Council of Representatives
February 20 & 21, 2026

DRAFT MINUTES

I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its August 5 & 6, 2025, meeting.

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) Council voted to approve withdrawal of the new business item titled, Expansion of Membership Eligibility to Master's-Level Psychology Professionals (NBI #17E/February 2025).

III. ETHICS

No items.

IV. BOARD OF DIRECTORS

No items.

V. DIVISIONS AND STATE AND PROVINCIAL AND TERRITORIAL ASSOCIATIONS

No Items.

VI. ORGANIZATION OF THE APA

A.(3) Council voted to extend the expiration date for the Specialty Guidelines for Forensic Psychology to December 31, 2027.

B.(4) Council voted to receive the Presidential Task Force Report on Disaster Preparedness, Response and Recovery entitled Integrating Psychological Science into Major Disaster Preparedness, Response, and Recovery and Advancing Disaster Behavioral Health Training and Response for Psychologists.

Council also voted to adopt the following as APA policy:

Policy Statement: Integrating Psychological Science into Major Disaster Preparedness, Response, and Recovery and Advancing Disaster Behavioral Health Training and Response for Psychologists

Background

Major disasters pose profound psychological and physical risks to communities nationally and disproportionately result in inequities for vulnerable populations such as children and their families (particularly mothers), older adults, individuals with disabilities, and those with low socioeconomic status (Bonanno et al., 2010; Dodgen et al., 2016). Disasters also have long-term

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psychological impacts that may hinder recovery and community resilience, especially among vulnerable populations who are commonly more at risk (Salzer & Bickman, 2013; Raker et al., 2019). The psychological toll of disasters has become increasingly evident with an escalating number of fires, floods, tornadoes, earthquakes, and hurricanes. These trends underscore the need for a robust disaster behavioral health (DBH) infrastructure and community-based support systems to aid in disaster preparedness, response, and recovery.

The 2025 APA President commissioned a Task Force on Disaster Preparedness, Response, and Recovery to address the implications of these trends for the field of psychology. The Task Force was charged with developing a comprehensive advisory report for the APA Council of Representatives that summarizes known psychological science, identifies critical gaps in research and service provision, and outlines best practices for a participatory, community-based approach to disaster management. This policy statement highlights the Task Force's findings and proposes next steps for the American Psychological Association (APA) to lead a national effort to strengthen disaster behavioral health capacity DBH in the discipline.

WHEREAS major disasters are defined under the Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. § 5122, 2018 42 U.S., 2018) law as meaning any natural catastrophe (including any hurricane, tornado, storm, high water, winddriven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which cause damage of sufficient severity and magnitude to warrant major disaster assistance to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby;

WHEREAS federal and non-governmental organizations (NGOs) have developed extensive resources for disaster preparedness, response and recovery, yet a critical gap remains in the integration of psychological science into disaster preparedness, response, and recovery;

WHEREAS, the American Psychological Association (APA) has emphasized the importance of culturally responsive, trauma-informed, and interdisciplinary approaches to disaster resilience, advocating for the inclusion of psychological expertise in public health and emergency management strategies (e.g., Abrams, 2020; American Psychological Association, 2024);

WHEREAS, psychologists play a critical role in disaster preparedness, response, and recovery. Psychologists' expertise in trauma, resilience, and community mental health is essential to mitigating the psychological impacts of disasters. However, current systems for training and mobilizing psychologists in DBH are fragmented and underdeveloped (Health and Human Services: National Biodefense Science Board, 2010);

WHEREAS the COVID-19 pandemic revealed systemic gaps in DBH preparedness and highlighted the need for proactive, community-based behavioral health strategies (Sheek-Hussein, Abu-Zidan, & Stip, 2021; Papa, 2025);

WHEREAS DBH integration in preparedness planning remains limited, despite the valuable resources for disaster response from federal agencies such as the Federal Emergency Management Agency (FEMA), and the Substance Abuse and Mental Health Service Administration (SAMHSA), and NGOs, like the American Red Cross (ARC);

WHEREAS case studies from disasters such as the Oso SR530 landslide, Hurricane Maria, Montecito mudslides, and the Maui wildfires demonstrate the usefulness of culturally informed, trauma-focused mental health interventions;

WHEREAS strategic partnerships between mental health professionals and emergency management agencies are essential for building resilient communities and ensuring equitable access to psychological support (Heris et al, 2022; Rosenberg, Errett, & Eisenman, 2022);

WHEREAS a unified, trauma-informed disaster framework that is informed by psychological science can enhance national preparedness and recovery efforts (Hobfoll et al., 2007; Ko et al., 2008; Kusmaul, 2020);

WHEREAS psychologists are essential contributors to disaster preparedness, response, and recovery efforts, providing critical mental health services to individuals and communities (Margolin, Ramos, & Guran, 2010; Jacobs, Leach & Gerstein, 2011);

WHEREAS shifts in state and federal disaster response strategies, coupled with declining engagement in traditional models, prompted the transition of the APA Disaster Response Network (DRN) to a web-based resource platform, while reflecting broader changes in the emergency management landscape, has disrupted leadership development pipelines within State, Provincial, and Territorial Psychological Associations (SPTAs);

WHEREAS targeted interviews of academic institutions found that 85% of psychology doctoral programs report no formal training in disaster behavioral health, and 91% expressed possible interest in offering such training (APA personal communication, 2025);

WHEREAS existing certificate programs offer structured DBH curricula but face challenges, including a lack of standardized certification, limited trained faculty, and insufficient funding;

WHEREAS no centralized national leadership or standardized framework exists for psychologists on DBH training, guidance, or coordination across jurisdictions that promote culturally responsive care and community-based interventions, which are essential to effective disaster response, particularly in vulnerable communities (Ting, et al., 2025; Everett et al., 2020; Marlowe, Neef, Tevaga, & Tevaga, 2018; Rahmani, Muzwagi, & Pumariega, 2022);

WHEREAS a recent Presidential Task Force assessed the state of disaster behavioral health engagement among psychologists, including among State, Provincial, and Territorial Psychological Associations (SPTAs) and academic psychology programs, and identified significant gaps in training, coordination, and infrastructure.

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WHEREAS there are known increases of violence, including interpersonal violence, resulting from disasters.

THEREFORE, BE IT RESOLVED, the APA shall support integrating psychological science into federal, state, and local disaster preparedness, response, and recovery frameworks, ensuring disaster behavioral health is a core component of emergency planning and public health strategies.

BE IT FURTHER RESOLVED, the APA supports the development and adoption of a unified competency framework for disaster behavioral health to guide education and practice in disaster behavioral health, including:

- Basic competencies, such as understanding disaster impacts, roles of psychologists, cultural competence, screening, acute interventions, and provider self-care.
- Advanced competencies such as individual and community needs assessment, use of evidence-based treatments, trauma informed care, community engagement, post-disaster needs assessment, and international collaboration.

BE IT FURTHER RESOLVED, the APA shall support exposure to disaster behavioral health concepts in graduate psychology training programs and the development and dissemination of interdisciplinary training programs that prepare licensed mental health professionals to participate in disaster preparedness and response, with a focus on cultural competence and trauma-informed care.

BE IT FURTHER RESOLVED, the APA shall facilitate collaborative partnerships among emergency management agencies and mental health organizations, including psychologists, social workers, faith-based organizations, and community health providers, to address disaster mental and behavioral health training, including but not limited to instances of interpersonal violence, and develop recommendations to improve coordination of disaster response efforts and deployment recommendations of mental health professionals.

BE IT FURTHER RESOLVED, the APA shall support the development and dissemination of accessible, age-appropriate, and culturally responsive disaster preparedness materials that address psychological well-being for individuals, families, and communities.

BE IT FURTHER RESOLVED, the APA shall support increased research and evaluation of disaster behavioral health interventions, including community-based models that promote resilience and recovery and effective training of psychologists and other mental health professionals.

BE IT FURTHER RESOLVED, that the APA shall seek to leverage existing resources to lead strategic partnerships, training standardization, and resource dissemination.

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BE IT FURTHER RESOLVED, that the APA shall support maintaining and updating a dynamic, web-based centralized repository of evidence-based, culturally informed disaster behavioral health resources and training materials.

BE IT FURTHER RESOLVED, that the APA shall facilitate access to guidance documents for psychologists on disaster preparedness, response, and recovery.

BE IT FURTHER RESOLVED, that the APA shall explore and engage in public education around interjurisdictional state licensure solutions and work with SPTAs to facilitate psychologists during natural disasters providing services across state, provincial and territorial lines.

BE IT FURTHER RESOLVED, that the APA shall explore ways to cultivate new leaders in disaster behavioral health across academic and practice settings, and provide peer support for existing leaders.

BE IT FURTHER RESOLVED, that the APA shall educate and support equitable access to behavioral health services during and after disasters, prioritizing underserved and high-risk populations.

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C.(5) Council voted to postpone Item #5, NBI #15A/Aug 2025: Proposed APA Ethnic Psychological Association with the Association of Jewish Psychologists, to its August 2026 meeting.

D.(5A) Council voted to approve the following motion:

That Council requests that a report be provided by March 1, 2026 on the process and progress for determining the CEO and beyond for March 2027 when the current CEO's contract expires. This is essential for Council to critically collaborate with the Board of Directors and conduct its

fiduciary responsibility to the association in advising the leadership direction of the association. Given that the Board of Directors must make a determination regarding whether or not the CEO will remain by March 20, 2026, this process requires clarity, transparency, and communication.

E.(16) Council received as information a report from the Advocacy Coordinating Committee.

F.(17) Council received as information an update on the Council Liaison Program.

G.(24) Council was provided with an update on the new business in progress item, Centralized Digital Dashboard (NBI 15E/August 2025).

VII. PUBLICATIONS AND COMMUNICATIONS

A.(18) Council received as information an update on the Publications and Communications Board activities.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(6) Council voted to approve the revised *Policies and Procedures Manual for the APA Approval of Sponsors of Continuing Education for Psychologists.*

B.(7) Council voted to adopt as APA policy *Standards of Accreditation for Programs in Health Service Psychology* (2026).

X. PROFESSIONAL AFFAIRS

A.(8) Council voted to adopt as APA policy the following *Resolution on Prioritizing the Behavioral Health Needs of Rural Communities*:

APA Resolution on Prioritizing the Behavioral Health Needs of Rural Communities

Consistent with the American Psychological Association (APA)'s mission to advance, communicate, and apply psychological science and knowledge to benefit society and improve lives, this Resolution reaffirms APA's commitment to justice, human rights, fairness, and dignity for all, especially for underserved rural communities across the United States (US). These communities are diverse, experience distinct behavioral and physical health needs compared with urban populations, and face unique barriers to timely, effective, and culturally responsive care.
WHEREAS rural communities are not a monolith, with differing behavioral health needs among farming, ranching, fishing, mining, drilling, forestry, mountain, frontier, Pueblos, Tribes, Nations, Appalachian, Delta, desert, industrial, and tourism-based populations (Slama, 2004);

WHEREAS rural populations are becoming increasingly diverse in age, race, ethnicity, and culture, driven in part by disproportionate immigration growth, rapid population aging, youth outmigration, and high rates of grandparent caregiving, particularly in rural and minoritized

communities (Johnson, 2022; Anderson et al., 2024). These intersecting dimensions of diversity are frequently segmented rather than integrated in policy and practice considerations (Cohen & Greaney, 2023; Monnat, 2025);

WHEREAS care that recognizes the diverse experiences and cultural perspectives of rural residents is essential, including perspectives related to race, ethnicity, age, sex gender identity, sexual orientation, disability status, socioeconomic background, and cultural traditions (Mendoza et al., 2020). Psychologists recognize that human behavior varies based on cultural norms and influences and are called to consider traditional wisdom derived through those cultures with knowledge derived from psychological research (APA, 2025);

WHEREAS cultural norms emphasizing stoicism and self-reliance may discourage help-seeking (Keller & Owens, 2021), though behavioral health stigma is often overestimated by providers relative to patients' own reports and integrated behavioral health care models can reduce stigma by normalizing services within routine medical settings (Allen et al., 2020);

WHEREAS rural people face structural barriers to safety and behavioral health care, including geographic isolation, limited service availability, transportation constraints, workforce shortages, delayed emergency response, emergency room closures and heightened privacy concerns in small communities, which together hinder timely and effective care (Human Resources and Services Administration [HRSA], 2022; Miller et al., 2020; Palomin et al., 2023);

WHEREAS approximately 15.3% of rural residents live below the poverty line, including 20.9% of children under age five (Farrigan et al., 2024), and economic hardship contributes to housing and food insecurity, barriers to employment and education, and increased reliance on public assistance programs (DeWitt et al., 2020; Mammen & Sano, 2018; Rabbitt et al., 2024; Rural Health Information Hub [RHIH], 2025a; Sano & Mammen, 2022; Theis et al., 2022);

WHEREAS rural communities are disproportionately affected by substance use disorders (RHIH, 2025b), with risks intensified by economic disadvantage (Palomin et al., 2023), long distances to treatment, limited recognition of substance use as a behavioral health condition, and a shortage of prevention programs (Raver et al., 2024);

WHEREAS rural communities experience elevated exposure to trauma, including natural disasters, occupational hazards, geographic and social isolation, economic downturns tied to single industries, child maltreatment, elder abuse, domestic violence/intimate partner violence (DV/IPV), and limited access to emergency and behavioral health services (HRSA, 2022; National Institute for Occupational Safety and Health, 2024; Palomin et al., 2023; SAMHSA Disaster Technical Assistance Center, 2020; Samp & Diamond, 2025). These exposures are compounded by intergenerational adversity, systemic inequities, overburdened child and adult protective services, limited prevention resources, increased suicide risk, and persistent behavioral health stigma, resulting in cumulative impacts distinct from those in urban and suburban contexts (Henninger et al., 2025; Lahr et al., 2024; Polaha, 2015; Western Interstate Commission for Higher Education, 2024);

WHEREAS disparities in maternal mental health are disproportionately affect rural communities, where pregnant and postpartum individuals face elevated risk for depression, anxiety, trauma-related conditions, and substance use disorders, compounded by limited access to prenatal,

perinatal, and postpartum care, workforce shortages, hospital and obstetric unit closures, long travel distances, and fragmented systems of care (Stoneburner et al., 2025; Policy Center for Maternal Mental Health, 2025);

WHEREAS suicide rates for rural groups are increasing at a greater rate than in urban areas since 2000, especially among Indigenous and white males (Pettrone & Curtin, 2020) and farmers (Narrod et al., 2023). Contributors to these disparities include access to firearms, substance use, economic stress, and reduced access to behavioral health care (Mohatt et al., 2021);

WHEREAS nursing home residents in non-urban communities are more likely to have diagnoses of dementia, depression, and other psychiatric conditions and have significant behavioral health needs (RUPRI Center for Rural Health Policy Analysis, 2022). Rural communities face shortages of direct care workers, higher mortality rates among persons living with dementia, and persistent rural–urban disparities in dementia care quality (Arsenault-Lapierre et al., 2023; Dill et al., 2023; Santoyo-Olsson et al., 2025);

WHEREAS access to telehealth and remote behavioral health services in rural communities is constrained by limited availability and higher costs of high-speed internet, restricting equitable delivery of care (Andrilla et al., 2018; Connolly et al., 2022; Li et al., 2020; Watanabe et al., 2023);

WHEREAS rural residents are often required to leave their communities for inpatient or residential behavioral health treatment, resulting in separation from family, cultural supports, and community-based sources of belonging and healing, which discourages engagement in needed care (Goss et al., 2017; Johnson & Cameron, 2001). These harms disproportionately affect the American Indian/Alaskan Native population (Cromer et al., 2019), older adults (Sharma et al., 2024), and incarcerated and formerly incarcerated individuals (Zajac et al., 2014);

WHEREAS rural communities face a persistent "rural brain drain," in which individuals do not return to or remain in their communities of origin, undermining workforce development, continuity of care, and the preservation of cultural and community resources (Artz, 2003; Estes et al., 2016; Henning-Smith et al., 2024);

WHEREAS behavioral health providers in rural communities face distinct ethical challenges, including reduced privacy, frequent dual relationships, overlapping personal and professional roles, caregiving responsibilities across the lifespan, and increased visibility of help-seeking, which can complicate ethical practice and provider well-being (Palomin et al., 2023);

WHEREAS increasing physical and psychological access to behavioral health care that is responsive to the unique needs of rural communities (e.g., threats to land and occupation) improves overall well-being (Mengell et al., 2025; Morales, 2020);

WHEREAS workforce shortages in rural communities cannot be resolved through recruitment pipelines alone due to structural and economic constraints in health care delivery, and evidence supports fully integrated behavioral health care models, characterized by shared workflows, unified clinical identity, warm handoffs, and team-based care within a single system, as more effective than co-located or coordinated care for expanding access and improving outcomes in rural settings (HRSA, 2022; Allen et al., 2020). Concurrently, approximately 65% of rural areas face primary care shortages, and ongoing rural hospital closures further limit access, underscoring the

critical role of school-based behavioral health programs (Henry, 2024; Caldwell, 2025; Sanchez et al., 2018);

BE IT RESOLVED APA reaffirms its commitment to prioritizing the behavioral health needs of rural America.

BE IT RESOLVED APA supports policies and adequate funding for federal, state, and local programs that increase access to evidence-based behavioral health services in rural communities, with explicit prioritization of school-based and fully integrated behavioral health care models in both primary care and specialty care that promote inclusive access through a single point of entry, improve care coordination, enhance referral follow-through, and reduce logistical barriers such as transportation and system navigation.

BE IT RESOLVED APA supports health equity for underserved and vulnerable populations in rural America through community-based, evidence-informed training for behavioral health providers and allied professionals emphasizing rural cultural competence, integrated behavioral health care, prevention and early intervention, trauma- and identity-affirming practices, maltreatment and abuse
reporting strategies specific to rural populations, mobile crisis units, and strategies to address structural barriers to access.

BE IT RESOLVED APA supports inclusive policy development and education regarding diverse cultural beliefs within rural communities across the lifespan. This includes explicit attention to the unique needs of spiritually, racially, and ethnically diverse rural populations, including Pueblos, Tribes, and Nations.

BE IT RESOLVED APA supports strategies to improve access to prevention, treatment, and recovery for substance use and other mental health disorders in rural communities, including community-based interventions, expanded telehealth, expanded high speed internet access, and increased access to peer-support networks.

BE IT RESOLVED APA advocates for expanding services to increase safe housing, food access, support for youth involved in juvenile justice and child protective systems, DV/IPV and sexual violence resources, elder abuse prevention and response, maternal mental health services, suicide prevention, and stronger partnerships between law enforcement and DV/IPV, sexual violence, and child/elder abuse advocacy agencies.

BE IT RESOLVED APA advocates for policies that reduce the need for rural residents to leave their communities for treatment by expanding local inpatient, residential, integrated behavioral health, independent practice, and culturally grounded services, ensuring family and community supports remain accessible during care, and providing consultation and support to family caregivers and long-term care facilities to deliver trauma-informed care and effectively address behavioral health needs.

BE IT RESOLVED APA supports initiatives to reduce stigma and cultural barriers to help-seeking in rural communities by promoting community education, peer-led programs, and partnerships with trusted local leaders, such as other health care providers, extension professionals, religious leaders, and traditional or community healers.

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BE IT RESOLVED APA advocates for the integration of behavioral health education and resources within rural K-12 schools, community centers, senior centers, and long-term care facilities to increase knowledge, reduce stigma, and build early awareness of community support across the lifespan.

BE IT RESOLVED APA supports efforts to strengthen and sustain the rural behavioral health workforce by recognizing the essential role of graduate students and early career professionals, incentivizing rural practice following training, and advancing policies that support viable rural practice through competitive reimbursement, scholarship and loan forgiveness programs, and partnerships with rural training sites across the educational continuum.

BE IT RESOLVED APA supports national and local strategies to retain talent and reduce rural brain drain, including investment in training pathways, mentorship opportunities, and community development efforts that encourage long-term workforce and population stability.

BE IT RESOLVED APA supports expanding training opportunities that prepare psychologists to practice effectively in integrative care models in rural communities, including appropriate consideration of prescriptive authority, and the development of rural-specific training and supervision guidance addressing ethics, role clarity, documentation, consultation boundaries, and professional identity within team-based medical settings.

BE IT RESOLVED APA supports the development and sustainability of rural-focused training pathways, including programs housed in smaller colleges and universities, to cultivate "homegrown" providers, reduce barriers to advanced education, and expand opportunities for academic psychologists in rural regions.

BE IT RESOLVED APA aims to expand access to education on rural health needs through continuing education offerings, dissemination of rural-specific resources, and support for research that identifies disparities and solutions for both behavioral health providers and referral sources (e.g., primary care providers, obstetric and maternal health providers, school psychologists, social workers, community health workers, and public health departments).

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B.(15) Council received an update on the business pending item, Policy and Position Statement on the Use of Seclusion and Restraint and Policy Initiatives: Avoiding Institutional Harm and Promoting Evidence-Based Practice (NBI #19A/Aug 2024).

C.(19) Council received as information an update on the work of the Advisory Steering Committee for Development of Clinical Practice Guidelines and APA Guideline Development Panels and plans for 2026.

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XI. SCIENTIFIC AFFAIRS

A.(19A) Council received as information ongoing reporting on the APA Plan on Climate Change.

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

XII. PUBLIC INTEREST

A.(9) Council voted to archive the following *2017 Resolution on Palliative Care and End-of-life Issues*:

Resolution on Palliative Care and End-of-life Issues

Whereas the issues and terminology of end-of-life have evolved since the American Psychological Association (APA)'s 2001 Resolution on End-of-life Issues and Care; and

Whereas palliative care is a team-based approach to care focused on: improving the quality of life for individuals facing serious or life-limiting illness and their care partners (e.g., families of origin or families of choice); preventing and relieving suffering by means of early identification; thorough, culturally sensitive assessment and treatment of pain and physical, psychosocial, and spiritual problems; and by providing bereavement care (Kelley & Morrison, 2015; National Consensus Project for Quality Palliative Care, 2013); and

Whereas palliative care is appropriate at any age and at any stage of a serious illness, can be provided at the same time as disease-directed or curative treatment, and is not dependent on prognosis (World Health Organization [WHO], 2016); and

Whereas end-of-life or hospice care, which is often tied in the United States to the Hospice Medicare Benefit, focuses on palliative care for terminally ill individuals who may have only limited time to live and have elected no longer to pursue curative treatment for their underlying disease (Kelley & Morrison, 2015); and

Whereas most hospice programs are limited in their present structure and reimbursement mechanisms to meet the needs of children with serious and life-limiting illness and their families (National Hospice and Palliative Care Organization, 2001); and

Whereas many more individuals with terminal diagnoses across the lifespan are living longer than before and thus have more opportunity to make end-of-life decisions (Morrissey, Herr, & Levine, 2015; Murtagh et al., 2014); and

Whereas death has become more frequently the result of advanced serious illness that must be managed for weeks and often years, with multiple health, functional, and emotional changes occurring throughout the disease process (Institute of Medicine [IOM], 2014); and

Whereas individuals with advanced serious illness will grapple with multiple conditions that may interact in complex ways and will face a system of care that is often fragmented, uncoordinated and confusing (Byock, 2012; Coalition to Transform Advanced Care [C-TAC], 2015; IOM, 2014); and

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Whereas the nature of death and dying has changed across the twentieth century, occurring primarily in an institutional setting rather than at home (Centers for Disease Control and Prevention [CDC], 2005); and

Whereas systemic barriers continue to exist to integrating evidence-based treatment programs and practices into standards of care system-wide (Allison & Sudore, 2013; Lynch, 2013; Weaver et al., 2015); and

Whereas medical technology has advanced to the point where patients in hospitals infrequently die without a decision to withhold or withdraw life-supporting therapy (Gedge, Giacomini, & Cook, 2007; Lantos, 2011) with those decisions being psychologically complex for all parties involved, especially in the absence of advance directives; and

Whereas end-of-life decision making is complex, involving areas of ethics, religion, medicine, psychology, sociology, economics, the law, public policy, and other fields (Baergen, 2001; National Consensus Project for Quality Palliative Care, 2013; Wells-DiGregorio, 2008); and

Whereas some evidence suggests that there are fluctuations in the will to live (Chochinov, Tataryn, Clinch, & Dudgeon, 1999) and in wishes regarding life-sustaining treatments (Fried et al., 2006); and

Whereas autonomy is an important principle in the law and in medical and ethical aspects of decision making, but in and of itself is insufficient to capture the full range of complex psychosocial, medical, familial, financial, cultural, spiritual, and legal issues involved in palliative care and end-of-life decision making (Byock, 2009; Winzelberg, Hanson, & Tulsky, 2005); and

Whereas in the United States, end-of-life decisions are made in the context of significant social stratification related, but not limited to, age, culture, disability status, ethnicity, gender identity, geographic location, health status, immigration status, marital status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status, leading to inequalities in access to resources such as basic health care and resources for in-home supported living (Canetto, 2011; Payne, 2016; Lee et al., 2017; Robinson, et al., 2009; Sue, 2001); and

Whereas severe health disparities in timely and adequate access to care profoundly influence the nature and availability of end-of-life care for underserved individuals and communities and, consequently, affect the concerns of individuals and their care partners making end-of-life care decisions (Johnson, 2013; Koffman et al., 2007; Lynch, 2013; Robinson et al., 2009; Williams et al., 2012); and

Whereas the 20 percent of the U.S. population living long-term with disability or chronic illness (e.g., HIV/AIDS) (Shorthill & Demarco, 2017) commonly experiences social stigma that can be further compounded by the stigma of approaching death, and end-of-life care offered to individuals with disabilities (e.g., often involving nursing home placement) may inadvertently compound their vulnerability by disrupting their carefully cultivated self-management and support systems (Stienstra, D'Aubin, & Derksen, 2012, thereby increasing social disconnection, lack of agency, and risk of abuse and coercion by caregivers (who may also have decisional authority); and

Whereas 42 percent of people with disabilities experience sexual abuse and 87 percent experience verbal abuse and inhumane practices in caregiving situations (Baladerian, Coleman, & Stream, 2013); and

Whereas over the next two decades, the number of individuals age 65 and older (the age group that encompasses the majority of people with advanced illness) will nearly double to more than 72 million, with racial and ethnic minority older adult populations projected to increase to 21.1 million in 2030 (Administration on Aging [AOA], 2015), thus significantly increasing the need for culturally competent palliative and hospice care; and

Whereas vulnerable populations of adults with diminished capacity for autonomous decision making and living with advanced serious illness may lack the ability to communicate medical decisions and may experience daily fluctuations in awareness or lucidity (American Bar Association [ABA] & APA, 2008; Stormoen, Almkvist, Eriksdotter, Sundstrom, & Tallberg, 2014; Trachsel, Hermann, & Biller-Adorno, 2015); and

Whereas there are 400,000 children in the United States with life limiting illness, with cancer as the leading cause of disease-related death for adolescents and young adults (Friebert, 2009; State Initiatives in End-of-life Care, 2002); and

Whereas survival with these illnesses has improved far less for 15 to 24-year-olds than it has for older individuals (Bleyer, O'Leary, Barr, & Ries, 2006; Institute of Medicine [IOM], 2013; Robison, 2011), and about one fourth of children with cancer will die prematurely (Murphy, Xu, & Kochanek, 2013; Vinchon, Baroncini, Leblond, & Delestret, 2011); and

Whereas individuals with serious or life-limiting illness often rely on family members (of origin or of choice) for care, and this care can be rewarding and also challenging and result in significant psychological and physical morbidity and strain, including economic strain, to the care partner (Morgan, Williams, Trussardi, & Gott, 2016; Roth et al., 2013; Rumpold et al., 2016; Vanderwerker, Laff, KadanLottick, McColl, & Prigerson, 2005; Wadhwa et al., 2013); and

Whereas care partners of individuals with serious or life-limiting illness often are at risk for complications associated with anticipatory grief and bereavement and many risk factors for grief and bereavement can be addressed through quality palliative and end-of-life care (Garrido & Prigerson, 2014; Hudson et al., 2014); and

Whereas for immigrant and first generation U.S. families, caregiving and end-of-life decisions may cross borders due to transnational circles of care, and health providers should be mindful of the implications of U.S. policies on caregivers and family decision makers who are either abroad or who hold different cultural views on palliative care and end-of-life decisions (Baldassar, 2011; Baldassar, 2017; Baldassar & Merla, 2013; Kilkey & Merla, 2014); and

Whereas diversity in human values, status, power, and resources leads to an equally diverse range of views and needs and power regarding palliative care and end-of-life care and decisions (Boucher, 2016); and

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Whereas reasonable, well-informed people start from different values and priorities concerning what is valuable at the end-of-life, and can and do hold different positions regarding end-of-life care and goals of care (Crawley, 2005); and

Whereas there is significant public support for individual control over end-of-life decisions but support for hastening death is weakest among groups who express concerns about being pressured to die (e.g., older adults, people with disabilities, people with less education, people with fewer financial resources, women, racial and ethnic minorities) (Crawley, Marshall, Lo, & Koenig, 2002; Krakauer, Crenner, & Fox, 2002; Lyon et al., 2008; Phillips et al., 2000); and

Whereas the absence or avoidance of advance care planning results in substituted decisions for or against aggressive care near death that may be incongruent with individual values, and associated with greater symptom and financial burdens, reduced quality of life, and greater risk of psychiatric complications for care partners (Alexi et al., 2008; Detering, Reade, & Silvester, 2010; Sucore & Fried, 2010; Temel, Greer, Muzikansky, Gallagher, & Admane, 2010); and

Whereas individuals living with advanced serious illness and nearing death experience a range of symptoms that often are unrecognized and/or undertreated, including but not limited to pain, depression, anxiety, worry, existential distress, dyspnea/breathlessness, fatigue, and anorexia (Azuero, Allen, Kvale, Azuero, & Parmelee, 2014; Fisher et al., 2002; Hughes et al., 2016; Kamal, Nipp, Bull, Stinson, & Abernethy, 2015; Kissane, 2012; Moens, Higginson, & Harding, 2014; Yennurajalingam et al., 2013); and

Whereas these symptoms can lead to suffering that may result in requests for, or assent to, medical interventions that affect the timing of death (Ruijs, Kerkhof, van der Wal, & Onwuteaka-Philipsen, 2013); and

Whereas psychologists have begun the important work of developing, evaluating, and disseminating evidence-based psychological interventions for people with advanced serious illness and their care partners, yet to date these interventions are limited in scope and underutilized (Allen et al., 2014; Hudson et al., 2012; Kasl-Godley, King, & Quill, 2014; Kuhne et al., 2012; Northhouse, Katapodi, Song, Zhang, & Mood, 2010; Wallio & Twillman, 2010); and

Whereas behavioral and psychological issues intersect and interact with the biological, social, and spiritual issues faced by people with serious illness, and psychologists' skills can enhance and optimize communication and interventions delivered by professionals from other disciplines (Feldman, Sorocco, & Bratkovich, 2014; Sullivan, Mongoue-Tchokote, Mori, Goy, & Ganzini, 2016); and

Whereas there is increasing consumer demand for psychological services (Bureau of Labor Statistics, 2016-17) and need for addressing end-of-life stressors and decision making with psychologists' support (Murtagh et al, 2014; Nydegger, 2008); and

Whereas psychologists have many areas of competence including, but not limited to, assessment, intervention, teaching, consultation, research, and advocacy skills that could contribute to the science of palliative care and end-of-life issues and to the treatment and support of people with advanced serious or life-limiting illness, their significant others, and

other health care providers (Carpenter, 2015; Connor, Lycan, & Schumacher, 2006; Gamino & Ritter, 2012; Golijani-Moghaddam, 2014; Johnson, Cramer, Conroy, & Gardner, 2014); and

Whereas psychologists possess these intervention, research, and teaching competencies and yet are underutilized due to reasons including, but not limited to, formal or informal exclusion from care systems and programs, lack of opportunities for reimbursement, perceptions that psychological services are not warranted, and lack of understanding by other providers regarding the specific skillset and competencies that psychologists provide near the end-of-life (Azuero et al., 2014; Haley, Larson, KaslGodley, Neimeyer, & Kwilosz, 2003; Patterson, Croom, Teverovsky, & Arnold, 2014); and

Whereas psychology has been integrated into interdisciplinary, palliative care teams in the Veterans Health Administration (VHA, 2016), but psychologists in clinical practice outside of the VHA have not typically been involved in palliative care and end-of-life decisions to the degree that they could be (Garrido, Penrod, & Prigerson 2014; Haley et al., 2003); and

Whereas current Medicare policy authorizes reimbursement for advance care planning conversations only for physicians, nurse practitioners, or their supervisees (Jones, Acevedo, Bull, & Kamal, 2016), yet psychologists trained in palliative and end-of-life care possess knowledge and skills to help people obtain the health information they need, effectively communicate questions to their providers, weigh the risks and benefits of different choices, reflect on their preferences and values, and communicate their wishes when contemplating end-of-life situations; and

Whereas there have been few systematic efforts to educate psychologists about end-of-life issues in comparison with the magnitude of the issue and opportunity (APA, 2000; Kasl-Godley, King, & Quill, 2014); and

Whereas core competencies in palliative and end-of-life care are now widely articulated and psychological issues are a core practice domain, yet psychologists remain largely absent from professional work groups involved in developing these competencies (Ryan et al., 2014); and

Whereas psychological research on palliative care and end-of-life issues is expanding but remains limited in comparison with the magnitude of the issue (Keall, Clayton, & Burtow, 2015; Naik, Martin, Moye, & Karel, 2016; Singer et al., 2016; Xiao, Kwong, Pang, & Mok, 2012); and

Whereas The National Institute of Nursing Research (NINR, 2013), the Coalition to Transform Advanced Care (C-TAC, 2015), and the Institute of Medicine (IOM, 2014) have identified gaps in compassionate science, including: (a) integrating behavioral and psychosocial sciences into palliative care; (b) developing a scientific basis for clinical practice for people with advanced serious illness of all ages, that is person- and family-centered; (c) relieving symptoms and suffering; (d) enhancing communication among persons with advanced serious illness, their care partners and clinicians; and (e) understanding decision making about care among persons with advanced serious illness; and

Whereas psychologists could assume a significant role in helping other health care providers understand and cope with the concerns and needs of individuals with serious or life-limiting

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illness and their care partners (Allen, Haley, Roff, Schmid, & Bergman, 2006; Gustin, Way, Wells-Di Gregorio, & McCallister, 2016); and

Whereas psychologists could be instrumental in supporting interprofessional public education efforts to increase health literacy and raise awareness of issues related to palliative and end-of-life care including advance care planning, symptom management, dying, death, grief, mourning, and loss (Higginson et al., 2014; Long, 2011); and

Whereas psychologists could assume a significant role in the development and implementation of standardized tools for measuring outcomes of palliative and end-of-life care (Kearns, Cornally, & Molloy, 2017); and

Whereas the practice of palliative and end-of-life care is, at its best, interprofessional to address the complex care needs of individuals and their care partners, and that collaborative practice operates from a biopsychosocial perspective to provide more patient-centered, comprehensive, ongoing assessment, treatment planning, and interventions in the most efficient and effective manner (APA, 2008; Kelly & Morrison, 2015; National Consensus Project for Quality Palliative Care, 2013); and

Whereas team-based health care results in higher quality care and interprofessional practice competencies are recognized as integral to palliative and end-of-life care, yet few professions, including psychology, have opportunities across all levels of professional education and development to train together, leaving them unprepared for the practice environments in which they will work (Interprofessional Education Collaborative Expert Panel, 2011; Ryan et al., 2014); and

Whereas a number of national and international organizations have issued their own policy statements and documents and have collaborated on developing guidance documents regarding end-of-life issues, often without the involvement of APA representatives or other psychologists, including The Clinical Practice Guidelines for Quality Palliative Care (The National Consensus Project for Quality Palliative Care, 2013), Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of-life (IOM, 2014), and the White Paper on Standards and Norms for Hospice and Palliative Care in Europe (European Association for Palliative Care, 2009).

Therefore , be it resolved that the American Psychological Association, an organization committed to promoting the psychological well-being of individuals across the life span, actively

Promotes and supports psychology's involvement in palliative care and end-of-life issues in the United States of America and as invited on international platforms.

In order to advance this involvement, be it further resolved that the American Psychological Association:

Promotes and encourages research and education in the areas of palliative care and end-of-life issues within psychology training at all levels.

Encourages psychological research and the use of clinical skills to assess and address the psychological factors that have an impact on end-of-life decision making and will to live,

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including, but not limited to, untreated or undertreated distressing physical symptoms, depression, anxiety, loss of perceived dignity, existential distress, cognitive capacity, and increased social marginalization experienced by individuals already living with marginalized health conditions (including HIV/AIDS, substance abuse, mental health disorders) or disabilities.

Promotes psychologists' collaboration with other disciplines and organizations in the formulation and implementation of a behavioral and psychological research agenda on palliative care and end-of-life issues.

Advocates for funding for behavioral and psychological research on palliative care and end-of-life issues, collaborating when possible with other palliative and hospice-focused professional organizations.

Encourages psychology to bring its perspective in organizational systems to close research gaps and to implement best practices system-wide for persons across the lifespan with serious or life-limiting illness.

Promotes psychologists' acquisition of knowledge and skill competencies with respect to palliative care and end-of-life issues, including, but not limited to, developmentally-sensitive assessment and treatment of bio-psycho-social-spiritual aspects of advanced illness; dying, death, and bereavement care; communication and advance care planning; interprofessional practice; legal and ethical issues; and, sensitivity to all diversity and developmental dimensions that affect end-of-life experiences.

Promotes psychologists' acquisition of competence in interprofessional collaboration that is the foundation of palliative and end-of-life care.

Encourages psychologists working with minors living with advanced serious or life-limiting illness to obtain training at all levels in the area of ethics as applied to decision making by and care of minors who may have no legal rights, but are supported by public policy to be involved in decision making about their health care, consistent with the principles of justice and respect for peoples' rights and dignity.

Encourages psychologists working with vulnerable populations of adults with diminished capacity for autonomous decision making and living with advanced serious illness to obtain training at all levels in the area of ethics as applied to decision making by individuals with diminished capacity, consistent with the principles of justice and respect for peoples' rights and dignity.

Encourages all psychologists to obtain training at all levels in the area of ethics (including APA ethical standards), social justice, and legal issues as they apply to palliative care and end-of-life issues. In addition, psychologists working with vulnerable persons living with serious or life-limiting illness are encouraged to obtain training in ethics as they apply to their research and practice when working with individuals of all developmental stages and cultures with serious or life-limiting illness.

Encourages psychologists to be aware of their own attitudes about palliative care and end-of-life issues that may influence their clinical practice, research, education/training, and advocacy, and

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to recognize possible biases about quality of life or entitlement to resources based on group identities and their related social statuses, including, but not limited to, age, culture, criminal justice involvement, disability status, gender identity, geographic location, health status (including stigmatized conditions such as HIV, substance use, mental health disorders), immigration status, marital status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status.

Encourages psychologists to obtain an understanding of how power, social status, and facets of identity, including, but not limited to, age, culture, criminal justice involvement, disability status, gender identity, geographic location, health status, immigration status, marital status, mental health status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status contribute to disparities in palliative and end-of-life care. Specifically, psychologists are encouraged to apply this understanding to: (a) promote the elimination of inequities related to access to care, retention, and outcomes; (b) increase awareness of provider and patient biases; (c) improve communication about goals of care and related decisions; (d) expand recognition that social disenfranchisement of marginalized individuals may intensify at end-of-life in ways that influence decision making; and (e) understand the treatment preferences and values of individuals to assist with advance care planning and decision making.

Encourages psychologists to familiarize themselves with the roles and competencies of, and clinical care provided by, medical, social work, nursing, and chaplaincy and other professional colleagues related to end-of-life issues, decision making, and care.

Encourages psychologists' efforts to increase the understanding of other health care professionals with regard to behavioral, psychological, and diversity aspects of palliative care and end-of-life issues.

Promotes high-quality and effective palliative and end-of-life care that includes support for individuals across the lifespan with advanced serious illness and their care partners all along the illness trajectory; culturally sensitive assessment and treatment; thorough symptom management; promotion of mental health and psychological wellbeing; optimal expression of cognitive capabilities; facilitation of effective communication and assistance with advance care conversations and decision making that is shared and informed by individual/family needs, values, and preferences; bereavement care; and promotion of quality of life in all these activities.

Advocates for access to, and insurance coverage for, mental health services for seriously ill individuals and their care partners, across all settings of care and geographic locations, and for family members during bereavement.

Promotes and endorses public policies that provide for behavioral and psychosocial services for seriously ill individuals across the lifespan, and their care partners.

Advocates for expansion of Medicare coverage to include psychologists among those providers who may conduct advance care planning conversations and provide hospice consultations.

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Advocates and endorses legislation to make public and private health, and mental health systems more flexible for meeting the health and mental health needs of children and adolescents with serious and life-limiting illness.

Advocates for public and private financial support of psychology and interprofessional training in palliative care and end-of-life issues at the pre-doctoral, internship, postdoctoral, and post-licensure level.

Advocates for psychologists' participation in national, state, and local interdisciplinary efforts to inform the development of policy and standards for palliative care and end-of-life issues including, but not limited to, involvement in research funding advisory groups, practice and treatment guideline and quality assurance outcomes development efforts, ethics committees, clinical care committees, and administrative work groups.

Supports interprofessional efforts to increase the competency of psychologists and other health care professionals in identifying and addressing the behavioral, psychological, and social aspects of serious or life-limiting illness.

Endorses the following principles on care for individuals with advanced serious illness as articulated in the Institute of Medicine Report entitled Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of-life (IOM, 2014):

Care for individuals with advanced serious illness should be comprehensive, of high quality, accessible, and available through governmental and private health insurers and care delivery programs. Comprehensive care is integrated, interdisciplinary, patient-centered and family oriented, coordinated across all providers and settings;
Individuals should have the opportunity to engage in conversations about their health care, the results of which should be incorporated into ongoing care plans. Clinician-patient communication and advance care planning should be guided by quality standards that reflect evolving population and health system needs, are measurable, actionable and evidence-based, are adopted by both payer and health care delivery organizations, and linked to reimbursement. Professional societies should adopt policies that facilitate tying standards to reimbursement, licensing and credentialing;
Educational institutions, credentialing bodies, accrediting boards, state regulatory agencies and health care delivery organizations should establish appropriate training, certification, and/or licensure requirements to strengthen basic palliative care knowledge and skills of all clinicians caring for individuals with advanced serious illness. This knowledge and these skills should include communication skills, interprofessional collaboration and symptom management;
Federal, state, and private insurance and health care delivery programs should integrate and finance coordinated medical and social services necessary to support the provision of quality care consistent with the values and goals of individuals with advanced illness. Payment and health care delivery systems should collect and report quality measures, outcomes and costs regarding care for individuals with advanced illness and near the end-of-life;
Public outreach, engagement, and education about care of individuals with advanced serious illness is needed to dispel myths and facilitate advance care planning and informed health care decision making. Renews its strong commitment and become a transformative force in the field of mental health and palliative care and end-of-life issues.

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Council also voted to adopt as APA policy the following *2026 Resolution on Palliative and End-of-life Issues*:

Resolution on Palliative and End-of-life Issues

1. INTRODUCTION

Psychological science and psychologists have contributed greatly to understanding and

addressing the needs of individuals and caregivers facing the end of life, as well as training and education in assessment and evidence-based interventions and the alleviation of suffering through basic and applied research. However, in the U.S. context, integration of psychologists into palliative care teams and scientific consensus groups have remained an aspirational goal of the American Psychological Association for more than a decade (Kasl-Godley et al., 2014). This document is an update of APA's 2017 resolution, focusing on contributions of psychology in palliative care and end-of-life issues in the United States due to differences in international law regarding these issues. Where appropriate, we use the acronym PEOL to refer to palliative care and end-of-life issues, and EOL when discussing end-of-life care. We spell out end of life when used as a noun (e.g., at the end of life).

According to the International Association for Hospice and Palliative Care (IAHPC)'s consensus-based definition developed by health professionals (including one psychologist) from countries with all income levels, palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to serious illness, especially nearing the end of life (Radbruch et al., 2020). Palliative care aims to improve the quality of life of individuals and their families/ caregivers by managing symptoms and coordinating care effectively, so that people may better understand their treatment choices, and treatment plans can reflect their goals and values. The World Health Organization (WHO) adds that palliative care improves quality of life through the prevention and relief of suffering across physical, psychosocial, and spiritual domains (2020).

Palliative care may begin at any stage of a person's serious illness/ health condition (e.g., at the time of diagnosis) and may co-occur with other disease-related treatments (Kelly & Morrison, 2015). When the person is no longer benefiting from curative treatments, they may transition to hospice care if their life expectancy is 6 months or less. Palliative care may be provided when a serious illness that carries a high risk of mortality either negatively impacts a person's daily function and quality of life or excessively strains their caregivers. As such, palliative care broadly covers many EOL issues, including advance care planning (ACP), EOL care, hospice care, and bereavement support for caregivers (Riordan et al., 2020).

Because palliative care requires an interdisciplinary approach, it fits directly within psychologists' expertise and scope of practice, and an estimate of 25,000 palliative care service delivery teams existed globally in 2017 (Connor et al., 2021). Unfortunately, psychologists are often not fully integrated into palliative care teams and, thus, many of these teams function without psychologists. There are significant gaps in training psychologists for palliative care practice, as well as disparities in palliative care access by region and socioeconomic status (WHO, 2020). The clear need for psychologists in palliative care and significant gaps in training and access motivated the current extensive revision of the 2017 Resolution.

2. ETHICAL CONSIDERATIONS IN PRACTICE AND POLICY

Whether psychologists are part of a palliative care team or not, their work may involve PEOL, such as during the ACP process; working with people with advanced, serious illness, and/or family caregivers; and participating in or directing treatment preference and goals of care discussions about EOL care. Psychologists also may be called to provide formal evaluation of a person's decisional capacity in many domains; for example to appoint healthcare power of

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attorney (HPOA), to consent or decline medical treatments and procedures (e.g., decisions related to "do not resuscitate" or "allow natural death"), and to execute an estate plan or engage in any form of planning for a person's remains and distribution of their assets following death. Psychologists also may conduct capacity evaluations in jurisdictions that provide Medical Aid in Dying (MAiD). Psychologists who are involved with ACP and decisional capacity evaluation abide by APA's *Ethical Principles of Psychologists and Code of Conduct* (2017) when working with families, caregivers, and interdisciplinary teams that guide ethical decisions in the PEOL context, especially potential ethical dilemmas involving protecting the welfare of all individuals, while respecting their rights and dignity (Principle E), with special consideration regarding privacy and confidentiality (Standard 4), multiple relationships (Standard 3.05), undue influence, and support versus surrogate decision making. Psychologists are particularly well-suited to contribute to evolving ethical guidelines in this area given competencies in evidence-based interventions and assessments, group dynamics, and social theory, among others.
In addition to ethical and legal considerations, psychologists are encouraged to familiarize themselves with policy considerations that contribute to significant barriers in access to palliative care. For example, health insurance in the US, namely Medicare, typically only reimburses primary care physicians to complete ACP once a year, limiting the kinds of professionals who might be reimbursed for treating patients and families and reducing access to these goals of care planning sessions. Indeed, the status of reimbursement for ACP discussions reflects limitations in palliative care policymaking at the state and federal levels and globally (Ouyang et al., 2025; WHO, 2020).

Access barriers to palliative care are exacerbated for people of color, rural-dwelling individuals, people with disabilities, those of low socioeconomic status, and individuals with multiple intersecting identities associated with minoritized status (WHO, 2020). This reflects limitations implementing the ethical principle of justice (APA, 2017; Principle D) in accessible and affordable palliative and EOL care. Such inequities are caused by disparities in Social Determinants of Health (SDOH), such as safe housing, transportation, employment opportunities, and income, which are non-medical factors that can be influenced by social policies; and contribute to health burdens across the life span and across medical conditions. Economic barriers to palliative care also are differentially experienced by individuals with minoritized status in the US. Community-based palliative care (CBPC) programs are often reimbursed through privately managed health care plans that may be inaccessible to those of low socioeconomic status (Dussault et al., 2025). Medicaid, state-managed health care, may include CBPC, but only five states (i.e., California, Colorado, Hawaii, Maine, and Oregon) do so. Importantly, the role of US states in supporting palliative care policy extends to the meaningful implementation of palliative care across health equity, access to quality care, workforce development, and education and training.

3. INDIVIDUAL, SOCIAL, AND SYSTEM CONSIDERATIONS IMPACTING ACCESS

Intersectionality and Health Disparities

Minoritized populations are at higher risk for chronic and acute illness and receive fewer palliative care services than White and non-disabled individuals (Bazargan & Bazargan-Hejazi, 2021; Cross et al., 2021; Velepucha-Iniguez et al., 2022). Common factors contributing to low utilization include: limited knowledge, or lack of access to information about palliative and hospice philosophy, systemic challenges (e.g., access to care, historic distrust of medical

systems), and implicit biases by healthcare providers, as well as cultural norms affecting prognosis and perceived quality of life, especially among people with disabilities (Adam et al., 2020; Bazargan & Bazargan-Hejazi, 2021; Cross et al., 2021; Griffith et al., 2021; Velepucha-Iniguez et al., 2022). Factors also include patient's religious and cultural beliefs about discussing EOL planning (Ashana et al., 2021), healthcare provider's biases (e.g., presuming patient preferences, limited awareness about palliative care needs of LGBTQIA+ individuals), language (e.g., scarcity of qualified interpreter and translation services, inaccessible language for those with sensory impairments), obstacles to effective patient-provider communication for deaf and hard of hearing clients, and lack of information or health care knowledge among those who need palliative care (Adam et al., 2020; Bazargan & Bazargan-Hejazi, 2021; Javier, 2021; Velepucha-Iniguez et al., 2022). Inequities in access and quality of medical care, including palliative and hospice care, often arise in part due to social biases and stigmas related to demographic factors. These inequities affect where and how individuals receive treatment through their end of life, and their comfort and dignity.

Racial/Ethnic Minoritized and Immigrant Populations

SDOH contributes to higher rates of chronic illness in racially-minoritized populations and lower rates of illness detection. For example, non-White populations (especially Black and Indigenous individuals) had the highest detected rates of cancer (American Cancer Society, 2021). Individuals from minoritized racial groups (especially Black and Indigenous groups) and lower socioeconomic statuses tended to receive diagnoses at later stages of cancer progression, and cancer mortality remained highest among Black individuals, those of low socioeconomic status, and those in the Southeastern region and Appalachia.

Language and cultural barriers can compound challenges to palliative care access, especially among and immigrant populations. Language background, access, and use are among numerous cultural dimensions of the healthcare context that play a significant role in palliative and EOL care (Ashana et al., 2021). Individuals with written and spoken English proficiency may need to or prefer to receive medical/health information in their first or primary native language. Religion, customs, and the role of families become critically important during palliative and EOL care. For example, some South Asian individuals and communities (e.g., India, Pakistan) are reluctant to engage in medical pain management. South Asian people may report having little awareness about palliative care, and that palliative care and discussions of death are against their values (Dosani et al., 2020). Similarly, qualitative research revealed limited knowledge about palliative and hospice care in a Hispanic community in the US, where a "good death" depended on having the entire family physically and emotionally present (Gallo Marin et al., 2024). Such practices may contradict the approach of clinical teams that tend to value patient autonomy in decision-making. When palliative care practices ignore these cultural dimensions, healthcare teams may not be able to fully respect the dying individual and their families' preferences about treatment, places to die, EOL rituals, and decision-making authority. All these considerations may lead to conflict, mistrust, and distress of health care providers, resulting in reduced satisfaction with palliative care (Aker et al., 2024).

Unauthorized or undocumented immigrants lack access to consistent medical care including palliative and hospice care. Many unauthorized immigrants face structural factors affecting their

health (e.g., unsafe living conditions, lack of access to consistent health care, lack of formal labor protections, and limited social and financial support). In most of the US, unauthorized immigrants are not afforded basic life-prolonging healthcare services including scheduled dialysis, resulting in emergency-only dialysis for life-saving purposes (Nguyen et al., 2019). More broadly, immigrants with advanced cancer were more likely to die in the hospital, away from their preferred place of death, and have a poorer quality of death than their non-immigrant peers (Tergas et al., 2022).

Women

Women's experiences of serious illness and EOL care differ from men's, as women live longer on average, have higher rates of chronic illness (e.g., dementia, autoimmune conditions, pain syndromes), and are more likely to experience undertreated pain and fatigue due to gender bias in palliative care (Gott et al., 2020). Women as a population are at risk for inequities in access, diagnosis, pain management, and culturally responsive services as care recipients and caregivers. Older women, particularly women of color, are more likely to live in poverty, which impacts access to quality palliative care (Jawed & Comer, 2024). Moreover, the US has some of the highest rates of maternal mortality/morbidity among high-income countries, especially for Black women (Khan et al., 2023). Maternal complications of pregnancy and bacterial sepsis increased in 2022. From an intersectional feminist lens, women at the intersections of multiple group identities, such as race, socioeconomic status, sexual orientation, gender identity, disability, and immigration status, experience compound disparities in palliative care access and outcomes because of overlapping forms of bias by health care providers uniquely affecting women in these contexts.

Across the lifespan, women are disproportionately likely to serve as unpaid caregivers, often balancing employment and parenting, with significant financial and health consequences (Shefeek et al., 2025). Psychologists have a unique role in supporting women and their families in caregiving contexts, including perinatal and maternal end-of-life care. Women caregivers face higher rates of depression, anxiety, and complicated grief. The gendered nature of caregiving highlights the importance of psychological support for women caregivers in palliative care context (Gott et al., 2020). This includes helping women face terminal illness (e.g., aggressive cancer) during pregnancy and bereavement care for mothers experiencing miscarriage and infant loss.

Children and Youth

The 2023 National Hospice and Palliative Care Organization (NHPCO) report on pediatrics found children in age groups 1-5 and 6-14 comprise 69% of palliative and hospice care pediatric patients. Oncological (36%), genetic (36%), and neurodegenerative conditions (27%) constitute most illnesses requiring pediatric palliative care (NHPCO, 2023). Medicaid data from 2011-2013 indicated that of 6,195 children under age 21 with a diagnosis of a mental health and/or developmental disability who were admitted to hospice care, 66% had a single complex chronic condition (e.g., neurologic, cardiovascular, respiratory conditions), nearly half had multiple complex chronic conditions, and nearly a third of those aged 15-20 had diagnoses of anxiety, depression, behavioral disorders, or other affective disorders (Lindley et al., 2021). Furthermore, almost 50% of the entire sample was reported to have developmental delays, the majority of which were less than one year of age (79%) or under 5 years of age (77%), while over one

quarter (26%) of those 15-20 years old had some other reported developmental disability (Lindley et al., 2021). Children living with serious illness and enrolled in Medicaid or Children's Health Insurance Program (CHIP) in the US may receive disease-directed treatment and interdisciplinary hospice services at the same time because of the Concurrent Care for Children requirement under the Affordable Care Act (ACA; 2020). This enables parents/caregivers to choose both disease-directed treatment and comfort care when their child is facing a terminal illness (NHPCO, 2023). Although hospice is an optional benefit to adults in state Medicaid programs, its provision to children is mandated under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. While pediatric palliative care often ranges from prenatal to young adulthood without a defined age limit, the ACA entitlement to concurrent care only applies to those under age 21.

In pediatric palliative care, psychological services are often provided to family members (e.g., parents, siblings, and other caregivers) in addition to the child. Parents/guardians and families report extraordinary emotional and financial strain caring for children in need of palliative care, including direct physical care, and advocacy and care coordination to navigate the healthcare systems, school systems, and larger communities (Bogetz & Lemmon, 2021). Integration of psychologists into pediatric palliative care settings could help improve outcomes among children and their family and reduce healthcare cost through developmentally appropriate and evidence-based assessment and intervention (Thompson et al., 2024).

Adults with Advanced Chronic Illness

Among adults, diseases requiring palliative care include heart disease, cancers, stroke, diabetes, end-stage kidney disease, Parkinson's disease, and Alzheimer's disease and other dementias, (CAPC, 2014). These diseases mirror the leading causes of illness-related deaths in the US, with COVID-19 being the third leading disease in 2022 (National Center for Health Statistics, n.d.). By 2016, 50% of all health care costs in the US were attributed to the top 5% of persons ranked by their health care expenditures, who were disproportionately 65 and older, White, covered by Medicare, and/or paying for inpatient services (Mitchell, 2019). This group includes those with one or more serious medical illnesses, functional dependence on others to complete basic daily activities, cognitive impairment, medical frailty, and/or reliance on family and other caregivers. Only 11% of this group were within the last 12 months of their lives, highlighting the need for longer-term primary palliative care (CAPC, 2019). Conversely, this also suggests the need to better understand the experiences of individuals living with chronic serious illness who report good quality of life, and how palliative care may be beneficial.

Older Adults

Although serious illness may occur at any age, the likelihood of being diagnosed with a serious illness is higher among older adults and, therefore, older adults are more likely to need palliative care. By 2040, adults aged 65 and older will reach 80.8 million, with racially and ethnically-minoritized older adult populations projected to increase to 27.7 million (Administration for Community Living, 2024). By 2050, 40% of LGBTQIA+ older adults are expected to be people of color (MAP & SAGE, 2017) and there is a clear need for enhanced culturally responsive palliative and EOL care for this population. One third of people age 85 and older (the fastest growing portion of the U.S. population) are expected to develop Alzheimer's disease or another neurocognitive disorder and will require significant support in their last two years of life (CAPC,

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2019). Many opportunities for psychologists exist to improve palliative care for people living with dementia, including conducting capacity evaluations for participation in ACP, improving health literacy and palliative care literacy about the benefits and drawbacks of artificial nutrition and hydration, working with individuals and families in dyadic medical decision-making regarding infections and cardiac arrest, exploring values related to medical care and communication priorities, ethical assessments of pain, education regarding pain control, and spiritual care (Gupta & Patel, 2024; Weisbrod, 2022).

People with Disabilities

Studies reveal biases among medical providers who believed that people with significant disabilities have a lower quality of life than those without (Adam et al., 2020; Velepucha-Iniguez et al., 2022). Additional barriers among healthcare providers to address the palliative care needs of those with disabilities included their limited knowledge of palliative care, questions regarding a patient's appropriateness for the service, and questions of decisional capacity and the involvement of surrogate decision-makers. Communication factors may create barriers for patients (e.g., limited awareness of serious illness among those with profound disabilities) and providers (e.g., low rates of detection related to severity of disability and communication; not communicating information in ways accessible to the patient). In the US, deaf and hard of hearing people who primarily use American Sign Language (ASL) are at greater risk for chronic health disease compared with hearing people. This health disparity is driven in part by systemic inequities (e.g. lack of language-accessible informational materials, scarcity of competently-trained health care professionals, limited health literacy, non-concordant patient–provider communication, and limited availability of qualified interpreters) (Kushalnagar et.al, 2018).

Disability rights activists have advocated for increased sensitivity around medical decision-making and disability culture (Ne'eman et al., 2021). For example, clinical practice guidelines at the institutional level have little information applicable to those with intellectual disabilities and their healthcare providers, who may have limited knowledge of primary palliative care (Adam, et al., 2020; Velepucha-Iniguez et al., 2022). There remain few tools for detection of underlying emotional and psychological distress among persons with intellectual disabilities (e.g., anxiety, depression, grief). A systematic review of 52 studies revealed that most studies of palliative and hospice care for this population came from the United Kingdom, with an overall lack of direct feedback reflected in those studies from people with intellectual disabilities and families, and few strategies to improve their access to palliative care (Adam et al., 2020).

Sexual and Gender Minorities

LGBTQIA+ youth and adults report low utilization of healthcare services due to experiences of discrimination, provider bias, and fear (e.g., homophobia, transphobia), limited knowledge among patients and providers, and distrust of medical systems (Haviland et al., 2021). Barriers also include healthcare provider discrimination (e.g., withholding forms such as Advanced Directives to LGBTQIA+ adults), lack of psychological safety (e.g., heterosexist language/policies), family dynamics (e.g., strained relationships, estranged next of kin, hesitation asking friends to serve as surrogates), and systemic disenfranchisement (e.g., limited rights for same-sex couples, state statutes about default surrogate decision-makers) (Haviland et al., 2020). Barriers may be compounded further for minoritized individuals of intersectional group identities, including LGBTQIA+ people of color, and LGBTQIA+ people with disabilities. For

example, deaf LGBTQIA+ people who primarily use ASL are at risk for greater health disparity for medical conditions (e.g. lung disease, arthritis, mood disorders) compared with deaf non-LGBTQIA+ adults (e.g. non-disclosure of gender or sexual health-related information to healthcare providers because of concerns about anti-LGBTQIA+ stigma and discrimination (Kushalnagar & Miller, 2019).)

Financial Barriers

A major barrier to palliative care access across the lifespan is financing, namely insurance coverage, reimbursement policies, out-of-pocket costs, service eligibility, and public-private coverage disparities. Although access to palliative care has generally expanded, reimbursement mechanisms may be inadequate and limiting, particularly for rural-dwelling individuals or those who self-identify as Black, Indigenous, or People of Color, along with their families (Delgado-Corcoran et al., 2024; Dussault et al., 2025; Suntai et al., 2021). Palliative care and healthcare systems may be fragmented and uncoordinated, and the public has limited knowledge and awareness of palliative care (Masoud et al., 2023; Patel & Lyons, 2020). Similarly, primary care providers need suggestions on how to integrate palliative care into their practices (Hughes et al., 2023). Most hospitals and establishments offering palliative care services are housed in urban/metropolitan locations (CAPC, 2020), highlighting access issues in rural communities.

4. SETTINGS AND INTERPROFESSIONAL COLLABORATION

Palliative care is provided in multiple settings, ranging from a person's home (including foster or group homes), independent outpatient and inpatient care facilities (short-term, rehabilitation, acute, or long-term), inpatient hospice care homes, or via telehealth. Psychologists are rarely integrated in many of these settings. Social work and chaplaincy have a longstanding presence as disciplines within palliative care teams to address psychosocial and spiritual needs, whereas psychologists are often introduced only when specialized psychological interventions are needed by a person receiving palliative care. The inclusion of psychologists on palliative care terms, who have a long history of working in a variety of settings with people who have serious medical illness, will increase and enhance the care provided, given psychologists' expertise in assessment, treatment, team dynamics, quality improvement, and program evaluation. *Guidelines for Psychological Practice in Health Care Delivery Systems* (APA COPPS, 2025).
The addition of psychologists to interprofessional palliative care teams would enrich care outcomes by integrating psychological science and implementing psychological assessments and interventions. Psychologists add a deep understanding of the ways in which mental health syndromes intersect with medical conditions and provide unique expertise in assessing capacity for decision making, mood, personality, cognition, and family dynamics, all of which may influence a patient's or families' experience. Psychologists bring a lifespan developmental and socioemotional focus that can place a patient in context for other team members and have competency in developing, evaluating, and administering evidence-based treatments for nonpharmacological interventions for physical symptoms.

Psychologists also could contribute to interprofessional team functioning by supporting patient-provider communication and reconciling varying needs and perspectives in creating a culture of trust (Foo et al., 2024). Greater team support may foster better emotional adjustment among team members, a higher degree of effective collaboration, and stronger relationships among patients, caregivers, and healthcare providers (Bergenholtz et al., 2020). Psychologists may

enhance communication given their understanding of group dynamics and social theories.

Telehealth delivery of palliative care would increase access for rural and other disadvantaged groups. A recent systematic review of 112 English-language articles on palliative care telehealth published between January 1, 1980, and July 25, 2024, indicated focus on telecoaching, an e-health app to monitor symptoms, and e-consultation (Hutchinson et al., 2025). Two-thirds of studies were published since 2020, but few focused on patient outcomes. In a review of 18 studies using PRISMA methodology in seven countries across five continents, videoconferencing was the typical modality for palliative telehealth, and most studies involved oncology patients (Gordon et al., 2022). Studies primarily focused on the structure or process of care delivery and symptom management, with few addressing spiritual, cultural or ethical concerns, particularly at the end of life. Moreover, quality metrics indicated study methodologies were poor as they rarely included control groups. In nursing homes, a scoping review of 11 articles found preference for live video as the preferred telehealth delivery modality, with five family and patient-centered themes of symptom management, ACP, quality of life, healthcare use and evaluation of care (Walton et al., 2023). Benefits included increased goals of care discussions and documentation with diminished acute care use, whereas challenges included technological difficulties and increased financial burden to nursing homes.

Despite the ways in which psychologists may improve palliative care delivery in integrated teams across practice settings, there are longstanding obstacles to the full integration of psychologists on palliative care teams, including limited workforce training in palliative care (Domino et al., 2019). Other barriers include limited insurance coverage and reimbursement structures, and hospital or healthcare system infrastructure. Because specialty mental health providers are not routinely included in palliative care teams (O'Malley et al., 2021), physicians providing palliative care reported that they had limited access to mental health providers, were unsatisfied with mental health training opportunities despite frequently encountering psychiatric comorbidities that they might be less comfortable managing (Shalev et al., 2024). These conditions included substance use disorders, suicidality, psychotic disorders, and personality disorders.

5. EDUCATION AND TRAINING

Education

Although educational opportunities in PEOL are underdeveloped before internship or postdoctoral training, evidence suggests students benefit from experiential learning opportunities in a palliative psychology research lab during their undergraduate studies (Hoerger, 2022). Death and dying topics are increasingly included as part of undergraduate psychology curriculum globally (Biancalani et al., 2023), as training to tolerate and manage death, dying, and bereavement concerns is a necessary pre-requisite for ethical practice in grief work (Gamino & Ritter, 2012). Such opportunities provide undergraduate early exposure-level training to the role of psychologists in palliative care. Some psychology graduate programs (e.g., US, Spain) have begun to embed palliative care content into their curricula. Leaders in palliative care have called for a national strategy to address policy and practice barriers to national adoption of interdisciplinary education and training guidelines that include psychology in the US (Meier et al., 2017; Testoni et al., 2022). Such strategies may be particularly appealing to women, as even

though psychology is a majority-female discipline, women and early-career psychologists often face additional barriers to entering palliative care including family responsibilities and gender and experiential inequities in academic medicine. More mentorship, leadership development, and equitable workforce policies are needed in palliative care settings to support all students and early career psychologists, including women psychologists, in pursuing palliative care careers.

Generally, few systematic efforts exist to educate psychologists about PEOL outside of the Veterans Health Administration (VHA) where veterans receive palliative care services as part of their veterans benefits, and a few academic medical centers (Abramson, 2022; Feldstain, 2024; Foo et al., 2024; Kasl-Godley et al., 2014). However, PEOL knowledge and skillsets are relevant for professional psychologists in most healthcare settings (e.g., health psychology, rehabilitation psychology, geropsychology, pediatric psychology, and neuropsychology). Early career psychologists increasingly forego specialized fellowship training (APA Workforce Center, 2021), making it crucial to identify and promote knowledge and experience through continuing education opportunities (e.g., APA webinars), as well as skills-based training opportunities and collaboration with and mentoring from palliative care physicians and social workers.

Although psychological issues such as grief, pain, and fatigue are core practice domains in palliative care, psychologists remain largely absent from professional work groups involved in developing these competencies (Ferrell et al., 2018). However, competencies for adult palliative and EOL care are embedded within Geropsychology competencies (APA, 2024; Karel et al., 2010).The Council of Professional Geropsychology Training Programs (CoPGTP) recommends an exposure level of training in EOL care for any psychologist who serves older adults, whether these professionals identify as geropsychologists, specialists in other areas, or generalists (Hinrichsen et al., 2018).

Since providing care to someone nearing the end of life could involve significant uplifts (Johannesen et al., 2023) and potential for psychological, physical, and economic strain (Gardiner at al., 2019; McAndrew et al., 2024), it is strongly encouraged that PEOL education and training include foundational and functional competencies in working with families and caregivers (Feldstain, 2024). Accreditors are encouraged to consider the inclusion of death and dying content standards for graduate coursework in psychology, as this content is not currently a required component in most professional psychology graduate programs, either through didactics or experiential learning (Feldstain, 2024; O'Malley et al., 2021). It is crucial to educate psychologists at all training levels about the difference between palliative and hospice care in relation to the timeframe of service, insurance coverage, goals of care among patients and caregivers, stigma, and cultural implications. Training on healthcare navigation and best practices to promote health literacy related to PEOL are critical to psychologists in guiding individuals and caregivers through EOL decision making, especially among those from minoritized/marginalized populations.

Assessment

Psychologists have specific professional strength in assessment. Relevant to PEOL are clinical interviewing, cognitive/personality evaluation, functional/behavior analysis, and observation. Much research on palliative care assessment focuses on adults and physical symptoms of

imminent death, communication among hospice team members, and when to notify family members (Lee et al., 2021). In the *Assessment Tools for Palliative Care*, Aslakson's (2017) workgroup identified 152 tools organized into eight domains from the National Consensus Project Clinical Practice Guidelines for Palliative Care. Despite this comprehensive compendium of measures, key assessment gaps exist. Few tools were included that measure 1) structure and process, 2) cultural, ethical, and legal domains, 3) spiritual experiences, and 4) patient-reported experiences. Measures such as the Palliative Performance Scale (PPS), modified based on the Karnofsky Performance Scale, are often used to assess a patient's overall status and functionality (Baik et al., 2018) to guide treatment decisions, monitor progress, enhance communication, guide EOL care, and identify ways to maintain or improve quality of life .

Another comprehensive measure is the Palliative Distress Inventory-Revised (Rossi et al., 2022), a psychometrically-sound measure of psychological distress encouraged for use with oncology patients in clinical settings. It has measurement equivalence for men and women and for those less than or greater than 65 years of age. Because PEOL issues include caregiving stress and burden and bereavement care, equally important are measures related to caregiver burden, anticipatory grief, and complicated and prolonged grief, such as the CAREPAL-8, a multidimensional screener of family caregiver burden in palliative care (Ullrich et al,, 2024), and the PG-13 Revised Scale for prolonged grief (Prigerson et al., 2021). In addition, psychosocial constructs such as mental health and wellbeing, two unique but overlapping constructs, also need to be measured in palliative and EOL care on a more regular basis.

Intervention

Psychologists have specific professional competency in the implementation of evidence-based Interventions, especially in health care delivery systems (APA COPPS, 2025). Much of the research on palliative care intervention has focused on pain management, feeding and hydration, and other medical and medication interventions (Huffman & Harmer, 2023). In recent years, there is an increasing emphasis on the role of applied psychological intervention in palliative care (Feldstain, 2024) because nonpharmacological and behavioral interventions are effective for relief of distress from physical symptoms such as dyspnea and pain. Management of spiritual, emotional, and social suffering is also important to the management of physical symptoms in EOL care, highlighting the need for psychological interventions (Feldstain, 2024).

Psychological contributions in palliative and EOL care include interventions designed specifically to address common issues (e.g., hopelessness, feelings of burden, loss of dignity, death anxiety, depression, and measures of positive psychological experience such as meaning in life) in a holistic manner, namely Dignity Therapy (Chochinov, 2012), meaning-making creative activity dyadic interventions such as Legacy Intervention Family Enactment (LIFE; Allen et al., 2014; Allen et al., 2016), and Meaning-Centered Psychotherapy (Rosenfeld et al., 2017; Saracino et al., 2019). Other evidence-based psychotherapies could be adapted to address anxiety, depression, and trauma within EOL care for people living with advanced serious illness, their caregivers, and palliative care staff, namely cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), and other mindfulness-based interventions (Abramson, 2022; Feldstain, 2024; Gibson Watt et al., 2023). These interventions could be adapted to address spiraling thoughts about death, negative emotions such as fear and shame, physical symptoms such as pain (e.g., ACT for chronic pain; Ye et al., 2024) and fatigue, and social withdrawal and aggression that may

occur towards the end of life (Beck & Fleming, 2021).

To address caregiver stress and long-term psychological outcomes, evidence-based psychological interventions such as meaning-making interventions may improve caregiver's wellbeing by increasing meaning in life and reducing existential distress (Allen et al., 2014; McAndrew et al., 2024). Other interventions for families and caregivers seek to address grief, psychoeducation around the dying process and procedures, and conversations on how to address ACP (Kishino, 2022). Because palliative care patients' caregivers, especially working caregivers, are at risk for experiencing increased burden and economic strain, burnout prevention may involve additional support and interventions from employers to accommodate caregiving needs (Bijnsdorp et al., 2022). As grief is embedded throughout all phases of EOL care, anticipatory grief interventions help to address separation anxiety, anticipation of loss, denial, and relational issues for care patients and their families or caregivers (Coelho et al., 2018). Because up to 25% of caregivers of palliative care patients experienced prolonged grief (Ribera-Asensi et al., 2025), grief-focused CBTs, namely Prolonged Grief Therapy (Shear & Gribbin Bloom, 2017), would appear beneficial (Komischke-Konnerup et al., 2024).

Abuse, Neglect, Exploitation, and Trauma

Psychologists have expertise in addressing and working with the effects of abuse, neglect, exploitation, and trauma across the lifespan (APA, 2025). Individuals nearing the end of life, especially those with other identities that present with vulnerabilities, may be at increased risk for abuse and neglect at home and in care settings. Abuse may include physical and sexual abuse, neglect of basic needs, and financial exploitation among older adults in nursing homes (Myhre et al., 2020). Children receiving pediatric palliative care may experience medical neglect in addition to other forms of childhood abuse (Cleveland et al., 2021; Levy et al., 2019). Older women and women with disabilities may also be at heightened risk of abuse and neglect by caregivers and in institutional settings (UN Women, 2022; Walter et al., 2024).Outside of the context of direct abuse and neglect, there is increasing recognition that medical events preceding admission into palliative and hospice care may constitute traumatic experiences for patients and families (Ganzel, 2018). Gender-based violence and trauma histories can resurface at the end of life through late onset post-traumatic stress disorder, impacting trust and decision-making (Ramos et al., 2022). Later-adulthood trauma reengagement may stem from multiple neurobiological pathways, including decreased cognitive reserve and increased search for meaning and life-narrative coherence (Smid et al., 2022). These changes may dovetail with recently experienced medical traumas and greatly amplify the need for trauma-informed palliative care (Mydin et al., 2021). As such, trauma-informed and gender-sensitive psychological care nearing the end of life are crucial.

6. RESEARCH AND ADVOCACY

Much of the psychology research on palliative care has focused on psychological interventions for adults receiving care. Despite the documented unmet psychological needs of palliative care patients (Antunes et al., 2020), recent meta-analyses revealed significant gaps surrounding psychological care in palliative care settings, with most multicomponent palliative care interventions showing no effect on psychological distress (Nowels et al., 2023). Psychological care in palliative care research and practice is highly variable and infrequently includes evidence-based strategies (Kozlov et al., 2018) despite the psychological and psych-oncological sciences

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demonstrating many effective mental health interventions for seriously ill patients and their caregivers (Lichtenthal et al., 2024; Rodin et al., 2020; Schweighoffer et al., 2022).

Current Trends and Future Directions

Psychological research in decision science is highly relevant to ACP and during acute medical circumstances. However, there is a research gap and a significant need to explore the social and psychological factors influencing decision-making related to PEOL, such as spiritual and cultural beliefs of the individual nearing the end of life, their families and healthcare providers, as well as family dynamics and decisional capacity. Importantly, psychologists' own bias and beliefs about death and dying may shape our knowledge about palliative care and related research priorities (Chiew et al., 2025).

An important area of research to advance psychological intervention in PEOL contexts are factors that impact the mental health of individuals adjusting to serious illness and loss including loneliness and social isolation (Maciejewski et al., 2022). In addition to effectiveness, studies now explore the feasibility, accessibility, and long-term outcome of interventions designed to reduce depression, anxiety, and existential distress that are often prevalent in individuals and caregivers needing palliative care; and support meaningful transformation, spiritual care, and meaning making at the end of life. Additionally, multicomponent palliative care interventions need to be reexamined, with an emphasis on refining those approaches that have shown little or no effect and identifying strategies that may exacerbate psychological distress.

Psychedelic-assisted psychotherapy and MAiD are two topics that warrant further psychological research because of growing interests in these options, as well as increasing interest in prescriptive authority among psychologists. Psychedelic-assisted psychotherapy has consistently reduced death anxiety and end of life anxiety in cancer patients (Kim et al., 2024; Ross et al, 2022). Psilocybin, a psychedelic, has been legalized in Oregon since 2020. Research on MAiD has primarily focused on demographic factors associated with pursuing MAiD and clinician attitudes about MAiD (Becker et al., 2024; Kozlov et al., 2025). More research on MAiD is essential to understanding the role and influence of psychological care within the EOL healthcare landscape. Psychological research is also vital to increase funding and support for PEOL behavioral and psychological sciences, integration of PEOL didactic and experiential content into psychology education and training, support for integrating palliative care into current professional psychology practice, and policy efforts to maintain and improve access to timely palliative care and interprofessional collaboration.

IN SUMMARY,

1. **Whereas** psychologists have many areas of competence including, but not limited to, assessment, intervention, teaching, consultation, research, and advocacy skills that could contribute to the science of PEOL and to the treatment and support of people with advanced serious illness, their families, caregivers, and other health care providers;

2. **Whereas** psychologists embrace and elevate ethical practice in palliative care, including addressing important decisional capacity concerns and policy considerations that impede equitable access to palliative care;

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3. **Whereas** psychologists recognize the critical need to provide palliative care across the lifespan in diverse populations and communities the experiences of which are not always directly informing palliative care research, practice, and policy priorities;

4. **Whereas** psychologists contribute to interprofessional team functioning across many settings in palliative care, including telehealth, by integrating psychological science, assessments and interventions, and by increasing health literacy and awareness of issues related to palliative care among patients and families in pediatric, adult, and geriatric care;

5. **Whereas** psychologists could assume a significant role in the education and training of trainees, practicing psychologists across the career span, and other healthcare professionals through understanding of assessment, intervention, and approaches to abuse and neglect within PEOL settings;

6. **Whereas** psychologists and psychological science have contributed to the development, evaluation, and dissemination of evidence-based psychological interventions in palliative care, and have contributed to theories in decision science that are relevant to advance care planning and during acute medical circumstances.

THEREFORE, be it resolved that the American Psychological Association:

1. Encourage psychologists' participation in national, state, and local interdisciplinary efforts to inform the development of policy and standards for palliative care and end-of-life issues to advocate for public policy initiatives that promote understanding and availability of the continuum of palliative care in all treatment settings, for all populations.

2. Advocate for improved palliative care policies and reimbursement mechanisms through Medicare, Medicaid, and private insurers to ensure the sustainability of psychological services in palliative care settings across the lifespan. This includes public and private financial support for psychology and interprofessional training in palliative care and end-of-life issues at the undergraduate, graduate, pre- doctoral, internship, postdoctoral, and post-licensure level.

3. Encourage psychologists to be familiar with the impact of individual, social, system characteristics, and intersectionality that contribute to health disparities and affect palliative care access and quality, and advocate for the inclusion of palliative care patient and caregiver experiences, especially from marginalized populations, in shaping psychological care, research agendas, training curricula, and policy development.

4. Support integration of psychologists into interprofessional palliative care teams by encouraging psychologists to:
    a. Familiarize themselves with ways to navigate complex healthcare systems and the roles and competencies of, and clinical care provided by, medical, social work, nursing, chaplaincy and others related to EOL issues, decision making, and care.
    b. Provide support and training to other healthcare professionals about psychological

determinants of health that impact access to and quality of palliative care.

c. Support the dissemination and implementation of evidence-based psychological interventions to address physical and psychological symptoms that arise in serious illness, effectively integrating these interventions for individuals, families/ caregivers, and healthcare professionals into the existing palliative care infrastructure.

5. Support development and implementation of education and training within psychology in the areas of palliative and EOL care across the educational/vocational span through didactic and experiential content, including telehealth initiatives, in:

a. Encouraging undergraduate and graduate psychology curricula to include death, dying, and EOL issues.

b. Encouraging the offering of continuing education programs and lifelong consultation/mentoring opportunities for psychologists to increase access to psychological services for individuals near the end of life and their families;

c. Encouraging the offering of palliative care skills-based workshops, on palliative care assessment, specific interventions for addressing existential distress at the end of life, and a key sign of abuse that may go unnoticed among those receiving palliative care.

d. Engaging in community outreach, in-service training, and consultation to paraprofessional and peer support specialists to increase the availability of palliative care services in person or via telehealth to increase access issues in communities where very few or no psychologists are present.

6. Promote the scientific exploration and prioritization of well-designed interdisciplinary and team-based studies:

a. Exploring how social marginalization, health disparities, and stigmatization affect EOL decision making and psychological distress.

b. Conducting research on interdisciplinary palliative care team compositions/ structures that include psychologists to deliver comprehensive palliative care, effectively addressing physical, behavioral, existential, and psychological needs, and addressing systemic barriers that keep psychologists from being a formal part of palliative care teams.

c. Discovering the most pragmatically efficacious methods for implementing evidence-based psychological treatments within palliative care settings (e.g., psychedelic-assisted psychotherapy) and exploring patient-centered delivery systems for psychological telehealth.

d. Examining the role of psychological care in decisions and preferences regarding MAiD among patients, families, and healthcare providers, to have more data backed by psychological science to support the development of ethical frameworks, culturally-responsive practices, and clinical guidelines for psychologists working in jurisdictions where MAiD is legal.

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B.(10) Council voted to archive the following *1996 Resolution on Sexuality Educ*ation:

Resolution on Sexuality Education

Whereas American youth are exhibiting behavior leading to increasing rates of life-threatening or health-compromising sexually transmitted diseases that in part reflect ignorance of sexual health promoting behaviors (National Guidelines Task Force, 1991);

Whereas youth infection with HIV/AIDS has reached an epidemic level, particularly among young gay men and ethnic minority youth (National Commission on AIDS, 1993), in part because of lack of knowledge and lack of training about protective behaviors;

Whereas children are becoming involved in sexual activities at younger ages (Ravoira & Cherry, 1992; Singh & Wulf, 1990);

Whereas over one million teenage women become pregnant annually (National Guidelines Task Force, 1991) and approximately 300,000 of these teenagers become homeless or runaways or both (Ravoira & Cherry, 1992);

Whereas the prevalence of sexual intercourse appears to be higher among youth who did not receive sexuality education (Furstenberg & Crawford, 1986);

Whereas youth whose sexual orientation or whose values, beliefs, and practices differ from those deemed acceptable by many in our society are subject to persistent, subtle, or overt harassment and violence which may lead to suicide (Schaecher, 1988);

Whereas youth with a physical or mental disability may be more vulnerable to sexual coercion;
Whereas stranger rape, date rape, sexual abuse, and other forms of sexual violence are traumatic events that have become increasingly prevalent (Koss et al., 1994);

Whereas sexual health, personal self-esteem, and the ability to participate in responsible, caring, and stable relationships, as well as to develop positive interpersonal social attitudes can be promoted through education (Gordon & Schroeder, 1995);

Whereas the American Psychological Association has a necessary and important role in influencing public policy to the benefit and protection of youth in particular and the society in general;

Resolution

Therefore be it resolved that the APA supports access to information on sexuality as critical to healthy development. Such information should be positive, age appropriate, and culturally suitable, and should respect the choice of abstinence; it should acknowledge women's rights, should foster shared responsibility among males and females for sexual behaviors, and should promote tolerance for sexual diversity; and

Therefore be it resolved that APA public policy support the development and adoption, including research and evaluation, of such comprehensive sexuality education curricula and programs for the promotion of healthy sexual attitudes and behaviors and the prevention and mitigation of endangering and destructive behaviors. It is to be noted that this resolution does not endorse any particular curriculum, procedure, or site for instruction[, but seeks to promote a choice of means for implementing this resolution].

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Council also voted to adopt as APA policy the following *2026 Resolution on Sexual Health Education in Youth*:

Resolution on Sexual Health Education in Youth

Sexual health, personal self-esteem, and the ability to participate in responsible, caring, and stable relationships, as well as to develop positive interpersonal social attitudes, can be promoted through education (Goldfarb & Lieberman, 2021;Bouris et al., 2016; The Trevor Project, 2023). Developmentally appropriate and comprehensive, positive, and inclusive sexual health education e.g. including but not limited to sexual health, bodily autonomy, personal boundaries, and consent for touch from early childhood onward is crucial for the mental, physical, and emotional well-being of youth; more attention is needed to address sexual and gender minoritized youth that are often

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overlooked (e.g., Goldfarb & Lieberman, 2021). Intentional focus on equity in sexual health education (e.g. sexual health education includes cultural responsiveness, contextual relevance, and the inclusion of diverse lived experiences across intersecting identities) helps eliminate racial gaps and contributes to lowered risks of negative outcomes (Lindberg & Kantor, 2022).

WHEREAS the World Health Organization considers sexual health a fundamental human right (World Health Organization 2019; 2024); sexual health is not merely the absence of disease or dysfunction, but also includes the possibility of pleasurable, safe, and affirming sexual experiences across the lifespan. When developmentally appropriate, individuals have the right to determine if, when, and how often they attempt to reproduce (Bhana et al., 2024), as well as receive education about this in a developmentally appropriate manner;

WHEREAS the quality or existence of sexual health education varies widely by state and country which leads to disparities in the dissemination of medically accurate and inclusive, sexual health information (Breuner et al., 2016; Henry J Kaiser Family Foundation, 2018), although there are evidence-based sexual education guidelines (Future of Sex Education Initiative, 2020);

WHEREAS parents/caregivers and families play an essential role in having positive and open conversations about sexual health education (e.g., Ashcraft, A. M., & Murray, 2017), although it may not be safe for children and adolescents to have these conversations in all families due to differing familial attitudes and cultural beliefs. Thus, alternative supportive and educational resources (e.g., schools, healthcare providers, and community programs) play a critical role for youth who are unable to rely on family-based discussions;

WHEREAS access to universal comprehensive and inclusive sex education is insufficient, and youth are inundated with information about sex and relationships from many sources (e.g., peers, providers, and families), much of which is inaccurate and not inclusive (e.g., Breuner et al., 2016). Additionally, information about sexual health is readily available online, often consumed by adolescents, and can be low quality, unreliable, and difficult to understand (von Rosen et al., 2017; Buhi et al., 2010) and is at times directly harmful;

WHEREAS comprehensive sexual health education can improve knowledge and reduce high-risk behaviors among youth, it often lacks relevance for gender and sexual minority youth leading to poor health outcomes for these individuals (Rabbitte, 2020), and program outcomes can differ among racial/ ethnic groups, exacerbating disparities (Merrit et al., 2024);

WHEREAS healthy relationship development is critical for adolescents' social-emotional well-being. Furthermore, healthy romantic relationships in adolescence have positive implications for adulthood (e.g., Araya et al., 2021; Collins et al., 2009; Roach, 2018);

WHEREAS sexual development, sexuality, and engaging in sexual behavior is normative and developmentally appropriate for many youth, and positive, affirming, comprehensive sexual education promotes numerous positive outcomes such as sexual well-being, health, and positive intimacy (e.g., Breuner et al., 2016; Goldfarb & Lieberman, 2021; Harden, 2014);

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WHEREAS sexual well-being for adolescents, which includes domains such as sexual self-esteem and self-efficacy, sexual satisfaction and pleasure, and freedom from sex-related pain and mental health difficulties (e.g., Goldfarb & Lieberman, 2021; Harden, 2014), is promoted by positive, affirming, and inclusive approaches to sexual health education;

WHEREAS technology use (e.g., cell phones, social media, phone apps, messaging servers) significantly impacts and elevates sexual risk-taking behaviors among youth (Herbenick et al., 2023; Wright et al., 2023); To promote healthy relationships and sexuality, education should include information about the safe and responsible use of as well as risk of technology and encompass guidance on social media use, online AI chatbots, deepfakes, pornography and pornography literacy, use of dating apps, safe sexting, and digital literacy training (Patchin & Hinduja, 2020; APA, 2019);

WHEREAS many trends of youth sexual behaviors differ by demographic factors and variations by race, gender, or access to sexual education, reflecting inequities in resources, policies, and lived experiences (Centers for Disease Control and Prevention, 2023). For example, the age of onset of sexual activity has decreased over time, with age of onset varying across identities including a child's race, gender, and access to sexual education (Lindberg et al., 2019; Lindberg & Kantor, 2022);

WHEREAS all persons progress through developmental milestones relating to sexuality, identity development, and relationships, including children and adolescents of all identities and backgrounds, and deserve access to evidence-based information about sexual health and development that acknowledges the impact of institutions and policies on sexual well-being (e.g., Breuner et al. 2016);

POTENTIAL CONSEQUENCES OF INSUFFICIENT SEXUAL HEALTH EDUCATION

WHEREAS increasing rates of life-threatening or health-compromising sexually transmitted infections (STIs) in part reflect a lack of medically accurate, inclusive, sexual health education (Abma & Martinez, 2023; Centers for Disease Control and Prevention, 2023). These disparities reflect inequities in access to prevention, testing, culturally responsive care, and broader social and structural conditions.

WHEREAS youth infection with HIV/AIDS remains a concern, and many youth are unaware of their health status, there is a higher likelihood of underdiagnosis of HIV/AIDS among youth, condom use has declined among teenagers, and Black youth are disproportionately represented among new infections (Centers for Disease Control and Prevention, 2023, 2024);

WHEREAS sexual violence, such as rape, sexual abuse, non-consensual sharing of explicit images, and other forms of non-consensual sexual encounters, are traumatic events that have become increasingly prevalent among youth (Clayton et al., 2023; Leemis et al., 2022; National Sexual Violence Resource Center, 2019), with even higher prevalence among LGBTQ+ youth (Williams & Gutierrez, 2022);

WHEREAS teen pregnancy has generally been decreasing since 2007, the United States continues to have more teenage pregnancies compared to other developed countries, with over 143,000

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American teenage pregnancies annually, and with youth of color most often represented in these numbers (Abma & Martinez, 2023; Osterman et al, 2025.);

CONCERNS AND ISSUES FOR MINORITIZED YOUTH

WHEREAS rates of sexual activity, teen pregnancy, STI testing, and contraceptive use vary by demographic and family characteristics (Abma & Martinez, 2023; Makrides et al., 2025; Osterman et al., 2025), highlighting that disparities faced by youth of color, such as lower rates of receipt and lower quality of sexual health services, may be attributed to systematic barriers shaped by structural racism, including provider discrimination, lack of culturally responsive sexual health education programs, and limited systemic reform (e.g., Makrides et al., 2025; Merritt et al., 2024; Parekh et al., 2023);

WHEREAS pregnant youth are at risk of becoming unhoused due to leaving home, being kicked out of their home, or running away (Fernandes-Alcantara, 2019);

WHEREAS sex education continues to pathologize and silence the lived experiences of minoritized sexual and gender minority youth through a heteronormative and cisnormative lens (Clonan-Roy et al., 2023; Marchia et al., 2019), despite substantial research illustrating the harm caused by heteronormative sexual education (e.g., shame, depression; de Heer et al., 2021);

WHEREAS transgender and nonbinary youth must navigate identity development and sexual development and health alongside safety, limited affirming spaces, and harmful politics, and the limited availability of queer-inclusive sexual education can be unhelpful and marginalizing (e.g., Goldfarb & Lieberman, 2021; Warwick et al., 2022);

WHEREAS youth whose sexual orientation, gender identity, or whose values, beliefs, and practices differ from those deemed acceptable by societal norms are subject to persistent, subtle, or overt harassment and violence that may lead to suicide (Bouris et al., 2016; The Trevor Project);

WHEREAS LGBTQ+ youth experience higher rates of sexual and dating violence (Williams & Gutierrez, 2022), which has been linked to restrictive sexual education policies (e.g., Murchison et al., 2019);

WHEREAS youth with physical, mental health or developmental disabilities may be more vulnerable to sexual coercion compared to youth without disabilities (Christofferson, 2022; Elklit et al., 2023; & Mailhot Amborski et al., 2022); they are also less likely to receive sexual health education (Colarossi et al., 2023);

WHEREAS the American Psychological Association (APA) has necessary and important role in educating the public and influencing policy to the benefit and protection of youth and society in general;

THEREFORE, BE IT RESOLVED that the APA supports access to comprehensive information on sexual health as a critical aspect of healthy youth development in the context of educational settings, pediatric healthcare programs, community-based youth programs, and social service agencies for

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youth and families. Such information should be evidence-based, as well as positive, age and developmentally appropriate, and culturally suitable as a means to allow youth to make informed decisions on engaging in sexual behavior or abstinence; it should promote the rights of all individuals, foster shared responsibility among all youth for healthy and safe sexual behaviors, and acknowledge and normalize the existence of sexual diversity.

THEREFORE BE IT FURTHER RESOLVED that the APA supports programs that include comprehensive, developmentally appropriate, and medically accurate sexual health education for all youth and parents; education should be tailored to diverse racial, gender, ability, and cultural contexts, as well as specifically addressing the needs and experiences of minority sexual and gender communities. This education should promote acceptance and inclusion and provide a safe and supportive learning environment where youth, regardless of gender or sexuality, are encouraged to develop healthy and positive attitudes toward sexuality.

THEREFORE BE IT FURTHER RESOLVED that the APA underscores the value of the provision of accurate information by professionals in addition to educating caregivers and families to engage in non-judgmental conversations with their children when it is safe. Caregivers should have easy access to evidence-based information to support ongoing, safe, and healthy discussions about sexual health and behavior at home. It is important to involve and notify parents in these discussions.

THEREFORE BE IT FURTHER RESOLVED that the APA supports the development and adoption of policies, including research and evaluation, of such comprehensive sexual health curricula and programs, for the promotion of healthy sexual attitudes and behaviors and the prevention and mitigation of endangering and health-interfering behaviors. It is to be noted that this resolution does not endorse any particular curricula, procedure, or site for instruction, but seeks to promote a choice of means for implementing this resolution.

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C.(11) Council voted to archive the following *2007 Resolution on Anti-Semitic and Anti-Jewish Prejudice*:

APA Resolution on Updating 2007 Resolution on Anti-Semitic and Anti-Jewish Prejudice

WHEREAS prejudice and discrimination based on religion have caused untold human suffering throughout recorded history; and

WHEREAS anti-Jewish hostility, usually called anti-Semitism, has taken various forms over the centuries and has been perpetrated by many groups throughout history (Allswang, 1985); and

WHEREAS the intense prejudice, discrimination and hatred that grew out of long-standing anti-Semitism led to the Holocaust, perpetrated in Europe by the Nazis in the 1940s, which eventuated in the brutal annihilation of six million Jews (Charney, 2000); and

WHEREAS anti-Semitic acts of violence in the United States are increasing alarmingly, with 1,821 reported in 2004, the highest level in nine years and an increase of 17% over the number reported in 2003 (Anti-Defamation League, 2005); and

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WHEREAS "The increasing frequency and severity of anti-Semitic incidents since the start of the 21st century, particularly in Europe, has compelled the international community to focus on anti-Semitism with renewed vigor" (U.S. Department of State, 2004); and

WHEREAS the United States Congress has approved the Global Anti-Semitism Awareness/Review Act, which acknowledges a disturbing increase in anti-Semitism and establishes an office in the State Department to monitor and combat anti-Semitism worldwide (U.S. Department of State, 2004); and

WHEREAS the 2005 Survey of American Attitudes Towards Jews in America by the Anti-Defamation League found that 14% of Americans or nearly 35 million adults, hold views about Jews that are "unquestionably anti-Semitic" (Anti-Defamation League, 2005); and

WHEREAS much anti-Semitism today takes the form of "modern" or “new” anti-Semitism, in which actual bias against Jews is denied while prejudiced attitudes exist and discriminatory statements or acts are engaged in (Anti-Semitism Worldwide, 2004); and

WHEREAS this form of anti-Semitism may be more difficult for its perpetrators to identify and challenge, as their beliefs about themselves may be that they are not biased against Jews (Gaertner & Dovidio, 1986); and

WHEREAS this form of anti-Semitism may be asserted in the context of discourse regarding the actions of the Government of Israel, thus further disguising the anti-Semitic nature of the discourse (Anti-Semitism Worldwide, 2004); and

WHEREAS the link between extreme anti-Israel rhetoric and deeds directed against Jewish individuals and communities has become an observable global trend and has at times unleashed demonization and dehumanization of Jews; (Anti-Semitism Worldwide, 2004); and

WHEREAS every anti-Semitic act creates a climate of fear, anxiety and insecurity, both for the individual and the community; as such therefore, Jews are exposed to suffering the feelings of vulnerability, anger, depression and other sequelae of victimization (Crandall & Eshleman, 2003; Valent, 2002); and

WHEREAS anti-Semitic acts also harm the perpetrators by desensitizing them to violence, and raise concerns about their generalizing such acts to other groups (Crandall & Eshleman, 2003; Ezequiel, 1995, 2002; Staub, 1990, 2005); and

WHEREAS the American Psychological Association has recognized the profound psychological consequences of hate crimes motivated by prejudice (APA Council of Representatives, 2005); and

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WHEREAS the American Psychological Association opposes prejudice and discrimination based upon race, ethnicity, religion, sexual orientation, gender, gender identity or physical condition (American Psychological Association, 2002); and

WHEREAS as psychologists we respect the dignity and worth of all people and are committed to improving the condition of individuals, organizations, and society, we are aware of and respect cultural, individual, and role differences among individuals, including (but not limited to) those based on ethnicity, national origin, and religion (American Psychological Association, 2002); and

WHEREAS psychologists recognize and protect civil and human rights and strive to help the public develop informed judgments and choices concerning human behavior:

THEREFORE BE IT RESOLVED, that the American Psychological Association condemns all anti-Semitic attitudes and actions, both overt and covert, and will use its influence to promote fairness, respect, and dignity for all people, regardless of religion or ethnicity, in all arenas in which psychologists work and practice, and in society at large.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association will take a leadership role in opposing anti-Semitism.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association encourages all psychologists to act to eliminate all discrimination of an anti-Semitic nature.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association encourages research to better understand the characteristics, causes, and consequences of both overt and covert anti-Semitic and Anti-Jewish prejudice.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association will include appropriate information on anti-Semitism in its multicultural and diversity training material and activities, and that diversity and multicultural efforts will take cognizance of anti- Semitism, whether subtle or not, and will attempt to overcome it.

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Council also voted to adopt as APA policy the following *2026 Resolution on Antisemitism*:

Resolution on Antisemitism (2026)

WHEREAS prejudice and discrimination has caused untold human suffering throughout recorded history; and

WHEREAS anti-Jewish hostility has been perpetrated by many groups throughout history (United Nations, 2019) and was a central factor in the perpetration of the Holocaust in Europe by the Nazis in the 1940s, which eventuated in the brutal annihilation of six million Jews (e.g., Charney, 2000); and

WHEREAS multiple contemporary definitions of antisemitism all share the recognition that antisemitism involves hostility, prejudice, discrimination, harassment, hatred, or violence against Jews as Jews (International Holocaust Remembrance Alliance, (n.d.); Jerusalem Declaration on Antisemitism, (n.d.); Nexus, (n.d.); T'ruah: The Rabbinic Call for Human Rights, (n.d.)); and

WHEREAS antisemitic acts of violence in the United States and around the world have increased dramatically since the Hamas-led attacks of October 7, 2023 and Israel's invasion of Gaza that followed (Institute for Economics & Peace, 2025; Vision of Humanity, 2025); and

WHEREAS many college campuses have become sites of heightened debate, tension, and conflict since the October 7, 2023 Hamas-led attacks and Israel's subsequent assault on Gaza, creating intense tension between the need to counter antisemitism, while safeguarding principles of free speech (APA, 2025; Mazower, 2025); and

WHEREAS there is broad agreement that, in regard to the state of Israel, it is antisemitic to hold Jews collectively responsible for the actions of the state of Israel; to require Jews to publicly condemn Israel; to assume that Jews are more loyal to Israel than to their home countries; and

to deny Jews in Israel/Palestine the right to exist and flourish as Jews on the basis of legal equality (e.g., International Holocaust Remembrance Alliance, (n.d.); and

WHEREAS the weaponization of antisemitism — the manipulative or bad faith invocation of accusations to silence legitimate criticism, scholarship, or activism — creates significant adverse consequences for Jews and non-Jews who oppose the state of Israel's actions and support Palestinian rights (Mann & Yona, 2025; Stern, 2019); and

WHEREAS every antisemitic act creates a climate of fear, anxiety and insecurity, both for the individual and the community; as such, Jews are exposed to suffering from feelings of vulnerability, anger, depression and other sequelae of victimization (e.g., Altman et al., 2010; Bowers & Yehuda, 2016; Valent, 2002); and

WHEREAS antisemitic acts also harm the perpetrators by desensitizing them to violence, and raise concerns about their generalizing such acts to other groups (e.g., Crandall & Eshleman, 2003; Ezequiel, 1995, 2002; Staub, 1990, 2005); and

WHEREAS the American Psychological Association has recognized the profound psychological consequences of hate crimes motivated by prejudice (APA Council of Representatives, 2005); and

WHEREAS the American Psychological Association opposes prejudice and discrimination based upon race, ethnicity, religion, sexual orientation, gender, gender identity or physical condition (American Psychological Association, 2021); and

WHEREAS as psychologists, we respect the dignity and worth of all people and are committed to improving the condition of individuals, organizations, and society, we are aware of and respect cultural, individual, and role differences among individuals, including (but not limited to) those based on religion and/or ethnicity (American Psychological Association, 2021); and

WHEREAS psychologists recognize and protect civil and human rights and strive to help the public develop informed judgments and choices concerning human behavior (American Psychological Association, 2017):

THEREFORE BE IT RESOLVED, that the American Psychological Association condemns all antisemitic attitudes and actions, and will use its influence to promote fairness, respect, and dignity for all people, regardless of religion or ethnicity, in all arenas in which psychologists work and practice, and in society at large.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association will take a leadership role in opposing antisemitism.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association encourages all psychologists to act to eliminate all discrimination of an antisemitic nature.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association will conduct regular impact assessments to ensure that our antisemitism policy addresses the harms of antisemitism along with intersecting forms of oppression.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association encourages research to better understand the characteristics, causes, and consequences of antisemitism.

THEREFORE BE IT FURTHER RESOLVED, that the American Psychological Association will include appropriate information on antisemitism in its multicultural and diversity training material and activities, and that diversity and multicultural efforts will take cognizance of antisemitism and will attempt to overcome it.

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D.(12) Council voted to approve withdrawal of the new business item titled, Identifying Resources to Support Inclusion and Intra-group Dialogue within Groups and Organizations (NBI #17D/Feb 2025).

E.(12A) Council voted to adopt as policy the following *APA Policy Statement on Reaffirming APA's Commitment to Human Rights and Freedom of Expression*:

APA Policy Statement on Reaffirming APA's Commitment to Human Rights and Freedom of Expression

The American Psychological Association "stands for human rights and the psychological and physical health and well-being of all people worldwide" (American Psychological Association, 2021) and encourages members of our profession "to support and advocate for populations at risk of human rights violations, including marginalized populations both domestically and globally" (American Psychological Association, 2021). In light of the escalating trauma and

suffering caused by the humanitarian crisis worldwide, the APA's Council of Representatives accordingly resolves to affirm the following principles:

1. **APA affirms, consistent with APA's mission to "to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives,"** our global commitment to human rights and freedom of expression as universal principles, applicable to all people regardless of race, religion, ethnicity, age, social class, disability, national origin, gender identity, sexual orientation, or immigration status.

2. **APA affirms, consistent with the final report of the APA Task Force on Human Rights**, that "on the topic of human rights concerns, especially in the case of severe human rights abuses with clear relevance to psychology" (American Psychological Association, 2021), it is appropriate for APA to engage in advocacy with its own government and to enter into international dialogue through its partnerships with psychology organizations in different countries, or with coalitions of organizations who have the authority to speak with governments.

3. **APA condemns, consistent with our opposition to bigotry in all its forms** (American Psychological Association, 2021), all forms of discrimination, prejudice, hostility, and violence.

4. **APA rejects, consistent with our recognition that the free exchange of ideas is essential to science, human welfare, and the just resolution of conflict** (American Psychological Association, 2021), the claim that criticism of any government's policies or actions is intrinsically racist, xenophobic, antisemitic, transphobic, anti Muslim, misogynistic, ableist, or prejudiced based on age, religion, nationality, ethnicity, gender identity, sexual orientation, disability or any other group circumstances. We therefore oppose efforts aimed at silencing or punishing non-violent advocacy directed towards safeguarding human life and upholding human dignity and human rights. We call for APA to commit to transparency and accountability by publicly documenting progress on its human rights efforts by developing guidance to academic, professional, and licensing bodies on safeguarding psychologists' rights to engage in non-violent political speech without professional retaliation.

Through these commitments, APA reaffirms its role as a global leader in advancing psychology in the service of human rights and freedom of expression.

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F.(26) Council was provided with an update on the new business in progress item, APA Resolution on Developing Mechanisms for Addressing Global Armed Conflict (NBI #19C/February 2025).

G.(27) Council was provided with an update on the new business in progress item, APA Resolution on Collecting Data, Promoting Critical Conversations, and Addressing Intra-Group Conflict related to Racism and the De-Centering of Anti-Black Ideology Within APA CoR, Divisions, and SPTAs (NBI # 15B/Aug 2025).

XIV. INTERNATIONAL AFFAIRS

A.13) Council voted to adopt as APA policy the following 2017 *Resolution on Promoting Global Perspectives in U.S. Psychology*:

> WHEREAS the psychology produced and taught in the United States remains largely U.S.-mainstream oriented and European-heritage grounded in its traditions, theories and evidence base, and often does not incorporate perspectives, content, and data relevant to other U. S. perspectives (e.g. rural, minority, indigenous, immigrant) or generated in other countries, (Arnett, 2008; Castillo, 2001; Draguns, 2001; Heinrich, Heine, & Norenzayan, 2010 ; Legare & Harris, 2016; Nagai, 2007; Segal, Lonner & Berry, 1998); and
>
> WHEREAS most research studies published in U.S. psychology journals, based on U.S. convenience samples (e.g., undergraduate students), are assumed to be representative of population demographics (Adair & Huynh, 2012; Arnett, 2008; Heinrich et al., 2010), and samples with data from outside the U.S. are often dismissed as non-representative (Canetto, Yang, Borrayo, & Timpson, 2003, Fine, 2012); and
>
> WHEREAS psychologists outside the United States have generated frameworks, methods, practices, and research relevant in the United States and globally (Adair, 2006; Allwood & Berry, 2006; APA, 2004; Christopher, et al., 2014; Cheung, 2012; Kitayama & Cohen, 2010; Silbereisen, Ritchie & Panday, 2014; Van de Vijver, 2013); and
>
> WHEREAS the majority of studies published in U.S. psychology journals utilize quantitative methods, although qualitative, participatory or community-based methods may be better suited for cross cultural research and although there is increased visibility of and attention to mixed methods research (Den Hartog , & Dickson , 2004; Denzin & Lincoln, 2001; Karasz 2011; Psaki, 2016; Sparrow & Davis, 2000); and
>
> WHEREAS assessment methods and interventions primarily developed and normed in English, with samples from high income countries, have often been used widely throughout the world without considering cultural differences that affect assessment and intervention validity and without the use of strategies to ensure fair use across groups (Achenbach, et al., 2008; Braun, Fine, Greif & Devenny, 2010; Dana, 2000; Hambleton & Zenisky, 2011; Hill, Pace & Robbins, 2010; Mezzich, 2002; Nakane & Nakane, 2002); and

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

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

WHEREAS it is important to recognize that a comprehensive global perspective combines worldwide, transnational and intercultural themes, encompassing societies, nations and countries; recognition of variety and diversity within and across societies, nations, and countries; and recognition of variety and diversity in individual and group experiences within those societies, nations and countries; and WHEREAS high-income countries, including the U.S., are becoming increasingly global (Banks, 2004; Fearon, 2003; Fisher, 2013 ; Hugo, 2005; Marsella & Pedersen, 2002; Woolf, Hulsizer & McCarthy, 2002); and

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

WHEREAS many U.S. psychological organizations promote international engagement;

THEREFORE, be it resolved that the American Psychological Association will:
Promote inquiry that includes comprehensive global perspectives and content in psychological theory, practice, education, advocacy and policy.

Encourage critical reflection on the meaning and use of psychological constructs and definitions that are assumed to be universal and generalizable.

Encourage the development and dissemination of sound assessment and intervention methodologies and education that respect local communities and are grounded in ethical principles of psychology.

Acknowledge and consider research findings, publications, training programs, guidelines, and regulatory processes developed outside the United States.
Recommend language changes in APA communications and publications to avoid U.S.-centric perspectives and to include global and diversity perspectives. Examples of these language changes include:

- Use “in the United States” for research, tests, training curricula, and practices that are developed and tested with U.S. samples;
- Include “the global implications” of research findings, tests, and practices where relevant;

Encourage psychologists to use language that reflects awareness of global frameworks. For example:

Evaluate language in statements of research findings, opinions, policies and conclusions to ensure that these statements do not present U.S. perspectives as though they were universal and universally generalizable. Restrict the use of the term “Western” to geographical location. “Western” should not be used to refer to ideas or experiences from Europe or the United States (as in “western culture”).
Replace terms such as “exhaustive literature search” with a more precise description of which databases were searched. When databases in languages other than English are searched provide information for accessing those databases.
Be explicit about the national origin of the literature reviewed in literature summaries and note where the data were collected.
Be cautious of claims of universality or generalizability beyond the specific populations studied. Make statements about “people in general” only when theory or evidence are about a representative global population.
Be mindful of not assuming U.S. norms or U.S. readership when using terms such as “we” or “our” or “us.”

Recommend that APA boards and committees routinely and systematically incorporate comprehensive global perspectives in their work and develop criteria against which to evaluate this impact:

Strategies might include assessing whether a statement, policy or guideline is intended to refer to the U.S. only or to be generalizable, asking whether statements have referenced the international literature, or reflecting on whether U.S. definitions of populations of population dimensions (such as dimensions of diversity) are universally applicable to the issue at hand.
Evaluation criteria might include attention to language (as noted in #5), source of references, inclusion of examples from outside the U.S. context, and the like.

Promote collaborative international partnerships grounded in a comprehensive global perspective; initiatives that facilitate international partnerships; training in global competencies; and develop guidance and best practices for ethically sound, culturally responsive international collaborations.

Encourage psychologists to understand that international collaborations are often influenced by power hierarchies, and that dominant frameworks marginalize subordinate frameworks on global and local levels.

Encourage U.S. undergraduate and graduate psychology programs to promote opportunities for students to learn other languages and experience other cultures.

Encourage U. S. psychologists to learn and use local languages in conducting professional work in communities domestically and internationally.

Promote comprehensive global focused curricula for high school, undergraduate, and graduate psychology.

Promote comprehensive global perspectives across association activities including publication practices, public interest, science, education, and professional initiatives.

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Council also voted to adopt as APA policy the following 2026 *Resolution on Promoting Global Perspectives in U.S. Psychology:*

Resolution on Promoting Global Perspectives in U.S. Psychology

WHEREAS The Resolution on Promoting Global Perspectives in U.S. Psychology (hereinafter '2017 Resolution') was adopted as APA Policy by the APA Council of Representatives in February 2017; and

WHEREAS, although there is variability across subdisciplines, the psychology produced and taught in the United States of America (U.S.) remains primarily based on U.S. and European samples and theory in its traditions, theories, and evidence base and often does not incorporate perspectives, content, and data relevant to other perspectives (e.g. rural, minoritized, Indigenous, immigrant) or generated outside of the U.S. (American Psychological Association, 2025; Arnett, 2008; Buchanan et al., 2021; Castillo, 2001; Cheon et al., 2020; Draguns, 2001; Henrich, et.al. 2010; Legare & Harris, 2016; Lin & Li, 2023; McGorray et al., 2023; Nagai, 2007; Rad et al., 2018; Segal, et al. 1998; Thalmayer et al., 2021; Thong et al., 2025); and

WHEREAS most research studies published in U.S. psychology journals based on U.S. convenience samples (e.g., undergraduate students) are taken as representative of population demographics (Adair & Huynh, 2012; Arnett, 2008; Cheon et al., 2020; Henrich et al., 2010; Nielsen et al., 2023; Rad et al., 2018; Roberts et al., 2020; Roberts & Mortenson, 2023; Thalmayer et al., 2021) and samples with data from outside the U.S. are often dismissed as non-representative (Canetto et al., 2003; Fine, 2012); and

WHEREAS psychologists outside the U.S. have generated frameworks, methods, practices, and research relevant to the U.S. and globally (Adair, 2006; Allwood & Berry, 2006; American Psychological Association, 2004, 2017; Bullock et. al., 2025; Cheung, 2012; Christopher, et al., 2014; Hatzichristou & Rosenfield 2017; Hatzichristou et al., 2024; Henrich, 2020; Kitayama & Cohen, 2010; Silbereisen, et al., 2014; Ting et al., 2025a; Van de Vijver, 2013); and

WHEREAS the majority of studies published in U.S. psychology journals and in international journals (e.g., Pepe et al., 2024) utilize quantitative methods. In some cases this is appropriate; in others, participatory, or community-based approaches, which may employ qualitative, quantitative, or mixed methods, may be better suited for cross cultural research (American Psychological Association, 2023; Chowdhury et al., 2022; Collins et al., 2018; Den Hartog & Dickson, 2004; Denzin & Lincoln, 2001; Gone, 2021; Karasz, 2011; LaVela, et. al., 2025; Rodriguez Espinosa & Verney, 2021; Sparrow & Davis, 2000; Ting et al., 2025b; Tuck & Yang, 2014); and

WHEREAS assessment methods and interventions primarily developed and normed in English, with samples of convenience including participants from high income countries, have often been used widely throughout the world without considering sociocultural differences that affect assessment and intervention validity and without the use of strategies to ensure fair use across groups (Achenbach, et al., 2008; Braun et al., 2010; Dana, 2000; Hambleton & Zenisky, 2011; Hill et al., 2010; Mezzich, 2002; Nakane & Nakane, 2002; Okazaki & Sue, 2016; Sundararajan et al., 2013); and

WHEREAS psychologists have an ethical responsibility to understand and consider the cultural values, mores, history, and policies of the societies and countries to which they apply U.S.-generated research, guidelines, or practices (American Psychological Association, 2003, 2017; Berry, 2013; Bernal et al., 2009, 2012; Dadlani et al., 2012; Gauthier et al., 2010); and

WHEREAS U.S. psychology and APA would benefit from an expanded knowledge base through the inclusion of global perspectives, theories, research findings, and practices from outside the U.S., including from the Global South (American Psychological Association, 2025; Arnett, 2008; Brock, 2006; Henrich et al., 2020; Legare & Harris, 2016; Lutsky, et al., 2005; Marsella, 2009); and

WHEREAS it is important to recognize that a comprehensive global perspective combines worldwide, transnational, and intercultural themes; encompassing variety and diversity within and across societies, nations, and countries; and recognition of variety and diversity in individual and group experiences within those societies, nations, and countries (Bullock et al., 2025; Okorodudu & Bryant-Davis, 2023; Sundararajan, 2015; Sundararajan et al., 2020); and

WHEREAS many countries, including the U.S., are becoming increasingly global on a societal level, contributed to by migration, creating mutual opportunities for learning and growth (Banks, 2004; Fearon, 2003; Fisher, 2013; Fisher & An, 2023; Hugo, 2005; Jensen et al., 2021; Woolf et al., 2002); and

WHEREAS partnerships across countries, cultural groups, and disciplines have promise for reciprocal benefit and increased synergy in solving global problems, promoting new discoveries, and building more equitable international relationships (American Psychological Association Committee on International Relations in Psychology, 2011; Blume et al, 2022; Chin & Trimble, 2014; Chiu & Hong, 2005; International Project on Competence in Psychology, 2016; Kirkbride et al., 2024; National Research Council, 2014); and

WHEREAS many U.S. psychological organizations, including APA, promote international engagement;

WHEREAS the issues identified in the 2017 Resolution remain current and the APA/APASI Strategic Plan (American Psychological Association, 2019), revised and adopted by Council in February 2024, commits APA to "Embrace a global perspective" (Operating Principle 4) and to "Focus on outcomes" (Operating Principle 2); and

WHEREAS additional steps are needed to more fully implement the points of action identified in the 2017 Resolution;

THEREFORE, be it resolved that the American Psychological Association will:

a. Endorse and communicate the importance of taking a global perspective, including as intersecting with other important variables such as, but not limited to, culture, sex, gender, race, ethnicity, sexual orientation, age, socioeconomic status, and disability status;
b. Practically implement a global approach as outlined in the domains of focus below;

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c. Actively ensure that this is implemented in processes and outcomes laterally throughout the Association.

Domains of Focus

1) Promote global perspectives

Taking practical action that will facilitate a global perspective in project planning and implementation.

1.1 Promote inquiry that includes comprehensive global perspectives and content in psychological theory, practice, education, research, policy, and advocacy, including to combat systemic inequities.

1.2 Recommend that APA boards and committees routinely and systematically incorporate comprehensive global perspectives in their work and develop criteria against which to evaluate this impact:

a. Strategies might include assessing whether a statement, policy, or guideline is intended to refer to the U.S. only or to be generalizable, asking whether statements have referenced the international literature, or reflecting on whether U.S. definitions of populations or population dimensions (such as dimensions of diversity) are universally applicable to the issue at hand.
b. Evaluation criteria might include attention to language (as noted in #4), source of references, or inclusion of examples from outside the U.S. context.

1.3. Promote comprehensive global perspectives across association activities including publication, public interest, science, education, and communication practices, Convention, and professional initiatives.

2) Include global input

Drawing on globally diverse sources of data and lived experience to include a range of voices in projects.

2.1 Encourage critical reflection on the meaning and use of psychological constructs and definitions that are assumed to be universal and generalizable.

2.2 Suggest the development and dissemination of sound assessment and intervention methodologies and education that respect local communities and are grounded in ethical principles of psychology, for example as defined in the *Universal Declaration of Ethical Principles of Psychologists* (Gauthier et al., 2010).

2.3 Acknowledge and consider research findings, publications, training programs, guidelines, and regulatory processes developed outside the U.S**.**

3) Situate in a global context

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Acknowledging the greater context in which any locally-focused work is situated in relation to other approaches globally.

3.1 Urge U.S. undergraduate and graduate psychology programs to promote opportunities for students and faculty for international collaboration, communication in other languages, and experience in other cultures.

3.2 Promote comprehensive globally informed curricula for high school, undergraduate, and graduate psychology.

3.3 Develop learning opportunities for psychologists in other contexts to consider the extent to which their work would benefit from a global perspective.

4) Use inclusive language

Avoid considering a given language, methodology, approach, or spokesperson to be normative in projects.

4.1 Recommend language changes in APA communications and publications to avoid U.S.-centric perspectives and to include global and diverse perspectives. Examples of these language changes include:

a. Use “in the United States” for research, tests, training curricula, and practices that are developed and tested with U.S. samples;
b. Include “the global implications” of research findings, tests, and practices where relevant;

4.2 Suggest that psychologists use language that reflects awareness of global frameworks. For example:

a. Evaluate language in statements of research findings, opinions, policies, and conclusions to ensure that these statements do not present U.S. perspectives as though they were universal and universally generalizable. Refer directly to a specific culture or context and restrict the use of general terms such as “Eastern” or “Western” to geographical location.
b. Replace terms such as “exhaustive literature search” with a more precise description of which databases were searched. When databases in languages other than English are searched, provide information for accessing those databases.
c. Be explicit about the national origin of the literature reviewed in literature summaries and note where the data were collected.
d. Be cautious of claims of universality or generalizability beyond the specific populations studied. Make statements about “people in general” only when theory or evidence are about a representative global population.
e. Be mindful of not assuming U.S. norms or U.S. readership when using terms such as “we” or “our” or “us.”

4.3 Propose that U. S. psychologists learn and use spoken and written local languages in conducting professional work in communities domestically and internationally.

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5) Encourage global partnerships

Consider how projects can contribute to creating a positive impact globally in equitable collaboration with others.

5.1 Promote collaborative international partnerships grounded in a comprehensive global perspective; encourage initiatives that facilitate equitable international partnerships and global knowledge sharing, ensuring findings are shared with communities of focus in local languages; support training in global competencies; and learn from and develop guidance and best practices for ethically sound, culturally aware international collaborations.

5.2 Encourage psychologists to understand that international collaborations are often influenced by power hierarchies and that dominant frameworks may marginalize subordinate frameworks on global and local levels.

5.3 Support psychologists' practicing cultural humility, inclusion, and reflexivity when engaging in global partnerships such as research or training to avoid cultural myopia.

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B.(20) Council was provided with information on APA at the United Nations: 2025 Annual Report.

XVI. FINANCIAL AFFAIRS

A.(21) Council received as information the 2024 IRS Tax Form 990 and 990-T Amendment.

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On Thursday evening, Council also engaged in a group activity where it was asked to consider questions related to APA's joint strategic priorities.

On Saturday afternoon, presidential citations were award to 1) the APA Council of Representatives Rural Health Caucus, the Committee on Rural Health, and the Division 31 Rural Health Section and Division 22 (Rehabilitation Psychology), Division 25 (Behavior Analysis), and Division 33 (IDD/Autism), and other psychologists serving patients with autism, their families, and their caregivers.

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