

COUNCIL OF REPRESENTATIVES

February 26 & 27, 2021

DRAFT MINUTES

I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its August 5 & 6, 2020, meeting.

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

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

No items.

III. ETHICS

A.(20) Council received as information an update on the activities of the Ethics Code Task Force.

IV. BOARD OF DIRECTORS

No items.

V. DIVISIONS AND STATE AND PROVINCIAL AND TERRITORIAL ASSOCIATIONS

No items.

VI. ORGANIZATION OF THE APA

A.(2) Council voted to 1) extend the expiration date for the *National Standards for High School Psychology Curricula*, the *Guidelines for Psychological Evaluations in Child Protection Matters*, the *Guidelines for Psychological Practice in Health Care Delivery Systems*, the *Guidelines for the Practice of Parenting Coordination*, the *Specialty Guidelines for Forensic Psychology* and the *Principles for Quality Undergraduate Education in Psychology* to December 31, 2022 and 2) extend the expiration date for the *Guidelines for Assessment of and Intervention with Persons with Disabilities* to February 28th, 2022.

B.(3) The item titled, Creation of Lifetime Term Limits for the Council of Representatives was withdrawn from the February 2021 agenda.

C.(4) Council voted to approve withdrawal of Council New Business Item #12B/Feb 2020 entitled, Requiring APA/APASI Consolidated Risk Register Development and Maintenance.

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 If the motion fails, Council members' votes will not be published for that meeting).

D.(21) Council was provided with information that the *Guidelines for Prevention in Psychology* automatically sunset on December 31, 2020 and *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* automatically sunset on February 28, 2021.

E.(22) Council received as information a report from the APA Presidential Work Group on the Modernization of APA Bylaws.

F.(23) Council was provided as information an update from the Advocacy Coordinating Committee.

G.(27A) Council received an update on the new business in progress item titled, Remove Hoffman Reports (aka Independent Review), dated July 2, 2015 and September 4, 2015, from APA Website (NBI 12A/Feb 2020).

H.(27B) Council was provided with an update on the new business in progress item titled, Resolution on Interrogations of Criminal Suspects (NBI 18A/Aug 2020).

VII. PUBLICATIONS AND COMMUNICATIONS

A.(24) Council received as information an update on the Publications and Communications Board activities.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(5) Council voted to adopt as APA policy as APA policy the *Standards of Accreditation for Health Service Psychology: Master's Programs* and approve December 31, 2030 as the expiration date for the Standards.

B.(16) Council received as information an update on the business pending item, Reiteration of APA's Values on Discrimination in Light of Contemporary Resurgence in Discrimination and Hates Crimes (NBI #20A/Feb 2019).

X. PROFESSIONAL AFFAIRS

A.(6) Council voted to adopt as APA policy the *Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care* and approves December 2030 as the expiration date for the Guidelines.

B.(17) Council received as information an update on the business pending item, Healthcare Practice Guideline Policy (NBI #13B/March 2018).

C.(19) Council voted to reject the following motion:

That Council supports the formation of a ten-member task force (TF) appointed by the current president of the APA. This TF would be comprised of distinguished experts in psychosocial

dimensions of mental health care and representative of the profession as a whole. Correspondingly, the TF should include representatives from the APA Policy, Advocacy, Public Interest, and Communications Offices, and be charged with exploring the merit of recommending to the U.S. Congress an office of Psychological Consultant to the United States. The primary purpose of this position would be for the Psychological Consultant's office to work in coordination with the APA, Surgeon General, SAMHSA, NIMH and other government agencies to provide counsel directly to lawmakers (including the U.S. president) on psychosocial dimensions of public mental health care. Secondly the purpose would be to disseminate advisories on psychosocial remedies to public mental health care to bolster and streamline the advisories of APA and allied agencies.

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

XI. SCIENTIFIC AFFAIRS

No items.

XII. PUBLIC INTEREST

A.(7) Council voted to approve the following amendments to Association Rule 50-2 (bracketed/strikethrough material to be deleted; underlined material to be added):

50-2. EQUAL OPPORTUNITY REPRESENTATION

50-2.1 The APA is enhanced by the full and effective involvement of its members regardless of race, color, sex, religion, national origin, ethnicity, age, sexual~~/affectional~~ orientation, gender, gender identity or expression, disability (visible or non-visible), or socioeconomic status. The APA shall promote [diversity] the inclusion of diverse representation on all boards, committees, task forces, and other governance bodies at all levels of responsibility.

B.(8) Council voted to adopt as APA policy the following 2021 APA Resolution on Racism titled, *Harnessing Psychology to Combat Racism: Adopting a Uniform Definition and Understanding*:

Harnessing Psychology to Combat Racism: Adopting a Uniform Definition and Understanding

WHEREAS racism has been an enduring, insidious, and pervasive feature of the United States (U.S.) landscape that often operates outside of the conscious awareness of its targets, perpetrators, and beneficiaries, and has had an incalculable, negative toll on the basic human rights to survival, security, health, well-being, and societal participation of generations of people in the U.S. and across the globe (Alvarez et al., 2016; APA, 2012; 2019);

WHEREAS the belief that people of color were inferior was used to justify Indigenous peoples' forced removal and genocide and the enslavement of Africans, thereby establishing racism and settler colonialism and violence at the root of the ascendant U.S. and legitimizing racial and economic inequality;

WHEREAS racism was constructed as a basis to create and sustain White supremacy by assigning value to people of European descent and disproportionately allocating societal resources and opportunities to them, while limiting or refusing access to opportunity among Black, Indigenous, and People of Color (BIPOC), thereby severely marginalizing their status and blunting the potential of the entire society (C.P. Jones, 2018; Mosley et al., 2021);

WHEREAS positionality refers to one's own position or place in relation to race, ethnicity, and other statuses and how our identities relate to the systems of privilege and oppression that shape our psychological experiences, relationships, and access to resources (APA, 2019);

WHEREAS White privilege is unearned power that is afforded to White people on the basis of status rather than earned merit and protects White people from the consequences of being racist and benefitting from systemic racism; such power may come in the form of rights, benefits, social comforts, opportunities, or the ability to define what is normative or valued (APA, 2019; Neville et al., 2013);

WHEREAS White supremacy—the ideological belief that biological and cultural Whiteness is superior, as well as normal and healthy – is a pervasive ideology that continues to polarize our nation and undergird racism (Helms, 2017; Liu et al., 2017; Liu, 2019);

WHEREAS racism is not only limited to racist ideas, attributions, expectations, assumptions, and behaviors held by individuals but also has shaped and undermined almost every aspect of U.S. society, including our laws, policies, educational systems, customs, and cultural narratives, weakening our political and civic institutions and creating many political and social fissures (Anderson, 2016; Helms, 2017, 2020; Liu et al., 2019);

WHEREAS in the current anti-immigrant climate, xenophobia and discrimination adversely impact the lives of Latino/a/x people (APA, 2012), and policies and programs that exclude, segregate, separate, detain, and physically remove immigrants from the U.S. reproduce racial inequalities in other areas of social life through spillover effects that result in significant negative consequences for immigrants and their families (Aranda & Vaquera, 2015).

WHEREAS hate crimes against Asian Americans have increased dramatically in the wake of the COVID-19 pandemic, spurred by the current social and political climate in which COVID-19 has been labeled as the “China virus” or “Chinese virus” (Zhang et al., 2021);

WHEREAS racism intersects with other social and personal identities (e.g., age, gender, sexual orientation, religion, ability status, socioeconomic status, etc.) in ways that compound experiences of oppression among diverse groups in the form of sexism, heterosexism, ableism, etc. (Deschamps & DeVos, 1998; Gee & Ford, 2011; Helms 2015; Liu et al., 2017);

WHEREAS cultural racism is the individual and institutional expression of the superiority of one's racial and cultural heritage over another (e.g., designing a curriculum that overwhelmingly features the accomplishments of people deemed “superior;” APA, 2019, citing J.M. Jones, 1979);

WHEREAS to overcome and eliminate the pervasive harms of racism, it is essential to directly confront oppression using a culturally-centered and strengths-based approach to achieve

psychological liberation, promote empowerment, and influence social reality through cultural and humanistic change (Akbar, 1984);

WHEREAS, the field of psychology has historically contributed to the belief in human hierarchy through allowing – or not challenging – racial bias throughout the discipline and profession, such as in peer review, publishing, research motivated by racism, racial disparities in psychological research, and the valuation of certain types of research), as well as in Eurocentric models of clinical practice, including psychological assessment, while largely ignoring the contributions of, and adversities facing, BIPOC (APA, 2019; Roberts et al., 2020);

WHEREAS some prominent psychologists historically have perpetuated and others continue to perpetuate racism through pseudoscientific theories that postulate racial differences in intelligence, propensity to violence, limits on educability, and other psychological characteristics, thereby contributing to eugenics and other racist movements in the United States and abroad (Editorial Board, *Personality & Individual Differences*, 2012; Guthrie, 2004; Helms, 2012);

WHEREAS the American Psychological Association (APA) has adopted several resolutions and guidelines over the past two decades acknowledging and denouncing the societal damage caused by racism (APA Resolution on Racism and Racial Discrimination: A Policy Statement in Support of the Goals of the 2001 World Conference Against Racism, Racial Discrimination, Xenophobia, and Related Intolerance [2001], <https://www.apa.org/about/policy/chapter-4#2001-world-conference>; APA Resolution on Racial/Ethnic Profiling and Other Racial/Ethnic Disparities in Law and Security Enforcement Activities [2001] <https://www.apa.org/about/policy/racial-profiling>; APA's Race and Ethnicity Guidelines [2019] <https://www.apa.org/about/policy/summary-guidelines-race-ethnicity>);

WHEREAS to eradicate racism, we must understand what it is, how it operates, and who it benefits and harms, with the knowledge that many White people who do not personally harbor racial animus nonetheless benefit from racism (C.P. Jones, 2018);

WHEREAS psychology as a discipline, and other related scientific societies, lack a commonly agreed-upon definition of racism and an understanding of the many ways in which racism operates in society;

WHEREAS such a definition and understanding of racism's manifestations are necessary to advance antiracist research and develop effective prevention and intervention strategies;

WHEREAS the field of psychology has traditionally focused on intrapersonal and interpersonal racism, rather than forms of systemic racism (defined below) and the impact of historical racism on racial inequities and racial injustice (Trawalter et al., 2020);

WHEREAS this relatively narrow focus limits psychology's effectiveness in mitigating and ultimately eradicating racism, because it fails to fully address the many manifestations of racism in our institutions, systems, policies, and practices;

THEREFORE, BE IT RESOLVED that APA reaffirms its denunciation of racism in all forms for its destructive psychological, social, educational, and economic effects on human rights and human

welfare throughout the lifespan;

THEREFORE, BE IT RESOLVED that APA will undertake an analysis of psychology's history, with the goal of understanding the harms that marginalized racial groups have experienced and the actions necessary to create a more equitable, diverse, and inclusive association, discipline, and society going forward;

THEREFORE, BE IT RESOLVED that APA adopts the following definition of racism as an ideology to establish a common understanding for psychologists and other disciplines to inform and guide efforts to examine and eradicate racism:

Racism is a *system* of structuring opportunity and assigning value based on phenotypic properties (e.g., skin color and hair texture associated with "race" in the U.S.). This "system"—which ranges from daily interpersonal interactions shaped by race to racialized opportunities for good education, housing, employment, etc.—unfairly disadvantages people belonging to marginalized racial groups and damages their health and mental health, unfairly advantages individuals belonging to socially and politically dominant racial groups, and "ultimately undermines the full potential of the whole society" (C.P. Jones, 2003).

THEREFORE, BE IT RESOLVED that psychologists should consider the following four levels of racism in designing and implementing antiracist research, education, training, policy, and clinical applications through the lens of intersectionality (APA, 2019; J.M. Jones, 1979; Smedley, 2019; Yearby et al., 2020):

Structural racism results from laws, policies, and practices that produce cumulative, durable, and race-based inequalities, and includes the failure to correct previous laws and practices that were explicitly racist (Yearby et al., 2020).

Institutional racism results from policies, practices, and procedures of institutions—such as school, health care, law enforcement, and criminal justice systems—that marginalize diverse racial groups (APA Multicultural Guidelines, 2019; Kovera, 2019; Yearby et al., 2020).

Interpersonal racism occurs when individuals from socially and politically dominant racial groups behave in ways that diminish and harm people who belong to other racial groups. Interpersonal racism is therefore distinct from bigotry (negative attitudes about an outgroup, not necessarily tied to race) or prejudice (a preconceived opinion that is not based on reason or actual experience; APA, 2019; Yearby et al., 2020).

Internalized racism refers to the acceptance by diverse racial populations of the negative societal beliefs and stereotypes about themselves – including negative stereotypes and beliefs about complexion and color (i.e., colorism) that reinforce the superiority of Whites and can lead to the perception of themselves as devalued, worthless, and powerless (C.P. Jones, 2001). For example, following centuries of European colonization and/or domination, Black and Indigenous people, as well as Latino/a/x and Asian persons, may act out biased attitudes and behaviors, whereby lighter-skinned individuals of these groups assume the psychological demeanor of the dominant White group (Hall, 2002);

THEREFORE, BE IT RESOLVED that because these forms of racism are mutually reinforcing, efforts to mitigate and ultimately eradicate racism will require comprehensive interventions aimed at all of its four levels – structural, institutional, interpersonal, and internalized racism;

THEREFORE, BE IT FURTHER RESOLVED that APA will promote comprehensive strategies to address racism operating at multiple levels in its practice, education, training, research, publications, policies, and advocacy, as well as actively engage with other global entities to promote and defend human rights worldwide;

THEREFORE, BE IT FURTHER RESOLVED that since racism intersects and is intertwined with other systems of oppression (e.g., classism, sexism, heterosexism, ableism, etc.), APA will strengthen its antiracism practices and policies to call for an active dismantling of these other systems of oppression as well;

THEREFORE, BE IT FURTHER RESOLVED that while BIPOC and their communities possess and display tremendous strength and resilience in the face of racism as described above, APA will continue to advocate for increased funding for culturally-competent research to promote resilience and protective factors, as well as for expanded culturally-informed, accessible, and affordable services to enhance well-being in communities of color;

THEREFORE, BE IT FURTHER RESOLVED that APA will call upon all psychologists to eliminate processes and procedures that perpetuate racial injustice in research, practice, education, and training; speak out against racism; take proactive steps to prevent the occurrence of intolerant or racist acts; and promote effective strategies based on psychological research to alleviate racial injustice;

THEREFORE, BE IT FURTHER RESOLVED that APA will strengthen its antiracism policies by developing specific resolutions and accompanying materials regarding how the field of psychology can help to mitigate and eradicate racism in such areas as health care, education, and criminal justice, as well as increase work and economic opportunities.

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C.(9) Council voted to archive the 2011 *Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change*.

Additionally, Council voted to adopt as APA policy the 2021 *Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* and approves December 2030 as the expiration date for the Guidelines.

D.(10) Council voted to adopt as APA policy the *Guidelines for Psychological Practice with Sexual Minority Persons* and approve December 31, 2030 as the expiration date for the Guidelines.

E.(11) Council voted to adopt as APA policy the following 2021 *Resolution on Sexual Orientation Change Efforts*:

Resolution on Sexual Orientation Change Efforts

Introduction

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

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

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

orientation may also make less visible the impacts of SOCE on communities of color. For example, in Black Memphis communities, SOCE might not be readily identified as such but appear as violence and “church hurt” (Hipp et al., 2019). SOCE may appear differently in different social contexts.

SOCE have included one or more of the following:

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

Contexts with Multiple Stigmas and Vulnerabilities

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

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

2014; Schroeder & Shidlo, 2001). The connection between stigma and SOCE has long been clear. As one scholar historically stated, “The very existence of sexual orientation conversion therapy is a significant causal element in the social forces causing some people to attempt changing their sexual orientation in the first place” (Davison, 1976).

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

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

In recent years, U.S. SOCE proponents have attempted to further export and legitimize SOCE outside the U.S. In some cases, these efforts have resulted in dire consequences to local LGBTQ+ communities and advocates such as life imprisonment and other criminal penalties for “homosexuality” (Bailey et al., 2016; Dicklitch, Yost, & Dougan, 2012; Global Philanthropy Project, 2018; Horne & McGinley, in press). SOCE adds to harm in parts of the world where sexual and gender minorities have few legal protections, or where attitudes towards them are extremely negative even if legal protections exist (e.g., Horne & McGinley, in press; Zahn et al., 2016). Scientifically and culturally accurate knowledge about sexual minorities is often limited or distorted in such regions and SOCE, including medical techniques such as hormone treatments (Horne & McGinley, in press) and aversive techniques such as electroshock treatment (Jahangir & Abdul-latif, 2016; Lewin & Meyer, 2002), are employed to “cure” sexual minorities. The instigation of SOCE by professionals serves to justify and reify stigma and discrimination directed against sexual minorities, making them more vulnerable to negative consequences, including human rights abuses (Horne & McGinley, in press; Lewin & Meyer, 2002; Winkell et al., 2017). Given the transnational consequences of SOCE, SOCE are opposed by a number of health organizations, such as the British Psychological Society (Memorandum of Understanding on Conversion Therapy in the UK, 2017), and a number of national psychological associations endorsed a statement rejecting SOCE as stigmatizing and often harmful and supporting instead affirmative therapeutic interventions for sexual and gender minorities (International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues, 2018). Furthermore, countries as different as Brazil, Ecuador, Germany, Malta, and Taiwan as well as regions of

Australia, Canada, and Spain have enacted laws to protect individuals from “conversion therapy” (Chaudhry, 2018; Gstalter, 2020). In 2013, the United Nations Human Rights Council’s (UNHRC) Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment stated some SOCE do rise to the level of human rights violations, labeling SOCE “abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment” (UNHRC, 2013). After a wide-ranging international exploration, the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity characterized the many efforts under the term “conversion therapy” as “relying on the medically false pathologization of sexual orientation and gender identity, manifested through interventions that inflict severe pain and suffering and result in psychological and physical damage” (UNHRC, 2020, p. 5). The report denies an ethical and evidentiary basis for conversion and calls for measures to prevent conversion efforts, which it defines as “degrading, inhuman and cruel” (UNHRC, 2020, p. 21).

Science and SOCE

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

Ethical Concerns

Application of ethical considerations about SOCE have long included concerns about their associations with stigma and their potential to be used coercively (e.g., APA, 1998). The charge to “do no harm” has historically been a foundational principle of practice for healthcare professionals. Aspirational principles such as “Respect for People’s Rights and Dignity” (Principle E, APA Ethics Code), which includes respecting the rights of individuals to self-determination, are held in dynamic tension with other principles, including “Beneficence and Nonmaleficence” (Principle A, APA Ethics Code). Shidlo and Gonsiorek (2017) argued that self-determination is not intended to be used as the only or more important ethical principle in clinical decision-making. There are a number of patient-requests a psychologist would decline (e.g., a request for a behavioral weight loss program from a patient with anorexia nervosa) in the interest of the patient’s health and well-being. Ethics Code Standard 2.04 also states “Psychologists’ work is

based upon established scientific and professional knowledge of the discipline” (APA, 2017b, p. 5). Moreover, Standard 3.04(a) of the APA Ethics Code requires that “psychologists take reasonable steps to avoid harming their clients/patients and to minimize harm where it is foreseeable and unavoidable” (APA, 2017b, p. 6). Self-determination does not necessitate or justify dispensing with other ethical obligations regarding patient care.

Current Contexts

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

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

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

Sexual Orientation Diversity is Normal and Healthy

WHEREAS diversity in sexual orientation represents normal human variation (APA, 2009); WHEREAS there is no scientific basis for regarding any sexual orientation negatively or as a deficit or deviance or result of trauma or parenting (American Psychiatric Association, 2000; APA, 1975; Drescher, 2015; Shidlo & Gonsiorek, 2017); furthermore, sexual behavior with same, other, and more than one gender occurs across species, time, and culture (Bagemihl, 2000; Tskhay & Rule, 2015) and sexual fluidity is normal (Diamond, 2008);

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

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

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

SOCE Reinforces Societal Stigma for Sexual Minorities

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

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

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

WHEREAS societal ignorance and prejudice about same-gender and multiple-gender sexual orientations have led to personal, family, moral, and religious conflicts and lack of information, which places some sexual minorities at risk for seeking sexual orientation change (Beckstead &

Morrow, 2004; Dehlin et al., 2015; Flentje, Heck, & Cochran, 2014; Haldeman, 1994; Hatzenbuehler, Pachankis, & Wolff, 2012; Mallory, Brown, & Conron, 2019; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

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

WHEREAS SOCE are empirically associated with stigma; specifically, research evidence supports the relationship between SOCE and constructs associated with stigma, including prejudice (McGeorge, Carlson, & Toomey, 2015), internalized homonegativity (Pachankis et al., 2015; Tozer & Hayes, 2004), and family rejection (Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan et al., 2018);

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

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

WHEREAS the UN HRC (2013; 2015; 2020) categorizes some practices of SOCE as rising to the level of human rights abuse, and these often occur in nations with other anti-LGBTQ+ laws and norms;

WHEREAS youth may be particularly vulnerable because they have been exposed to negative messages about sexual and gender minorities, but they have not developed the resources to cope with these messages (Baams, Dubas, Russell, Buikema, & van Aken, 2018; Rimes, Shivakumar, Ussher, Baker, Rahman, & West, 2019; SAMHSA, 2015);

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

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

SOCE and Risks of Harm

WHEREAS prejudice and minority stress cause adverse mental health and other negative consequences, and SOCE assumptions and interventions reinforce prejudice and sexual minority stress while neglecting education and exploration of affirming sexual-minority options/identities

and affiliations (Davison, 1976; Frost et al., 2017; Herek & McLemore, 2013; Meyer, 2013; Ramirez & Galupo, 2019);

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

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

- a) Suicidal behavior and depressive symptoms among youth (Green et al., 2020; Ryan et al., 2018) and adults (Blosnich et al., 2020; Shidlo & Shroeder, 2002); indeed, Green et al. found that SOCE “was the strongest predictor of multiple suicide attempts, even after adjustment for other known risk factors” (p. 1224)
- b) More mental health problems and lower levels of life satisfaction, social support, educational attainment, and socioeconomic status (Ryan et al., 2018)
- c) Sexual identity distress (Dehlin et al., 2015)
- d) Dissociation and emotional numbness, characterized by celibacy, compulsive behaviors, depression, and anxiety (Jacobsen & Wright, 2014; Shidlo & Shroeder, 2002)
- e) Unprotected anal intercourse with un-tested partners (Shidlo & Shroeder, 2002)
- f) Substance abuse (Ryan et al., 2018; Shidlo & Shroeder, 2002)
- g) Disorientation and confusion (Shidlo & Shroeder, 2002; Weiss, Morehouse, Yeager, & Berry, 2010)
- h) Feelings of inauthenticity in terms of disconnection with parts of themselves (e.g., emotions, thoughts, interests), feeling they would have to choose among parts of themselves, and loss of connection to community (Fjelstrom, 2013)
- i) Feelings of anger and grief at having lost time and money, and feelings that they were betrayed by mental health professionals (Dehlin et al., 2015; Shidlo & Shroeder, 2002);

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

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

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

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

- a) Change has been reported only by a limited sample of individuals, who are primarily White/Caucasian, cisgender men who are engaged in conservative religious communities and who aim to be celibate or be in a mixed-gender marriage (e.g., Byrd, Nicolosi, & Potts, 2008; Dehlin et al., 2014; Flentje et al., 2013; Jones & Yarhouse, 2011)
- b) In numerous cases reports of change have been reversed or retracted (e.g., Retraction notice, 2019; Spitzer, 2012; Weiss et al., 2010)
- c) Many people did not report change and, in fact, reported elevated distress about the ineffectiveness of SOCE and blamed themselves and/or were blamed for the SOCE failure, despite being “highly motivated” (e.g., Dehlin et al., 2014; Flentje, Heck, & Cochran, 2014; Maccio, 2011; Shidlo & Shroeder, 2002)
- d) Rather than decrease same-gender attraction, SOCE have been reported to suppress same-gender sexual/romantic behavior (Dehlin et al., 2015; Fjelstrom, 2013; Flentje et al., 2014; Shidlo & Shroeder, 2002)
- e) Differences in reported sexual attraction and behavior over time can be explained by extant sexual fluidity or bisexuality rather than changes in sexual orientation as a result of SOCE (e.g., Beckstead, 2012; Haldeman, 1994)
- f) SOCE places individuals at significant risk of serious harm (e.g., depressive symptoms, suicidality, dissociation, substance abuse; Blossnich et al., 2020; Bradshaw et al., 2015; Dehlin et al., 2015; Green et al., 2020; Ryan et al., 2018; Shidlo & Shroeder, 2002)
- g) Studies have used flawed methodological and statistical approaches that render their conclusions invalid (e.g., APA, 2009; Panozzo, 2013; Retraction notice, 2019; Spitzer, 2012);

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

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

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

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

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

Ethical and Professional Concerns

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

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

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

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

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

WHEREAS psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b);

WHEREAS minors who have been subjected to SOCE have reported more suicide attempts than those who have not (Green et al., 2020; Ryan et al., 2018), and these SOCE have been deemed “degrading, inhuman and cruel” creating “a significant risk of torture” by the UN HRC (2020, p. 21);

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

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

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

Alternatives to SOCE

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

- a) Acceptance and support
- b) Comprehensive assessment
- c) Active coping
- d) Social support
- e) Identity exploration and development
- f) Reduction of internalized stigma;

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

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

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

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

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

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

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

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

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

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

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

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

BE IT FURTHER RESOLVED that the American Psychological Association opposes SOCE because there is abundant evidence of former participants reporting harm resulting from their experiences of SOCE and the contribution that such efforts make to social stigma and prejudice directed at sexual minorities, consistent with other major professional mental health associations, including the Pan-American Health Organization (2012), American Counseling Association (2017), American Academy of Child and Adolescent Psychiatry (2018), American Psychiatric Association (2000), National Association of Social Workers (2015), and World Psychiatric Association (2016);

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

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

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

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

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

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

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

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

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

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

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

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F.(12) Council voted to adopt as APA policy the following 2021 *Resolution on Gender Identity Change Efforts*:

Resolution on Gender Identity Change Efforts

Introduction

The foundational professional guideline for working with gender diverse persons acknowledges that, “Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person’s gender identity may not align with sex assigned at birth.” (APA, 2015, p. 834). *Gender identity* refers to “a person’s deep felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; [or another] gender” (APA, 2015, p. 862). While gender refers to the trait characteristics and behaviors culturally associated with one’s sex assigned at birth, in some cases, gender may be distinct from the physical markers of biological sex (e.g., genitals, chromosomes). Gender identity is also distinct from gender expression, which refers to “the presentation of an individual including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity” (APA, 2015, p. 861). Cisgender refers to “a person whose gender identity aligns with sex assigned at birth” (e.g., an individual assigned female at birth who identifies as a woman/girl; APA, 2015, p. 861). Transgender is “an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth” (APA, 2015, p. 863). For the purpose of this resolution, we are using a broad definition of transgender to include transgender women/girls, transgender men/boys, nonbinary individuals (i.e., people who may identify as a gender other than a woman/girl or a man/boy), and any individual who articulates a gender identity different from societal expectations based on their sex assigned at birth.

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

The fields of psychiatry and psychology have a long history of pathologizing individuals and those who question their gender identity (Barkai, 2017; Benson, 2013; Bouman et al, 2014; Burke, 2011; Drescher, 2010; Nadal et al., 2010; Riggs et al. 2019). This history is informed by,

and parallels, the larger Western and United States-based, medical-model, narratives that 1) define gender as binary and conflate it with physical markers, 2) define masculinity, and characteristics historically attributed to men/boys, as superior to femininity and characteristics historically attributed to women/girls, 3) create systems that confer privilege to cisgender people and label cisgender identities and expressions as normative, 4) discriminate against transgender and gender nonbinary individuals (Stryker, 2017).

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

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

GICE cause harm by reinforcing anti-transgender and anti-gender nonbinary stigma and discrimination (Turban et al., 2020); and by creating social pressure on an individual to conform to an identity and/or presentation that may not be consistent with their sense of self (e.g., Bockting et al., 2013; Egan & Perry, 2001; Meyer, 2003; Nadal et al., 2012; Russell et al., 2012; Toomey et al., 2010; Sandfort et al., 2007). Furthermore, GICE are not supported by empirical evidence as effective practices for changing gender identity and are associated with psychological and social harm (Brinkman et al., 2014; Carr, 1998; Gagné & Tewksbury, 1998; Horn, 2007; Price et al., 2019; Smith & Leaper, 2006). The American Psychological Association (APA), as well as other healthcare organizations, (e.g., American Counseling Association, World Professional Association for Transgender Health) have established empirically-supported practice guidelines that encourage clinicians to use gender-affirming practices when addressing gender identity issues (ACA, 2010; APA, 2015; Coleman et al., 2012). Additionally, a number of national and international professional healthcare organizations have publicly warned against the harmful effects of GICE and SOCE (Sexual Orientation Change Efforts) by endorsing the

United States Joint Statement Against Conversion Efforts (USJS, n.d.), including the American Academy of Family Physicians, American Academy of Nursing, American Association of Sexual Educators, Counselors and Therapists, American Counseling Association, American Medical Association, American Medical Student Association, American Psychoanalytic Association, The Association of LGBTQ Psychiatrists, Society for Affectional, Intersex, and Gender Expansive Identities, Clinical Social Work Association, GLMA: Health Professionals Advancing LGBTQ Equality, The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies, and the World Professional Association for Transgender Health. A growing number of states and municipalities have enacted laws that prohibit licensed mental health professionals from engaging in sexual orientation and gender identity change efforts with minors (Movement Advancement Project, n.d.)

Gender Diversity, Stigma, & Discrimination

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

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

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

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

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

GICE and Risks of Harm

WHEREAS individuals who have experienced pressure or coercion to conform to their sex assigned at birth or therapy that was biased toward conformity to one's assigned sex at birth

have reported harm resulting from these experience such as emotional distress, loss of relationships, and low self-worth (Brinkman et al., 2014; Carr, 1998; Gagné & Tewksbury, 1998; Horn, 2007; Price et al., 2019; Smith & Leaper, 2006);

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

WHEREAS GICE have not been shown to alleviate or resolve gender dysphoria (Bradley & Zucker, 1997; Cohen-Kettenis & Kuiper, 1984; Gelder & Marks, 1969; Greenson, 1964; Pauly, 1965, SAMHSA, 2015);

WHEREAS GICE can cause undue stress and suffering and interfere with healthy sexual and gender identity development (Hiestand & Levitt, 2005; SAMHSA, 2015);

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

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

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

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

Gender Affirming Practices

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

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

WHEREAS individuals who have experienced gender-affirming psychological and medical practices report improved psychological functioning, quality of life, treatment retention and engagement, and reductions in psychological distress, gender dysphoria, and maladaptive

coping mechanisms (Austin & Craig, 2015; de Vries et al., 2014; Haas et al., 2011; Sevelius, 2013; White Hughto & Reisner, 2016);

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

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

APA Policy

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

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

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

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

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

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

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

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

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

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

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

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

BE IT FURTHER RESOLVED that Transgender and gender nonbinary identities, as well as other gender identities that transcend culturally prescriptive binary notions of gender, represent normal variations in human expression of gender.

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

BE IT FURTHER RESOLVED that APA opposes portrayals of transgender and gender nonbinary people as mentally ill because of their gender identities and expressions.

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

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

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

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

BE IT FURTHER RESOLVED that the APA opposes the dissemination of inaccurate information about gender identity, gender expression, and the efficacy of GICE, including the claim that gender identity can be changed through treatment, the characterization of transgender or gender nonbinary identity as a mental disorder and the promotion of treatments that prescribe gender identity or expression consistent with one's birth-assigned sex as effective for clients with gender dysphoria;

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

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

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

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

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

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

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

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G.(18) Council received as information an update on the business pending item, Police Citizen Contact New Business Item from Peace Psychology Division Violence Summit (NBI #21A/Feb 2017).

XIII. ETHNIC MINORITY AFFAIRS

No items.

XIV. INTERNATIONAL AFFAIRS

A.(13) Council voted to receive the report of the Task Force on Human Rights.

B.(14) Council voted to adopt as APA policy the following 2021 *Resolution on APA, Psychology, and Human Rights*:

Resolution on APA, Psychology, and Human Rights

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

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

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

WHEREAS APA has for nearly 50 years expressed its strong commitment to human rights, most recently through its 2019 Strategic Plan, which includes the Guiding Principle that APA will "respect

and promote human rights” and the Strategic Objective that APA will “foster the advancement of human rights, fairness, diversity, and inclusion” (APA, 2019a);

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

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

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

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

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

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

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

- Children (Resolution on Violence Against Children by Governments (APA, 1989));
- Women (Resolution on the Equal Rights Amendment (APA, 1975));
- Ethnic minorities (**Resolution on Racism and Racial Discrimination: A Policy Statement in Support of the Goals of the 2001 World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance (APA, 2001b)**);

- People with disabilities (Resolution on the Americans with Disabilities Act (APA, 2008a));
- Sexual and gender minorities (Resolution on Opposing Discriminatory Legislation and Initiatives Aimed at Lesbian, Gay, and Bisexual Persons (APA, 2004); Resolution on Transgender and Gender Identity and Gender Expression Non-discrimination (APA, 2008b); Resolution on Sexual Orientation & Marriage (APA, 2010b); Resolution on Marriage Equality for Same-Sex Couples (APA, 2011));
- Older adults (Resolution on Ageism (APA, 2020));
- Low-income people (Resolution on Poverty and Socioeconomic Status (APA, 2000));
- Other marginalized and at-risk groups (Resolution against Genocide (APA, 2008c); Resolution on Human Trafficking in the United States, Especially of Women and Girls (APA, 2017b); Immigration and Refugee Policy Statement (APA, 2019b); Principles for Healthcare Reform (APA, 2007));

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

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

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

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

- APA's human rights efforts have often been informed by international standards as defined by the *Universal Declaration of Human Rights* and related conventions, protocols, and treaties²;
- Yet APA's failure to define human rights in relation to psychology has led to a lack of clarity about how to enact its commitment to human rights;
- Furthermore, the lack of foundational human rights knowledge within APA undermines its ability to effectively oppose the misuse of psychological science and practice and any harm done to marginalized populations made vulnerable by societal inequalities as a result of the misuse;
- While APA's research, applied initiatives, and federal advocacy efforts have often been resonant with human rights, they have rarely been informed by an explicit human rights framework;

² As shown in the Appendix, these include the core nine human rights treaties and nine optional protocols, the UN human rights declarations on sexual identity and the rights of indigenous peoples, the *Convention on the Prevention and Punishment of the Crime of Genocide*, and the standards of international humanitarian law (the laws of war), which are regarded as "human rights law applicable to armed conflict" (Dosweld-Beck & Vité, 1993).

- Likewise, APA's efforts to promote academic freedom, respond to the persecution of psychologists, or ensure that all people receive the benefits of psychological science and practice have generally been carried out without explicit reference to human rights instruments or principles;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Appendix

A. The Nine Core International Human Rights Treaties and Their Optional Protocols

*International Covenant on Civil and Political Rights (1966, 1976)**

First [*Optional Protocol to the International Covenant on Civil and Political Rights*](#) (1966, 1976).

This optional protocol establishes a "right of petition" that allows individuals or groups to petition the Human Rights Committee that a nation has violated their civil and political rights.

[*Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty*](#) (1989, 1991).

International Covenant on Economic, Social, and Cultural Rights (1966, 1976).

*International Convention on the Elimination of all Forms of Racial Discrimination (1965, 1969).**

Convention on the Elimination of All Forms of Discrimination against Women (1979, 1981).

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (1999, 2000), establishing a right of petition, and allowing investigation of possible "grave or systematic violations" of the Convention by a nation.

*Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984).**

Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (2002, 2006), allowing independent investigation of a nation's detention facilities to verify that torture is not occurring.

Convention on the Rights of the Child (1989, 1990);

*Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (2000, 2002)**

*Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (2000, 2002)**

[*Optional Protocol to the Convention on the Rights of the Child on a communications procedure*](#) (2011, 2014), establishing a right of petition against a nation for violating the rights of the child.

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990, 2003).

Convention on the Rights of Persons with Disabilities (2006; 2008).

[*Optional Protocol to the Convention on the Rights of Persons with Disabilities*](#) (2006, 2008), allowing a right of petition against states for violating these rights.

International Convention for the Protection of All Persons from Enforced Disappearance (2006, 2010).

B. Additional Relevant UN Statements

UN General Assembly:

*The Declaration on the Rights of Indigenous Peoples (13 September 2007)**

Joint statement on human rights, sexual orientation, and gender identity (18 December 2008)*

Human Rights Council:

Resolution on human rights, sexual orientation and gender identity (17 June, 2011)*

Human Rights, sexual orientation, and gender identity (2 February, 2014)*

Protection against violence and discrimination based on sexual orientation and gender identity (15 July, 2016).³

C. Convention on the Prevention and Punishment of the Crime of Genocide*

D. International Humanitarian Law Treaties

The four *Geneva Conventions*, dating in development from 1864 to 1977, these address the treatment of war wounded and prisoners of war, the protection of civilians during conflict and while under enemy occupation*

Convention on the Laws and Customs of War on Land (1899 and 1925). Also known as the *Hague Conventions*, they prohibit the bombardment of undefended cities and the use of particular weapons such as expanding bullets and poisonous gasses*

Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction (1972), also called the *Biological Weapons Convention*, banning all biological weapons*

Convention on Prohibitions or Restrictions on the Use of Certain Conventional Weapons Which May Be Deemed to Be Excessively Injurious or to Have Indiscriminate Effects (1980)*

Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on their Destruction (1993), also called the *Chemical Weapons Convention*, banning all chemical weapons*

Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction (1997) also called the *Mine Ban Treaty*, banning all anti-personnel land mines

Convention on Cluster Munitions (2008), banning munitions with multiple warheads or "bomblets"

* Ratified or endorsed by the United States.

Note: The first date following each treaty refers to the date of its adoption by the UN General Assembly, the second to when the required number of nations had ratified it to make the

³ The United States was not a member of the Human Rights Council when this resolution was adopted.

treaty international law. Detailed information on each convention is available on the website of the UN High Commissioner for Human Rights (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx>)

XVI. FINANCIAL AFFAIRS

A.(26) Council received as information the 2019 IRS Tax Form 990 and 990-T Amendment.

On Friday, Chester Copemann, PhD, and Carrie Kennedy, PhD, were presented with Presidential citations.

On Saturday morning, Maysa Akbar, PhD, APA Chief Diversity Officer, provided an overview of the Equity, Diversity and Inclusion framework and next steps. Dr. Akbar's presentation was followed by a panel discussion composed of members on the [Presidential Task Force on Psychology and Health Equity](#).

On Saturday morning, Council had a discussion about the recommendations included in the Council Effectiveness Work Group report that was received by Council in August 2020 and proposed next steps to implement those recommendations.

On Saturday afternoon, Jean Carter, PhD, APA Treasurer, provided Council with the financial report.
