, A. A., Roche, K. M., & Falusi, O. O. (2021). “I am affected in all the ways...”: A phenomenographic analysis of Latinx adolescents’ perceptions of family separations at the border. *Cultural Diversity & Ethnic Minority Psychology*, 27(4), 736.
- Kaiser Family Foundation & The New York Times. (2025, November 18). *KFF/New York Times 2025 survey of immigrants: Worries, experiences, and impacts amid increased immigration enforcement*. Kaiser Family Foundation. <https://www.kff.org/kff-nytimes-2025-survey-of-immigrants/>
- Kaufmann, N. T., & Beltrán del Río, E. (2025). Perceptions of Mexican nationals on recent deportation experiences from the United States: A qualitative study. *American Journal of Community Psychology*, 75(3–4). <https://doi.org/10.1002/ajcp.12781>
- Klein, J., & von dem Knesebeck, O. (2018). Inequalities in health care utilization among migrants and non-migrants in Germany: a systematic review. *International journal for equity in health*, 17(1), 160.

- Lebrón, A. M. W., Torres, I. R., Kline, N., Lopez, W. D., DE Trinidad Young, M. E., & Novak, N. (2023). Immigration and immigrant policies, health, and health equity in the United States. *The Milbank Quarterly*, 101(S1), 119–152. <https://doi.org/10.1111/1468-0009.12636>
- Lemon, E., Ruiz, K., Ling, A., Campos, J. P., Roche, K. M., Suglia, S., Livingston, M., & Woods-Jaeger, B. (2025). “Together we are stronger”: YPAR and Latinx immigrant youth resilience and resistance to oppressive immigration policies. *American Journal of Community Psychology*, 75(3–4), 433–446. <https://doi.org/10.1002/ajcp.12812>
- Lindert, J., Von Ehrenstein, O. S., Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees—a systematic review and meta-analysis. *Social science & medicine*, 69(2), 246–257.
- Lisiecki, M., Velasco, K., & Watson, T. (2025). What will deportations mean for the child welfare system? *The Brookings Institution and Center for Migration Studies*. <https://www.brookings.edu/articles/what-will-deportations-mean-for-the-child-welfare-system/>
- Lopez, W. D. (2019). *Separated: Family and community in the aftermath of an immigration raid*. Johns Hopkins University Press.
- Lopez, W. D., Kruger, D. J., Delva, J., Llanes, M., Ledón, C., Waller, A., ... & Israel, B. (2017). Health implications of an immigration raid: Findings from a Latino community in the Midwestern United States. *Journal of Immigrant and Minority Health*, 19(3), 702–708. <https://doi.org/10.1007/s10903-016-0390-6>
- López-Cevallos, D. F., Vargas, E. D., Valdez, C. R., & Sanchez, G. R. (2026). Avoiding medical care due to heightened immigration enforcement concerns: Findings from a national Latino immigrant sample. *Journal of General Internal Medicine*, 1–4. <https://doi.org/10.1007/s11606-026-10244-6>
- Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., ... & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 24–36.
- Manek, J., Riedl, T., & Mühlich, H. (2024). Migration detention, mental health, and its relations to torture: A scoping review. *Community Psychology in Global Perspective*, 10(1), 151–176.
- Marquez, B. A., Marquez-Velarde, G., Eason, J. M., & Aldana, L. (2021). Pushing them to the edge: Suicide in immigrant detention centers as a product of organizational failure. *Social Science & Medicine*, 283, 114177. <https://doi.org/10.1016/j.socscimed.2021.114177>
- Martinez, O., Wu, E., Sandfort, T., Dodge, B., Carballo-Dieguez, A., Pinto, R., ... Chavez-Baray, S. (2015). Evaluating the impact of immigration policies on health status among undocumented immigrants: A systematic review. *Journal of Immigrant and Minority Health*, 17(3), 947–970.

- Martinez, A. D., Ruelas, L., & Granger, D. A. (2017). Household fear of deportation in Mexican-origin families: Relation to body mass index percentiles and salivary uric acid. *American Journal of Human Biology*, 29(6), e23044. <https://doi.org/10.1002/ajhb.23044>
- Menjívar, C., & Abrego, L. J. (2012). Legal violence: Immigration law and the lives of Central American immigrants. *American Journal of Sociology*, 117(5), 1380–1421.
- Mercado, A., Venta, A., Morales, F., Palomin, A., Garcini, L., Silva, M., & Domenech Rodríguez, M. M. (2024). Trauma in the American asylum process: Experiences of immigrant families under the migrant protection protocols. *Psychological trauma: theory, research, practice, and policy*, 16(S2), S379.
- Naseh, M., Ilea, P., Aldana, A., & Sutherland, I. (2023). Family separation as an oppressive tool: A scoping review of child separation from the primary caregiver as the result of migration policies. *Children and Youth Services Review*, 155, 107157. <https://doi.org/10.1016/j.childyouth.2023.107157>
- Negrete, A., Ramirez-Arellano, L., Lucas, M., & Hurd, N. M. (2025). Critical reflection and action in response to an anti-immigration context: What we can learn from migrant young adults from Latin America. *American Journal of Community Psychology*, 75(3–4). <https://doi.org/10.1002/ajcp.12780>
- New York Lawyers for the Public Interest. (2020). Still detained and denied: The health crisis in immigration detention continues. <https://nylpi.org/wp-content/uploads/2020/04/NYLPI-reportDetained-Denied.pdf>
- Olcese, M., Cardinali, P., Madera, F., Camilleri, A. P., & Migliorini, L. (2024). *Migration and community resilience: A scoping review*. *International Journal of Intercultural Relations*, 98, 101924. <https://doi.org/10.1016/j.ijintrel.2023.101924>
- Ornelas, I. J., Yamanis, T. J., & Ruiz, R. A. (2020). The health of undocumented Latinx immigrants: What we know and future directions. *Annual Review of Public Health*, 41, 289–308. <https://doi.org/10.1146/annurev-publhealth-040119-094211>
- Palacios, M. P., Patel, S. G., Martinez, W., Reed II, D. E., Liu, K. Y., & Mercado, A. (2024). “Estuvimos en una hielera”: Migration trauma and detainment among newcomer Latinx adolescents. *Psychological trauma: theory, research, practice, and policy*, 16(S2), S330.
- Patel, S. G., Bouche, V., Martinez, W., Barajas, K., Garcia, A., Sztainer, M., & Hawkins, K. (2021). “Se extraña todo:” Family separation and reunification experiences among unaccompanied adolescent migrants from Central America. *New Directions for Child and Adolescent Development*, 2021(176), 227–244.
- Pew Research Center. (2025). *Striking findings from 2025 immigration data*. <https://www.pewresearch.org/short-reads/2025/12/09/striking-findings-from-2025/>
- Philbin, M. M., Flake, M., Hatzenbuehler, M. L., & Hirsch, J. S. (2018). State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Social Science & Medicine*, 199, 29–38. <https://doi.org/10.1016/j.socscimed.2017.04.007>

Phinney, J. S., Horenczyk, G., Liebkind, K., & Vedder, P. (2001). Ethnic identity, immigration, and well-being: An interactional perspective. *Journal of Social Issues*, 57(3), 493–510. <https://doi.org/10.1111/0022-4537.00225>

Rabin, J., Stough, C., Dutt, A., & Jacquez, F. (2022). Anti-immigration policies of the Trump administration: A review of Latinx mental health and resilience in the face of structural violence. *Analyses of Social Issues and Public Policy*, 22(3), 876-905.

[Robjant, K., Hassan, R., & Katona, C. \(2009\). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry*, 194\(4\), 306–312. <https://doi.org/10.1192/bjp.bp.108.053223>](#)

Rojas-Flores, L., Clements, M. L., Hwang Koo, J., & London, J. (2017). Trauma and psychological distress in Latino citizen children following parental detention and deportation. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(3), 352–361. <https://doi.org/10.1037/tra0000177>

Santos, C. E., Menjívar, C., & Godfrey, E. B. (2018). Effects of perceived immigration enforcement threat on Latino adolescents' mental health and risk behavior. *Journal of Adolescent Health*, 62(6), 735–742. <https://doi.org/10.1016/j.jadohealth.2018.01.004>

Schwartz, S. J., Unger, J. B., Zamboanga, B. L., & Szapocznik, J. (2010). Rethinking the concept of acculturation: Implications for theory and research. *American Psychologist*, 65(4), 237–251. <https://doi.org/10.1037/a0019330>

Sherif, B., Hocking, D. C., Rees, S., Affaticati, L. M., & Sundram, S. (2025). A systematic review of qualitative research on the physical and mental health impacts of immigration detention on asylum seekers and refugees. *PLOS Global Public Health*, 5(10), e0005196. <https://doi.org/10.1371/journal.pgph.0005196>

Shonkoff, J. P., & Garner, A. S. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1), e232–e246.

Siim, B., & Meret, S. (2021). Patterns of reflective solidarity and migrant resistance in Copenhagen and Berlin. *Critical Sociology*, 47(2), 219-233. <https://doi.org/10.1177/0896920520944517>

Society for Community Research and Action. (2018). Statement on the effects of deportation and forced separation on immigrants, their families, and communities. *American Journal of Community Psychology*, 62(3–4), 373–382. <https://doi.org/10.1002/ajcp.12256>

Society for Community Research and Action. (2021). The roles of settings in supporting immigrants' resistance to injustice and oppression. *American Journal of Community Psychology*, 68(1–2), 1–18. <https://doi.org/10.1002/ajcp.12515>

Stateline. (2026, February 5). *Immigration detention passed 70,000 in January*. <https://stateline.org/2026/02/05/immigration-detention-passed-70000-in-january/>

- Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science & Medicine*, 72(7), 1149-1256. <https://doi.org/10.1016/j.socscimed.2011.02.007>
- Suarez-Balcazar Y. (2025). Promoting caring communities through collective action. *American Journal of Community Psychology*, 76(3-4), 259–267. <https://doi.org/10.1002/ajcp.70030>
- The APA Presidential Task Force on Immigration. (2013). Crossroads: The psychology of immigration in the new century. *Journal of Latina/o Psychology*, 1(3), 133–148. <https://doi.org/10.1037/lat0000001>
- Torres, S. A., DeCarlo Santiago, C., Kaufka Walts, K., & Richards, M. H. (2018). Immigration policy, practices, and procedures: The impact on the mental health of Mexican and Central American youth and families. *American Psychologist*, 73(7), 843–854. <https://doi.org/10.1037/amp0000184>
- Torres, J. M., & Young, M. D. (2016). A life-course perspective on legal status stratification and health. *SSM - Population Health*, 2, 141–148. <https://doi.org/10.1016/j.ssmph.2016.02.011>
- TRAC Reports. (2026). *Immigration detention and enforcement statistics*. <https://tracreports.org/immigration/quickfacts/>
- United Nations General Assembly (2018). Global compact for safe, orderly and regular migration. *International Journal of Refugee Law*, 30(4), 774-816.
- U.S. Census Bureau. (2026, January). *Historic decline in net international migration*. <https://www.census.gov/newsroom/blogs/random-samplings/2026/01/historic-decline-in-net-international-migration.html>
- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement. (2026). Referrals of unaccompanied children to the Office of Refugee Resettlement by fiscal year. <https://www.acf.hhs.gov/orr/uac/referrals>
- U.S. Department of Homeland Security. (2025, December 10). *DHS enforcement operations update*. <https://www.dhs.gov/news/2025/12/10/>
- U.S. Department of Homeland Security, Office for Civil Rights and Civil Liberties. (2016–2019). *Office for Civil Rights and Civil Liberties inspection reports* [Inspection reports]. U.S. Department of Homeland Security.
- Valdez, C. R., Ayón, C., Barajas-Gonzalez, R. G., Brabeck, K., Rojas-Flores, L., & Walsdorf, A. (2023). Clinical implications of an immigration-related adverse childhood experiences (ACES) framework for Latinx children of immigrant parents. In *Handbook of adverse childhood experiences: A framework for collaborative health promotion* (pp. 139-152). Cham: Springer International Publishing.

- Valdez, C. R., Brabeck, K. M., Barajas-Gonzalez, R. G., Ayón, C., & Rojas-Flores, L. (2024). Sociopolitically and trauma-informed public health practice with Latinx families: Conceptual framework and best practices. *American Journal of Public Health*, 114(S6), S485–S494. <https://doi.org/10.2105/AJPH.2024.307589>
- Vargas, E. D. (2015). Immigration enforcement and mixed-status families: The effects of risk of deportation on Medicaid use. *Journal of Health Politics, Policy and Law*, 40(5), 1051–1078. <https://doi.org/10.1215/03616878-3150082>
- Verhulsdonk, I., Shahab, M., & Molendijk, M. (2021). Prevalence of psychiatric disorders among refugees and migrants in immigration detention: systematic review with meta-analysis. *BJPsych open*, 7(6), e204.
- Verkuyten, M. (2018). *The social psychology of ethnic identity* (2nd ed.). Routledge.
- [von Werthern, M., Robjant, K., Chui, Z., Schon, R., Ottisova, L., Mason, C., & Katona, C. \(2018\). The impact of immigration detention on mental health: A systematic review. *BMC Psychiatry*, 18\(1\), 382. https://doi.org/10.1186/s12888-018-1945-y](https://doi.org/10.1186/s12888-018-1945-y)
- Wallace, S. P., Young, M. E. D. T., & Rodríguez, M. A. (2018). A social determinants framework identifying state-level immigrant policies and their influence on health. *Journal of Immigrant and Minority Health*, 21(2), 1–12. <https://doi.org/10.1016/j.ssmph.2018.10.016>
- Warner, T. D., Leban, L., Pester, D. A., & Walker, J. T. (2023). Contextualizing adverse childhood experiences: The intersections of individual and community adversity. *Journal of Youth and Adolescence*, 52(3), 570–584. <https://doi.org/10.1007/s10964-022-01713-2>
- World Health Organization. (2023). *Mental health of refugees and migrants: Risk and protective factors and access to care*. World Health Organization. <https://doi.org/10.4060/9789240081840>
- World Health Organization. (2024). *WHO global action plan on promoting the health of refugees and migrants, 2019–2030*. World Health Organization. <https://iris.who.int/handle/10665/378211>
- Winters, J. P., Owens, F., & Winters, E. (2023). Dirty work: Well-intentioned mental health workers cannot ameliorate harms in offshore detention. *Journal of Medical Ethics*, 49(8), 563–568. <https://doi.org/10.1136/jme-2022-108348>
- Wood, L. C. (2018). Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. *BMJ Paediatrics Open*, 2(1), e000338.
- D.(22) Council voted to approve the following *APA Resolution to Prioritize the Elimination of Gender-Based Violence Against Women and Marginalized Populations*:

Introduction

Gender-based violence (GBV), particularly intimate partner violence (IPV), is a persistent public health crisis of pandemic proportions. During the COVID-19 pandemic, the United Nations

Secretary-General described violence against women as a “shadow pandemic,” highlighting the widespread and escalating nature of these harms. GBV includes physical, sexual, psychological, economic, and technology-facilitated abuse, as well as stalking. These forms of violence disproportionately affect women, Sexual and Gender Minoritized (SGM) individuals, and people from historically marginalized communities. Psychological research consistently identifies a range of structural barriers that can prevent survivors from leaving abusive relationships, including economic dependence, lack of affordable housing, cultural and familial pressures, immigration-related concerns, and prior negative experiences with legal or institutional systems. Psychological research has also highlighted critical psychological barriers that can prevent survivors from leaving abusive relationships, including fear of retaliation and abusive relational patterns that involve periods of manipulation, shaming, and threats of harm with periods of calm and displays of affection. These long-term, repeated intermittent reinforcements can create a cycle where the woman begins to rely on the abuser for a sense of self-worth and attachment, thus maintaining the abusive relationship. Thus, the barriers women face when trying to leave abusive relationships are multidimensional and complex. Approaches that rely solely on punitive or criminal-legal responses often fail to address these underlying barriers and, in some cases, may discourage survivors from seeking support.

The experiences of cisgender women, transgender and nonbinary individuals, women of color, Indigenous women, immigrant women, women with disabilities, SGM individuals, and older adults are distinct yet interconnected. That said, safely leaving individuals perpetrating GBV and IPV can be particularly significant and complex for survivors from communities affected by historical and intergenerational trauma, including Black, Indigenous, immigrant, and SGM individuals who may experience bias, discrimination, or mistrust within formal systems of care and response.

The American Psychological Association (APA) affirms that psychological science holds both the evidence base and the professional responsibility to inform, shape, and evaluate approaches to addressing GBV and IPV. Decades of research in trauma, prevention, community intervention, and survivor-centered care have produced critical knowledge needed to develop effective policies, strengthen systems of response, and reduce the long-term impacts of violence on individuals, families, workplaces, and communities. APA's policy engagement on GBV and IPV is grounded in the ethical obligations of the profession and the evidentiary weight of psychological science. Decades of peer-reviewed research have established the profound and lasting psychological consequences of GBV specifically IPV, including post-traumatic stress disorder, depression, anxiety, substance use disorders, suicidality, and complex trauma, as well as the neurobiological, developmental, and intergenerational impacts on survivors and their children. Additionally, psychological science has equally demonstrated that prevention is possible. Trauma-informed intervention, perpetrator accountability programs with clinical oversight, community-based crisis response, and survivor-centered legal advocacy all carry evidentiary support.

APA Resolution to Prioritize the Elimination of Gender-Based Violence Against Women and Marginalized Populations Prevalence, Lethality, and Psychological Impact

WHEREAS, The most recent National Intimate Partner and Sexual Violence Survey (NISVS 2023/2024) found that more than one in three women (34.0%, or nearly 43.5 million) in the United States experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime. In addition, the estimated lifetime economic cost of IPV is approximately \$103,767 per female victim, totaling nearly 60% of the \$3.6 trillion nationally. These data affirm IPV as a primary driver of preventable female morbidity and mortality that

demands sustained federal public health investment (CDC, 2024; Leemis et al., 2022; Peterson et al., 2018; Rowh & Jack, 2024);

WHEREAS, GBV/IPV is associated with significant adverse physical and mental health outcomes as well as substance use. Survivors face two times greater risk of alcohol and substance abuse, three times greater risk of depression and posttraumatic stress disorder with lifetime prevalence rates of 31.5% for physical abuse and 64.5% for rape by a partner. Furthermore, IPV is associated with adverse health behaviors such as smoking and binge drinking among victims (Campbell et al., 2021; CDC, 2026; Leemis et al., 2022);

WHEREAS, GBV/IPV is associated with increased health care utilization and costs. The polytrauma clinical triad (TBI with persistent neurobehavioral symptoms, PTSD, and chronic pain) significantly worsens outcomes. Sharon E. Leong et al. (2025) found IPV-related TBI survivors had 3.84 times higher odds of the complete triad (N=198). Further, 14% of IPV-PA (physical abuse) female survivors reported mental health symptoms 27 years after the violence. Another study reported that IPV constituted \$2.1 trillion (59%) of the annual \$3.6 trillion economic burden, as survivors are more likely to require medical care and have higher overall health service use (CDC, 2026; Johnson et al., 2022; Peterson et al., 2018; Jenkins et al., 2025);

WHEREAS, existing surveillance and data collection systems may undercount the true scope and complexity of sexual violence and intimate partner violence due to limited definitions, barriers to disclosure, insufficient privacy protections, and challenges in capturing the experiences of diverse populations. Data challenges persist despite the importance of accurate, inclusive, and trauma-informed data collection for understanding prevalence, identifying disparities, improving interventions, and evaluating the effectiveness of prevention and support efforts (Barrick et al., 2025; Chen et al., 2023; Kelleher et al., 2025);

WHEREAS, research shows that healthcare providers experience significant gaps in their capacity to identify and care for women subjected to sexual exploitation, trafficking, and GBV/IPV, which makes healthcare systems inadequate in their identification and responses for these populations. These challenges underscore the strong need to train healthcare providers in IPV and GBV. Consequences of insufficient training include missed identification of applicable trauma symptoms, lack of use of screening and identifying tools for risk and lethality, delayed or lack of appropriate screening, increased likelihood of poor physical health outcomes, re-traumatization of patients, and reduced access for patients to receive necessary treatment and supportive services. A 2021 study found post-utilization of the Emergency Room visit, one in four did not disclose their sexual assault. (Alvarez et al., 2020; Andersson & Örmon, 2024; Barrick et al., 2025; Chen et al., 2023; Kelleher et al., 2025; Flores et al., 2025; Short et al., 2021);

Women of Color, Indigenous Women and Immigrant Women

WHEREAS, Black women are disproportionately represented among victims of intimate partner homicide in the United States. They constitute approximately 13.4% of the population yet account for 29.9% of all intimate partner homicide victims during 2018–2021, a racial disparity that widened during 2020–2021. Research identifies structural racism, residential segregation, poverty, and inadequate access to affirming legal and psychological services as key structural drivers of this lethal inequity (Rowh & Jack, 2024; Waller et al., 2024; Wilson & Blair, 2024);

WHEREAS, Native American and Alaska Native women are reported to be victimized by intimate partners at higher rates than any other racial or ethnic group in the United States. From 2021 to 2023, law enforcement reported 25,817 incidents of violent crime against American Indian or

Alaska Native females. Research identifies histories of colonization, structural racism, federal jurisdictional barriers, and lack of culturally congruent services as compounding their vulnerability and limiting access to safety and justice (FBI, 2025; Jock et al., 2022; Fedina et al., 2023);

WHEREAS, Undocumented immigrant women face a formidable use of immigration status as a tool of coercive control within abusive relationships. Qualitative research documents that fear of deportation and family separation, language barriers, mistrust of law enforcement rooted in racialized exclusion, intentional manipulation by their abuser, lack of knowledge about immigration laws, cultural and religion, and lack of knowledge about VAWA immigration protections such as U and T visas are among the most significant barriers to disclosure and help-seeking (Flores et al., 2025; Hulley et al., 2022; Sabri et al., 2022; Zero et al., 2023);

WHEREAS, approximately 20% of women in Hispanic households experience IPV. Latina survivors often encounter a range of cultural, economic, and structural barriers that may impede their ability to leave abusive relationships. These barriers include strong familial obligations, religious and cultural beliefs that discourage divorce, isolation, financial dependence on an abusive partner, limited English proficiency, and fears associated with immigration status and potential legal consequences. (Peterson, 2020; Rizo & Macy, 2011);

WHEREAS Limited research is available on East Asian women, immigrant South Asian women are particularly vulnerable to partner abuse due to spousal visas which preclude their working in the US, while another study found that 40% percent of the 160 immigrant women respondents reported physical IPV, sexual IPV, or injury/need for medical services due to IPV from current male partners. Patriarchy, family honor, and collectivism were barriers to reporting. (Tasbiha, N. S., & Zaidi, A. U., 2025, Bhandari, S., & Sabri, B., 2020);

Risks to Pregnancy and Maternal Health

WHEREAS, GBV/IPV during pregnancy is a preventable cause of injury, infant low birth weight, preterm birth, and death. CDC's Pregnancy Risk Assessment Monitoring System data from 2016 to 2022 found that 5.4% of women with a live birth experienced IPV while pregnant, with all IPV types associated with delayed prenatal care, depression, and adverse birth outcomes. Black, American Indian or Alaska Native, multiracial, and younger women experienced disproportionately high rates of pregnancy-related IPV. IPV and reproductive coercion among Hispanic women significantly increased unintended pregnancy risk, with 3,725 participants demonstrating this association persisted across marital status groups. (Campbell et al., 2021; CDC, 2024; Morrison et al., 2022; National Partnership for Women & Families, 2024; Steele-Baser et al., 2024; Espinoza et a., 2025);

WHEREAS, Maternal homicide is among the leading causes of pregnancy-associated death in the United States. The National Violent Death Reporting System data (2018-2022) found that 51% of identified maternal homicides were associated with IPV and that firearms accounted for 78% of those deaths. Independent research from Harvard T.H. Chan School of Public Health confirms that pregnant women are more likely to be murdered than to die from common obstetric causes such as hypertensive disorders, hemorrhage or sepsis (Cliffe & Miller, 2025; Lawn & Koenen, 2022; Morrison et al., 2022);

Women with Disabilities

WHEREAS, A 2023 systematic review of 26 studies confirmed that the frequency and risk of all types of IPV namely, physical, psychological, sexual, and financial, are consistently greater in

women with disabilities than in those without disabilities. Interpersonal abuse within this population frequently co-occurs with enforced isolation, financial dependency, fear of retribution, and reliance on an abusive partner for caregiving, compounding both vulnerability as well as barriers to departure and recovery. Women with disabilities are also more likely to experience multiple types of violence by multiple perpetrators and for longer durations than women without disabilities (Anyango et al., 2023; Garcia-Cuellar et al., 2023; Namatovu et al., 2024);

Elder Care

WHEREAS, IPV among women in late life stages frequently includes financial exploitation, neglect, emotional abuse, abandonment, physical violence, and sexual violence. Emerging research has identified adverse health outcomes associated with late-life IPV including pain disorders, gastrointestinal conditions, and mental health aftereffects. Unfortunately, many healthcare providers and elder care professionals continue to lack standardized, evidence-based training to effectively screen for and respond to the needs of this rapidly growing and underserved population (Administration for Community Living, 2025; Hoy-Ellis et al., 2024; Kong et al., 2024; Reisenhofer et al., 2023);

Women in Rural Areas

WHEREAS, A 2023 national study found that rural residents had both a higher prevalence of IPV and a significantly higher risk of not being screened for IPV in a healthcare setting compared to urban residents. Rural survivors face compounded barriers including geographic and social isolation, limited shelter capacity, extended emergency service response times, inadequate transportation, broadband issues that prohibit adequate telehealth and resource access, inadequate housing options once out of relationships, unique cultural considerations, and the stigma of small-community visibility that together render existing resources functionally inaccessible to those who need them most. Qualitative research further documents that coercive control in rural settings is intensified by women's deep ties to land, animals, and community, creating unique barriers to departure (Wuerch et al., 2025; Rural Health Information Hub, 2024; Wood et al., 2025);

SGM and Marginalized Populations

WHEREAS, Research consistently documents that SGM individuals experience IPV at rates equal to or exceeding those of heterosexual cisgender populations. A 2023 cross-sectional probability-based study found transgender and gender-diverse individuals face substantially elevated rates of physical, sexual, and IPV compared to cisgender women, while bisexual women report some of the highest lifetime IPV victimization rates of any demographic group in the United States (Chen et al., 2023; Closson et al., 2024; Kelleher et al., 2025);

WHEREAS, Transgender and gender-diverse adults experience IPV at approximately 1.7 times the rate of cisgender individuals, with disparities increasing to 2.2 times for physical IPV and 2.5 times for sexual IPV. A national study of SGM adults aged 50 to 95 further found that transgender respondents experienced IPV at more than double the rate of their non-transgender LGB counterparts, with IPV strongly predicting depressive symptomatology and diminished mental health quality of life (Hoy-Ellis et al., 2024; Peitzmeier et al., 2020);

WHEREAS, Nonbinary, gender-nonconforming, and intersex individuals face heightened vulnerability to IPV, with persistent gaps in research including these populations. A 2024 BMC Global Public Health study confirmed that evidence on IPV in SGM populations, particularly intersex and nonbinary individuals, is disproportionately concentrated in the Global North,

leaving critical policy gaps globally. APA's 2024 Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals explicitly identifies this invisibility as requiring immediate redress (APA, 2024; Gram et al., 2024);

Systemic and Structural Dimensions

WHEREAS, psychological research indicates that the current disproportionate emphasis on criminal legal responses has not produced significant reductions in the prevalence of sexual violence. Many survivors, particularly those from communities with adversarial histories with law enforcement, find the criminal justice process retraumatizing, inaccessible, or antithetical to their safety and healing needs. Latina and immigrant survivors specifically report that mistrust of law enforcement rooted in racialized exclusion remains one of the most significant barriers to help-seeking (Flores et al., 2025; Leemis et al., 2022; Zero et al., 2023);

WHEREAS, the Violence Against Women Act (VAWA) has promoted areas under STOP grants to fund violence prevention services for marginalized survivors, yet implementation has been uneven, underfunded relative to demonstrated need, and insufficient to overcome entrenched structural barriers. Furthermore, the absence of affirming shelter infrastructure continues to prevent survivors from accessing federally mandated protections (Chen et al., 2023; Kelleher et al., 2025; Gram et al., 2024);

WHEREAS, survivors across all populations face common structural barriers to leaving abusive relationships, including economic insecurity, lack of affordable housing, lack of safe housing access, unsafe reporting conditions, cultural and familial norms, fear of retaliation, concerns about child custody, concerns about safe housing of pets, immigration vulnerability, and substance use co-occurrence (Clough et al., 2015; Hardesty et al., 2013; Heron et al., 2022; Peterson, 2020);

WHEREAS, existing GBV surveillance data systematically undercounts victimization among SGM individuals, women of color, Indigenous women, women with disabilities, and immigrant women due to reliance on binary gender categories, English-only instruments, and criminal justice reporting thresholds that fail to capture the full spectrum of coercive control, identity-based abuse, and technology-facilitated violence. Community-based advocate research with AAPI survivors specifically demonstrates that NCVS data substantially understates IPV rates in immigrant communities (Chen et al., 2023; Cheng et al., 2025; Kelleher et al., 2025);

WHEREAS, the misuse of artificial intelligence including the generation of non-consensual intimate imagery, AI-assisted stalking, fake imagery, fake audio, and the manipulation of audio and visual evidence, represents an emerging and rapidly escalating form of technology-facilitated GBV. Between 2019 and 2023 deepfake videos increased by 550%, with 98% constituting non-consensual pornography featuring women globally. Existing federal law has not adequately addressed these harms and current NISVS measures only partially capture technology-facilitated IPV (Ding et al., 2026; UN Women, 2024; Zhang Kudon et al., 2026);

WHEREAS, APA's broader policy commitments to health equity, the dismantling of systemic racism, and affirming care for gender-diverse individuals, codified in its 2021 resolutions on dismantling systemic racism and advancing health equity and its 2024 policy statement on affirming inclusive care, require that GBV policy explicitly account for the intersecting identities and layered vulnerabilities of those most at risk, and that federal legislation be designed with these populations at the center rather than as afterthoughts (APA, 2021; APA, 2024; Gram et al., 2024).

RESOLUTION

THEREFORE, BE IT RESOLVED that APA advocates for strengthening federal structures for IPV/GBV survivor safety, which would require funding and reauthorization of the Violence Against Women Act (S.3623) and the sustained expansion of evidence-based programs, treatment and prevention services, and systems that address GBV and IPV across all communities.

THEREFORE, FURTHER BE IT RESOLVED that APA advocates for federal and state legislative, regulatory, and funding initiatives and grants that expand housing protections and affordable housing opportunities for survivors of IPV/GBV, recognizing that housing security is critical to preventing continued victimization and promoting long-term well-being.

THEREFORE, BE IT FURTHER RESOLVED that APA affirms the critical need for inclusive, accessible, and culturally responsive data collection practices and will serve as a technical expertise resource for the expansion of longitudinal, qualitative, and quantitative research on GBV and IPV. APA calls upon the Bureau of Justice Statistics to modernize the National Crime Victimization Survey to reflect the current breadth and complexity of victimization in all communities.

THEREFORE, BE IT FURTHER RESOLVED that APA affirms its commitment to provide evidence-based educational tools on IPV/GBV for psychology graduate training programs. APA will provide resources on GBV and IPV for training programs to meet accreditation requirements, offer continuing education (CE) programs, and advance curriculum for training on IPV and GBV.

THEREFORE, BE IT FURTHER RESOLVED that APA advocates for and supports the development, funding, implementation, and evaluation of evidence-based, trauma-informed substance use disorder treatment services for survivors of IPV/GBV, recognizing the need for integrated care that addresses both trauma-related symptoms and substance use to promote long-term recovery and family stability.

THEREFORE, BE IT FURTHER RESOLVED that APA advocates for increased federal, state, and local investment in evidence-based prevention, intervention, and support services for survivors of IPV in rural communities, including expanded access to mental health care, telehealth services, emergency shelter, legal assistance, transportation resources, and culturally responsive care, recognizing the unique geographic, economic, and social barriers faced by rural survivors.

THEREFORE, BE IT FURTHER RESOLVED that APA will advocate for training and technical assistance for GBV and IPV screening within pediatric, primary care, obstetrical, gynecological, emergency, behavioral health, and elder care settings to identify, treat and refer survivors of IPV/GBV to community programs and mitigate the economic burden of healthcare costs.

THEREFORE, BE IT FURTHER RESOLVED that APA further advocates for increased visibility of IPV resources in public spaces with the goal to create safer communities.

THEREFORE, BE IT FURTHER RESOLVED that APA affirms it will take a leadership role by partnering with major developers of AI, to prevent the misuse of artificial intelligence and emerging technologies in the perpetration, facilitation, or concealment of GBV and IPV.

REFERENCES

- Administration for Community Living. (2025, February 6). Late life domestic violence. U.S. Department of Health and Human Services. <https://acl.gov/programs/protecting-rights-and-preventing-abuse/elder-justice/late-life-domestic-violence>
- Alvarez, C., Fedock, G., Grace, K. T., & Campbell, J. (2020). *Provider screening and referral practices for intimate partner violence in an outpatient care setting*. *Journal of Interpersonal Violence*, 35(23–24), 5877–5888. <https://doi.org/10.1177/0886260517724253>
- American Psychological Association. (2021). Psychology's role in dismantling systemic racism in the United States: Resolution adopted by the APA Council of Representatives on October 29, 2021. <https://www.apa.org/about/policy/dismantling-systemic-racism>
- American Psychological Association. (2024, February). *Policy statement on affirming evidence-based inclusive care for transgender, gender diverse, and nonbinary individuals, addressing misinformation, and the role of psychological practice and science*. <https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care>
- Andersson, M., & Örmön, K. (2024). Healthcare providers' experience of identifying and caring for women subjected to sex trafficking: A qualitative study. *BMC Women's Health*, 24, Article 149. <https://doi.org/10.1186/s12905-024-02992-6>
- Anyango, C., Goicolea, I., & Namatovu, F. (2023). Women with disabilities' experiences of intimate partner violence: A qualitative study from Sweden. *BMC Women's Health*, 23, Article 384. <https://doi.org/10.1186/s12905-023-02524-8>
- Barrick, K., Beckett, M., & Rand, M. (2025). *From policy reform to public reckoning: Exploring shifts in reporting of sexual violence victimizations in the NCVS between 1992 and 2021*. *BMC Public Health*, 25, Article 1757. <https://doi.org/10.1186/s12889-025-22832-y>
- Bhandari, S., & Sabri, B. (2020). Patterns of abuse among South Asian women experiencing domestic violence in the United States. *International social work*, 63(1), 55–68. <https://doi.org/10.1177/0020872818767250>
- Campbell, J., Matoff-Stepp, S., Velez, M. L., Cox, H. H., & Laughon, K. (2021). *Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence*. *Journal of Women's Health*, 30(2), 236–244. <https://doi.org/10.1089/jwh.2020.8875>
- Centers for Disease Control and Prevention. (2024). About intimate partner violence. <https://www.cdc.gov/intimate-partner-violence/about/index.html>
- Centers for Disease Control and Prevention. (2026). *About intimate partner violence*. <https://www.cdc.gov/intimate-partner-violence/about/index.html>
- Chen, J., Khatiwada, S., Chen, M. S., Smith, S. G., Leemis, R. W., Friar, N. W., Basile, K. C., & Kresnow, M. (2023). *The National Intimate Partner and Sexual Violence Survey (NISVS) 2016/2017: Report on victimization by sexual identity*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. <https://stacks.cdc.gov/view/cdc/98137>
- Cheng, S. Y., Lee, J., Kim, J. H., & Jiwatram-Negrón, T. (2025). *Beyond the numbers: Community advocate perspectives on national IPV data among AAPI survivors*. *Families in Society: The Journal of Contemporary Social Services*. Advance online publication. <https://doi.org/10.1177/10443894251383217>
- Cliffe, C., & Miller, J. M. (2025). *Maternal homicide rates among U.S. states*. *BMC Public Health*, 25, Article 3509. <https://doi.org/10.1186/s12889-025-24818-2>
- Closson, K., Boyce, S. C., Johns, N., Inwards-Breland, D. J., Thomas, E. E., & Raj, A. (2024). Physical, sexual, and intimate partner violence among transgender and gender-diverse individuals. *JAMA Network Open*, 7(6), e2419137. <https://doi.org/10.1001/jamanetworkopen.2024.19137>

- Clough, A., Draughon, J. E., Njie-Carr, V., Rollins, C., & Glass, N. (2014). "Having housing made everything else possible": Affordable, safe and stable housing for women survivors of violence. *Qualitative Social Work*, 13(5), 671–688.
<https://doi.org/10.1177/1473325013503003>
- Ding, M. L., Suresh, H., & Venkatasubramanian, S. (2026). *How to stop playing whack-a-mole: Mapping the ecosystem of technologies facilitating AI-generated non-consensual intimate images* [Preprint]. arXiv. <https://doi.org/10.48550/arXiv.2602.04759>
- Espinoza, L. E., Espinoza, L. E., Diosdado, L., Nguyen-Finn, K., & Talleff, J. L. (2025). The Role of Hispanic Women's Marital Status on Intimate Partner Violence and Reproductive Coercion Resulting in Unintended Pregnancy. *Journal of Interpersonal Violence*, 40(23-24), 5475-5495.
- Federal Bureau of Investigation. (2025, January 14). *Violence against American Indian or Alaska Native females, 2021–2023 special report*. <https://www.fbi.gov/news/press-releases/fbi-releases-violence-against-american-indian-or-alaska-native-females-2021-2023-special-report>
- Fedina, L., Shyrokonis, Y., Backes, B., Schultz, K., Ashwell, L., Hafner, S., & Rosay, A. (2023). Intimate partner violence, economic insecurity, and health outcomes among American Indian and Alaska Native men and women: Findings from a national sample. *Journal of Interpersonal Violence*, 38(3-4). <https://doi.org/10.1177/10778012221127725>
- Flores, Y. R., Raut, S., Mengo, C., Kinsey-Dadzie, T., Zapcic, I., Nemeth, J., & Ramirez, R. (2025). *Service accessibility: Service providers' perspectives on barriers faced by immigrant women of color survivors of intimate partner violence*. *Journal of Family Violence*.
<https://doi.org/10.1007/s10896-025-00909-x>
- Garcia-Cuellar, M. M., Pastor-Moreno, G., Ruiz-Perez, I., & Henares-Montiel, J. (2023). The prevalence of intimate partner violence against women with disabilities: A systematic review of the literature. *Disability and Rehabilitation*, 45(1), 1-8.
<https://doi.org/10.1080/09638288.2022.2025927>
- Gram, L., Blevins, J., Miedema, S., Hoang, A. T., & Yount, K. M. (2024). *Intimate partner violence in lesbian, gay, bisexual, transgender, queer, and intersex relationships: A call for research-to-action partnerships in higher education settings*. *BMC Global and Public Health*, 2, 53. <https://doi.org/10.1186/s44263-024-00085-y>
- Hardesty, J. L., Khaw, L., Ridgway, M. D., Weber, C., & Miles, T. (2013). *Coercive control and abused women's decisions about their pets when seeking shelter*. *Journal of Interpersonal Violence*, 28(13), 2617–2639. <https://doi.org/10.1177/0886260513487994>
- Heron, R. L., Eisma, M. C., & Browne, K. (2022). *Why do female domestic violence victims remain in or leave abusive relationships? A qualitative study*. *Journal of Aggression, Maltreatment & Trauma*, 31(5), 677–694.
<https://doi.org/10.1080/10926771.2021.2019154>
- Hoy-Ellis, C., Jung, H., Cook-Daniels, L., Kim, H., & Fredriksen-Goldsen, K. (2024). Beyond the margins: Intimate partner violence and transgender older adults' health and well-being. *Innovation in Aging*, 8(Supplement_1), 670–671.
<https://doi.org/10.1093/geroni/igae098.2192>
- Hulley, J., Bailey, L., Kirkman, G., Gibbs, G. R., Gomersall, T., Latif, A., & Jones, A. (2023). *Intimate partner violence and barriers to help-seeking among Black, Asian, minority ethnic and immigrant women: A qualitative metasynthesis of global research*. *Trauma, Violence, & Abuse*, 24(2), 1001–1015. <https://doi.org/10.1177/15248380211050590>
- Jenkins, N.D., Ritchie, C.W., Ritchie, K., Terrera, G.M., Stewart, W. (2025). Intimate partner violence, traumatic brain injury and long-term mental health outcomes in midlife: the Drake IPV study. *BMJ Mental Health*. 28:e301439. <https://doi.org/10.1136/bmjment-2024-301439>.

- Jock, B. W., Dana-Sacco, G., Arscott, J., Bagwell-Gray, M. E., Loerzel, E., Brockie, T., Packard, G., O'Keefe, V. M., McKinley, C. E., & Campbell, J. (2022). 'We've already endured the trauma, who is going to either end that cycle or continue to feed it?': The influence of family and legal systems on Native American women's intimate partner violence experiences. *Journal of Interpersonal Violence*, 37(19-20). <https://doi.org/10.1177/08862605211063200>
- Johnson, L., Chen, Y., Stylianou, A., & Arnold, A. (2022). Examining the impact of economic abuse on survivors of intimate partner violence: A scoping review. *BMC Public Health*, 22(1), 1014. <https://doi.org/10.1186/s12889-022-13329-8>
- Kelleher, S., De Nicolas Audoin, C., Callaghan, L., & Travers, Á. (2025). *Evaluating measures of LGBTQ+ intimate partner violence using consensus-based standards of validity*. *Clinical Psychology Review*, 120, 102620. <https://doi.org/10.1016/j.cpr.2025.102620>
- Kong, J., Moorman, S., & Qin, Y. (2024). Lifetime abuse victimization and prospective health outcomes in older adults. *Innovation in Aging*, 8(Supplement_1), 179–180. <https://doi.org/10.1093/geroni/igae098.0575>
- Lawn, R. B., & Koenen, K. C. (2022). *Homicide is a leading cause of death for pregnant women in US*. *BMJ*, 379, o2499. <https://doi.org/10.1136/bmj.o2499>
- Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). The National Intimate Partner and Sexual Violence Survey: 2016/2017 report on intimate partner violence. Centers for Disease Control and Prevention.
- Leong, S. E., Logan, T. K., Badour, C. L., & Karr, J. E. (2025). The Polytrauma Clinical Triad Among Women with a History of Intimate Partner Violence. *Journal of Neurotrauma*, 42(19-20), 1816–1829. <https://doi.org/10.1089/neu.2025.0064>
- Morrison, P. K., Pallatino, C., Fusco, R. A., Kenkre, T., Chang, J., & Krans, E. E. (2022). Pregnant victims of intimate partner homicide in the National Violent Death Reporting System database, 2003-2014: A descriptive analysis. *Journal of Interpersonal Violence*, 37(5-6), NP2652-NP2670. <https://doi.org/10.1177/0886260520943726>
- Namatovu, F., Ineland, J., & Lövgren, V. (2024). *Exploring the perspectives of professionals on providing intimate partner violence services to women with disabilities*. *Violence Against Women*, 30(2), 622–640. <https://doi.org/10.1177/10778012221137916>
- National Partnership for Women & Families. (2024). Intimate partner violence endangers pregnant people and their infants. <https://nationalpartnership.org/report/intimate-partner-violence/>
- Peitzmeier, S. M., Malik, M., Kattari, S. K., Marrow, E., Stephenson, R., Agenor, M., & Reisner, S. L. (2020). Intimate partner violence in transgender populations: Systematic review and meta-analysis of prevalence and correlates. *American Journal of Public Health*, 110(9), e1-e14. <https://doi.org/10.2105/AJPH.2020.305774>
- Peterson, C., Kearns, M. C., McIntosh, W. L., Estefan, L. F., Nicolaidis, C., McCollister, K. E., Gordon, A., & Florence, C. (2018). Lifetime economic burden of intimate partner violence among U.S. adults. *JAMA Network Open*, 1(4), e180782. <https://doi.org/10.1001/jamanetworkopen.2018.0782>
- Peterson, C. (2020). *Interpersonal aggression: Complexities of domestic and intimate partner abuse*. Wheatmark.
- Reisenhofer, S., Hohl, S. D., Muench, U., Green, A. R., & Tisminetzky, M. (2023). *Adverse health correlates of intimate partner violence against older women: Mining electronic health records*. *PLOS ONE*, 18(3), e0281863. <https://doi.org/10.1371/journal.pone.0281863>
- Rowh, A., & Jack, S. (2024). Notes from the field: Intimate partner homicide among women—United States, 2018–2021. *Morbidity and Mortality Weekly Report*, 73(34), 754–756. <https://doi.org/10.15585/mmwr.mm7334a4>
- Rural Health Information Hub. (2024). *Violence and abuse in rural America*.

- <https://www.ruralhealthinfo.org/topics/violence-and-abuse>
- Sabri, B., Njie-Carr, V. P. S., Messing, J. T., Glass, N., Btoush, R., Campbell, J., & Parillo, K. M. (2022). Conducting intervention research with immigrant survivors of intimate partner violence: Barriers and facilitators of recruitment and retention. *Journal of Interpersonal Violence*, 37(19-20), NP18060-NP18084. <https://doi.org/10.1177/08862605211035866>
- Short, N. A., Lechner, M., McLean, B. S., Tungate, A. S., Black, J., Buchanan, J. A., Reese, R., Ho, J. D., Reed, G. D., Riviello, R. J., Rossi, C. H., Nouhan, P. P., Phillips, C. A., Martin, S. L., Liberzon, I., Rauch, S. A. M., Bollen, K. A., Kessler, R. C., & McLean, S. A. (2021). *Health care utilization by women sexual assault survivors after emergency care: Results of a multisite prospective study. Depression and Anxiety*, 38(1), 67–78. <https://doi.org/10.1002/da.23102>
- Steele-Baser, M., Brown, A. L., D'Angelo, D. V., Ko, J. Y., & Barfield, W. D. (2024). Intimate partner violence and pregnancy and infant health outcomes—Pregnancy Risk Assessment Monitoring System, nine U.S. jurisdictions, 2016–2022. *Morbidity and Mortality Weekly Report*, 73(48), 1093–1098. <https://doi.org/10.15585/mmwr.mm7348a1>
- Tasbiha, N. S., & Zaidi, A. U. (2025). The psycho-social factors that escalate intimate partner violence (IPV) among South Asian women in North America: An intersectional approach and analysis. *Journal of Human Behavior in the Social Environment*, 35(2), 196–244. <https://doi.org/10.1080/10911359.2023.2291436>
- UN Women. (2024). *AI-powered online abuse: How AI is amplifying violence against women and what can stop it.* <https://www.unwomen.org/en/articles/faqs/ai-powered-online-abuse-how-ai-is-amplifying-violence-against-women-and-what-can-stop-it>
- Waller, B. Y., Joseph, V. A., & Keyes, K. M. (2024). *Racial inequities in homicide rates and homicide methods among Black and White women aged 25–44 years in the USA, 1999–2020: A cross-sectional time series study. The Lancet*, 403(10430), 935–945. [https://doi.org/10.1016/S0140-6736\(23\)02279-1](https://doi.org/10.1016/S0140-6736(23)02279-1)
- Wilson, R. F., & Blair, J. M. (2024). *Racial inequities in homicide rates: Black women in the USA. The Lancet*, 403(10430). [https://doi.org/10.1016/S0140-6736\(23\)02585-0](https://doi.org/10.1016/S0140-6736(23)02585-0)
- Wood, K., Giesbrecht, C. J., Brooks, C., & Arisman, K. (2025). "I couldn't leave the farm": Rural women's experiences of intimate partner violence and coercive control. *Violence Against Women*, 31(4), 937–960. <https://doi.org/10.1177/10778012241279117>
- Wuerch, M. A., Giesbrecht, C. J., Hampton, M. R., & Wright, K. D. (2025). *Barriers to leaving and accessing services: Perspectives of service providers working with rural women experiencing intimate partner violence in Saskatchewan, Canada. Journal of Family Violence.* Advance online publication. <https://doi.org/10.1007/s10896-025-00940-y>
- Zero, O., Tobin-Tyler, E., & Goldman, R. E. (2023). *Barriers to disclosure of intimate partner violence among undocumented Spanish-speaking immigrants in the United States. Violence Against Women*, 29(15–16), 3182–3201. <https://doi.org/10.1177/10778012231196055>
- Zhang Kudon, H., Zhu, S., Chen, B., Breiding, M. J., Leemis, R. W., Zhang, X., Schwank, A., & Basile, K. C. (2026). *The National Intimate Partner and Sexual Violence Survey: 2023/2024 data brief—Intimate partner violence.* Centers for Disease Control and Prevention. <https://www.cdc.gov/nisvs>

XIII. ETHNIC MINORITY AFFAIRS

No items.

XIV. INTERNATIONAL AFFAIRS

No items.

XVI. FINANCIAL AFFAIRS

A.(23) Council voted to approve the following motion:

Pursuant to Association Rule 210-2.3, Council approves an unbudgeted expenditure that may exceed \$3 million in the aggregate for legal fees, outside counsel, political consulting, document review, production, and related costs arising from the following matters:

- 1) The House Committee on Education and Workforce investigation concerning allegations of antisemitism within APA and its divisions;
- 2) The U.S. Department of Health and Human Services, Office for Civil Rights investigation (OCR Transaction Number 25-634830) concerning allegations of antisemitism within APA and its divisions; and
- 3) Any related federal investigations, litigation, subpoenas, or enforcement activity arising from or connected to the above matters.

Council directs APA staff, under the direction of the CEO and the General Counsel, with oversight by the Board of Directors, to engage and compensate outside counsel, consultants, and vendors from the long-term investment portfolio as necessary to respond to these matters, subject to ongoing review by the Board of Directors and quarterly reporting to the Council of Representatives.

Additionally, consistent with Association Rule 30-6.6, the Board, the CEO and the General Counsel shall provide Council with periodic updates on the status of these matters and associated costs, while safeguarding applicable privilege and confidentiality protections.

B.(29) Council received as information the 2025 audited financial statements.

At its plenary session on Monday evening, Council engaged in a group activity related to practical steps APA can take to strengthen its culture and move toward improved respect and trust in Council.

On Tuesday afternoon, a presidential citation was awarded to Kensa Gunter, PsyD, for her exceptional leadership and sustained contributions to advancing mental health, well-being, and equity within psychology and professional sport.

On Wednesday afternoon, a presidential citation was awarded posthumous Frank H. Farley, PhD, in recognition of his extraordinary leadership, scholarship, and lifelong service to psychology.
