

Section on Child Maltreatment Newsletter

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President's Column

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As many of you know, the month of April has a special designation as National Child Abuse Prevention Month. Since 1983, the President of the United States has issued a proclamation every April encouraging public awareness of child abuse and neglect and promoting community involvement to address the problem. The U.S. Department of Health and Human Services' Administration for Children and Families has recently released the most current U.S. statistics on child abuse and neglect in its annual report "Child Maltreatment 2008" which can be found at: <http://www.acf.hhs.gov/programs/cb/pubs/cm08/>. Current statistics indicate that an estimated 772,000 children in the United States were determined to be victims of abuse or neglect during the year 2008. Perhaps most alarming is the fact that of those victims, children from birth to 1 year had the highest rate of victimization. These figures help to remind us of the Section's obligation to support and promote scientific inquiry, training, professional practice, and advocacy in the area of child maltreatment in order to improve the lives of children and their families.

In an effort to meet this obligation, various members of the Section have been engaged in a number of laudable activities over the last several months. There is a new interdivisional task force forming on adoption and foster care. We would like to include Section representation on this task force. **Mary Haskett** will serve as our initial liaison to this task force and would like to involve anyone from the Section who might be interested in being involved. Please contact Mary if you have interest (Mary_Haskett@ncsu.edu). **Amy Damashek**, our new Member-at-Large, is currently working on updating the Section's website which will include a brand new look and a greater number of resources for our members. **Lisa Jones**, Member-at-Large, has recently moved into the Section's position of Chair of the Social Policy Committee. In this role, she will be leading an effort to review the literature and provide policy recommendations on the need

for improved child abuse and neglect epidemiological data. If you are interested in helping Lisa with this effort, please feel free to contact me (cindy.perrin@pepperdine.edu). Efforts to maintain and increase membership in the Section continue, under the leadership of our hardworking membership Chair, **David Kolko** and Member-at-Large, **Rochelle Hanson**. If you have not renewed your membership, please do so as soon as possible at the Section's website (www.apa.org/divisions/div37/child_maltreatment/child.html). You can download the appropriate form and send your check directly to APA.

Our current APA Program Chair, **Jenelle Shanley**, has been busy planning Section activities for the 2010 APA Convention to be held in San Diego, California (August 12-15). The Section will soon be distributing a complete agenda of the Hospitality Suite schedule for the convention. In addition, both Division 37 and the Section are offering a number of presentations of interest to child maltreatment professionals (see the Division 37 Program Summary included in this issue of the Newsletter). These include several symposia that are

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relevant to the Section's efforts. The first is the Section's Presidential symposium entitled *Human Trafficking of Children*. The symposium will focus on some of the efforts of an interdivisional task force on human trafficking. Presenters will focus on the parameters of child trafficking, potential negative effects, as well as possible intervention and prevention efforts. The symposium will feature presentations by me as well as **Thema Bryant-Davis**, **Nathan Moon**, and **Melissa Anderson-Hinn**. Other symposia will focus on *Child Sexual Exploitation*, *Evidence-based Practices to Prevent Child Maltreatment*, and *Ethnicity, Culture, and Child Maltreatment*. In addition to offering these symposia, the Division and Section will host a Question and Answer period in the Hospitality Suite following each symposium.

In closing, I would like to invite anyone interested in becoming involved in the Section and its activities to our annual Executive Committee meeting at the APA Convention. The meeting will take place in the Section's Hospitality Suite on Friday, August 13 from 12-2 pm. We need your commitment and expertise! Please also feel free to contact me about the many ways in which you might be involved in the Section (cindy.perrin@pepperdine.edu). I would be pleased for you to join the Section in its efforts to promote safer families and communities. I hope to see you all in San Diego this August!

Best Practices

Treating Children with Sexual Behavior Problems: A Short Primer

Amy Damashek, Ph.D.

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Much progress has been made in recent years in understanding the nature of childhood sexual behavior problems and effective treatment for youth who engage in such behaviors. This article will provide a brief overview of information relevant to practitioners working with children exhibiting inappropriate sexual behaviors.

Friedrich's research on sexual behavior among children in the United States provided a basis for an understanding of normative sexual behavior among U.S. children. This research has indicated that it is relatively normal for children, as young as age 2, to engage in some types of sexual behavior (e.g., touching one's own genitals; Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991; Friedrich et al., 2001) and that normative sexual behavior varies with age, gender, and culture (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998; Friedrich, Sandfort, Oostveen, & Cohen-Kettenis, 2000). Continued work in this area has helped to delineate characteristics of inappropriate childhood sexual behavior. Currently, experts indicate that children with sexual behavior problems are children ages 12 and below who engage in sexual behavior that is non-normative or inappropriate for their developmental level or may be harmful to themselves or others (Chaffin et al., 2008). Sexual behaviors that are considered non-normative or inappropriate are those

that: involve a large age or developmental difference between children, involve coercion or force, do not stop after parental intervention, occur with great frequency, and are associated with strong emotion (Chaffin, Letourneau, & Silovsky, 2002).

The terminology that is used by professionals working with children with SBP's is important in effectively serving the needs of such children and the community. It is relatively common for professionals in various fields to refer to children with sexual behavior problems as "sex offenders, mini-perps, or predators." Such terms are used to refer to adult sexual offenders; however, given important differences between children with sexual behavior problems and adult sex offenders, the extension of such terminology to youth is inaccurate. It is important for practitioners to be aware that children with sexual behavior problems are quite different from adult sexual offenders. Data indicate that children's engagement in inappropriate sexual behavior is often transient and such children are unlikely to continue to engage in such behavior during their adolescence or early adulthood (Carpentier, Silovsky, & Chaffin, 2006). In addition, children with SBP's are quite responsive to short-term, community-based cognitive-behavioral interventions. For instance, one prospective study found that only 2% of children undergoing short-term community-based cognitive

behavioral treatment engaged in future inappropriate sexual behaviors 10 years later (Carpentier et al., 2006). The use of pejorative labels for children with SBP's may be tremendously damaging to children's personal identity and social development. Therefore, a taskforce from the Association for the Treatment of Sexual Abusers (ATSA) recently published recommendations suggesting that the term "children with sexual behavior problems" be used to refer to children engaging in inappropriate or non-normative sexual acts (Chaffin et al., 2008).

Research on etiology of childhood sexual behavior problems indicate that such factors vary for individual children. Common clinical lore suggests that all children who show such sexual behaviors have been sexually abused. However, research evidence indicates that, although sexually abused children may engage in a higher frequency of and more severe sexual behaviors, many children with sexual behavior problems have no history of sexual abuse (Friedrich et al., 2001; Johnson, 2006; Silovsky & Niec, 2002). For instance, one study of preschool children with sexual behavior problems found that 62% of the children had no substantiated history of sexual abuse (Silovsky & Niec, 2002). Other factors that are related to sexual behavior problems include the presence of internalizing and externalizing symptoms, life stress, exposure to sexually explicit media, and exposure to family violence (Friedrich et al., 2001; Friedrich, Davies, Feher, & Wright, 2003; Merrick, Litrownik, Everson, & Cox, 2008).

As noted above, the majority of children with SBP's are quite responsive to cognitive-behavioral interventions (St. Amand, Bard, Silovsky, 2008). For most children, such interventions can be delivered on a weekly basis in the community, and the child can remain at home and still attend a regular school. Effective treatments can be delivered in an individual or group format, but must include the participation of both the child and his or her caregivers (St. Amand et al., 2008). Child-focused components of effective interventions include: rules about appropriate sexual behavior, sex education (for school-aged children), emotion regulation skills, impulse control skills, social skills, and sexual abuse prevention skills. For parents, a key aspect of treatment involves learning about the importance of close supervision and monitoring of their children to prevent future sexual behavior problems. Parents also learn about: normative and non-normative childhood sexual behaviors, applying privacy rules at home, keeping sexually explicit materials out of the child's environment, discussing sexual development with their children, setting rules and limits with their children, and reinforcing the skills that the children learn. A group format for caregivers also allows them to gain support and encouragement from one another (Carpentier et

al., 2006; Chaffin et al., 2008; Silovsky, Niec, Bard & Hecht, 2007).

In summary, childhood sexual behavior problems have many potential causes and can be effectively treated with short-term cognitive-behavioral therapies. Such children are distinct from adult sex offenders and should not be assumed to have similar characteristics. For more detailed information on children with sexual behavior problems, the ATSA taskforce has published a comprehensive review of issues related to assessment, treatment, and public policy (Chaffin et al., 2008).

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Public Policy

HEALTH CARE REFORM SIGNED INTO LAW

Thomas L. Birch, J.D.

National Child Abuse Coalition

HOME VISITING IN HEALTH CARE LAW

For the first time, federally mandated funding dedicated for prevention to support home visitation services for new parents will be available to states through provisions in the health care reform legislation, the Patient Protection and Affordable Care Act, signed into law by President Obama on March 23. The new measure authorizes \$1.5 billion over five years – with \$100 million in 2010 – for Maternal, Infant, and Early Childhood Home Visiting Programs funded through Title V, the maternal and child health block grant, to support a range of voluntary home visitation services to pregnant women, young parents and their children. A three-percent share of the funds would be reserved for grants to Indian tribes.

Priority for services would go to low-income families, including pregnant women under age 21, living in communities in need of services. Eligible families would also include those with:

- a history of child abuse or neglect or involved with child welfare services,
- a history of substance abuse,
- children with low student achievement,
- children with disabilities or developmental delays, and
- family members serving in the military, including those “who have had multiple deployments outside the United States.”

Family members eligible for the home visitation services include a child’s parents or primary caregivers, such as grandparents or other relatives of the child, foster parents, and a noncustodial parent with an ongoing relationship with the child.

Within six months of the March 23 enactment of the bill, states are required to conduct a statewide needs assessment to identify communities at risk, those with concentrations of:

- premature and low birth-weight infants, infant mortality, including death due to neglect;

- poverty;
- crime;
- domestic violence;
- high rates of high school dropouts;
- substance abuse;
- unemployment; or
- child maltreatment.

The needs assessment must also evaluate the quality and extent of existing early childhood home visitation services, including numbers of families already receiving services and the gaps in home visitation services. States must also assess the capacity for providing substance abuse treatment and counseling. (If a state does not apply, or is not approved for a grant, HHS may award funds otherwise available for that state to a nonprofit organization with an established record of providing early childhood home visitation programs.)

The law directs states, in conducting a needs assessment, to coordinate with and take into account other needs assessments already ongoing, including those required by the Maternal and Child Health Block Grant, Head Start, and Title II of the Child Abuse Prevention and Treatment Act (CAPTA).

In applying for the home visitation grants, states must establish quantifiable benchmarks to demonstrate improvements at intervals of three and five years for families participating in the program in:

- maternal and newborn health;
- prevention of child maltreatment;
- school readiness;
- reduced crime or domestic violence;
- family economic self-sufficiency; and
- coordination with community support services.

If, after three years, improvements are not demonstrated in at least four of the six benchmarks, HHS may provide technical assistance to the state to move toward progress.

The new grant program would require that 75 percent of the funding to a state for home visitation would support models that are well-designed, research-based, and rigorously evaluated through randomized control trials or quasi-experimental research designs. The remaining 25 percent of grant funding could go to support promising and new approaches yet to be evaluated by a similar rigorous process.

The law specifies that the Maternal and Child Health Bureau and the Administration for Children and Families, both in HHS, must “collaborate” in reviewing and analyzing the statewide needs assessments, the awarding of grants, and the program evaluations. The statute does not specify or instruct the governors of the states applying for home visitation funds to designate a lead state agency.

The entitlement funding for the program would increase from \$100 million in 2010 to \$250 million in 2011, \$350 million in 2012, and \$400 million in each of 2013 and 2014.

The Patient Protection and Affordable Care Act, which passed the Senate in December, was approved by the House, 219-210, on March 21. Similar provisions mandating the home visitation funding were included in the health care reform bill drafted and passed in the House in November.

The House provisions would have authorized a total of \$750 million in mandatory spending over five years to states for support of a range of home visitation models, administered by the Department of Health and Human Services (HHS) through the Title IV child welfare services program; and a second provision offering states the option of dedicating Medicaid funds to pay for nurse home visitors. Because of the political and parliamentary barriers to passage of a health care bill incorporating the House and Senate versions, the Senate’s measure prevailed.

HEALTH CARE LAW: BENEFITS TO CHILDREN AND FAMILIES

The new health care reform law includes numerous provisions aimed at improving the health and well-being of children and youth and vulnerable adults. Among the provisions which would provide new coverage and advantages to children and youth are the following:

- Prohibits health insurers from denying coverage to children with pre-existing conditions, effective six months from enactment. (In 2014, the prohibition applies to all persons.) Insurance providers have denied coverage to children for pre-existing chronic conditions such as diabetes, asthma, ADHD, or autism spectrum disorder.
- Requires all health plans to extend coverage to young

people up to the age of 26 under their parents’ insurance policies, who live with their parent or are a student, and up to 30 years old, who are also unmarried and have no dependent child of their own.

- Streamlines continuing coverage through the new state exchanges for children already covered by the Children’s Health Insurance Program (CHIP) and extends CHIP funding through 2015.
- Provides Medicaid coverage to children who have been in foster care to continue up to the age of 26.
- Amends Medicaid to include diagnostic screening, preventive and rehabilitative services.
- Authorizes grants for the establishment and operation of school-based health centers, which provide comprehensive primary health services, including mental health.
- Authorizes funding of \$75 million annually for five years to support grants to states for a “personal responsibility education program” of evidence-based services aimed at educating adolescents about abstinence and contraception for the prevention of pregnancy and sexually transmitted diseases.
- Mandates information be available for children aging out of foster care and independent living programs about the importance of having a health care power of attorney to make health care decisions on behalf of the child who does not have a relative authorized to decide.
- Authorizes \$3 million in 2010 and such sums as necessary in the two following years to support education and research on postpartum depression, including a longitudinal study of the immediate and long-term mental health consequences of a pregnancy; and for grants to states for services to women with postpartum depression and their families, including health care, homemaker services, day care and respite care.
- Expands the adoption credit and adoption assistance program, increasing each by \$1000, makes the credit refundable, and extends the credit through 2011, effective for tax years beginning after December 31, 2009.
- Authorizes a loan repayment program for qualified health professionals, including psychologists, who agree to be employed full-time for no less than two years providing pediatric care (including mental and behavioral health care). Priority will be given to those have familiarity with linguistically and culturally competent health care services.

OBAMA 2011 BUDGET: \$10 MILLION CAPTA GRANTS FOR PREVENTION

On February 1, the Obama administration released its proposed budget for FY 2011, with most spending on child and family services frozen, as expected, at the current year's funding levels. The Obama budget includes the largest one-year increase in child care funding in over 20 years with \$1.6 billion above the FY 2010 level for a total of \$6.6 billion to serve 235,000 more children than could be served without the additional funds in 2011. Funding for Head Start and Early Head Start, requested at \$8.2 billion in the President's FY 2011 budget, would also get a substantial increase – an additional \$989.175 million to sustain services to the approximately 64,000 additional children supported by American Recovery and Reinvestment Act funding in 2010, and to support a full 2 percent cost of living adjustment to offset inflationary costs. According to budget documents, the Office of Head Start plans to promote community efforts to integrate early childhood services.

In the budget request for the Department of Health and Human Services (HHS) Administration for Children and Families, the Child Abuse Prevention and Treatment Act (CAPTA) discretionary grant funding is among the few programs with an increase in the funding line. The President's budget asks Congress for \$10 million in additional spending to establish a new competitive grant program for states to support the increased use of evidence-based and evidence-informed child maltreatment prevention programs. The new grants will focus on encouraging states to use existing funding streams to support community-based prevention activities rooted in a strong evidence base. Funds also will be used to insure that child abuse and neglect prevention is integrated with other state systems for children.

Missing from the 2011 budget request is any funding for the evidence-based home visitation initiative funded in FY08 and FY09 through CAPTA's discretionary grants. The \$13 million funding to 17 grantees and in support of a cross-site evaluation was dropped by Congress in the FY10 appropriations bill, with the conference report to the Labor/HHS appropriations noting that funds were not included for these activities in FY 2010 since mandatory funding was expected to be provided in health care reform legislation.

Other CAPTA grant funds are frozen at 2010 levels in the Obama budget for 2011: basic state grants for improvement of state child protective services at \$26.535 million, and community-based child abuse prevention grants at \$41.689 million.

The Family Violence Prevention and Services program would increase by \$10 million, with \$4 million used to fund 12 new discretionary grants for promising practices to enhance services for children exposed to domestic violence. The grants would support expanding child advocacy staffing in shelters and non-residential domestic violence services, offering training and technical assistance, and outreach to child welfare agencies and schools to enhance their response to children's exposure to domestic violence. The remaining \$6 million will go to respond to the increased demand for emergency domestic violence shelter services, especially to provide specific services for children in shelter with their non-abusive parent.

At the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control, the administration's 2011 budget would dedicate \$5 million to support the National Violent Death Review System (NVDRS), which gathers data from state and local agencies, medical examiners, coroners, police, crime labs, and death certificates to provides states with a more accurate and complete understanding of the violent deaths in their state. The NVDRS aims to fill the gaps in current data collection that does not always provide the information needed to assess accurately the facts of a violent death. For example, death certificates provide data on the victim but do not provide information on the perpetrator, information more commonly found in police reports.

CDC also plans to continue to support research to identify effective strategies to prevent child maltreatment, and to publicize and disseminate key findings.

Case Notes

Partner, Lover, or Sex Offender: Who Are the Perpetrators and Victims of Statutory Rape?

Barbara A. Oudekerk & N.
Dickon Reppucci

University of Virginia

Despite the contentious and rather prejudiced history of statutory rape and age of consent laws (Cocca, 2006), today these laws have the potential to protect adolescents from sexual exploitation by adults. Indeed, researchers have highlighted a host of negative outcomes experienced by adolescents who date older partners, most prominently higher rates of teen pregnancy, sexually transmitted infections, and other externalizing problem behaviors (Hines & Finkelhor, 2007). Recent legal cases, however, have prompted community members, policymakers, and researchers to question the fairness of statutory rape laws as they apply to older teen and young adult perpetrators (Gross, 2007; Rankin, 2008). Understanding statutory relationships involving older teen and young adults is important because 95% of statutory rape cases known to law enforcement involve adolescent girl partners, and of these, 75% involve perpetrators under the age of 25 (Troup-Leasure & Synder, 2005). Thus, even when perpetrators are much older than their teenage partners, they do not tend to be “predatory old men.”

Under existing laws, statutory relationships that come to the attention of law enforcement are often recognized as sexual abuse, even in cases involving two teens. For example, in some states (e.g., Alabama, Connecticut) a 17-year-old who engages in sexual intercourse with a 14-year-old could face up to 20 years in prison and be required to register as a sex offender. In 2004, 18-year-old Robert DiPiazza was placed onto probation and required to register as a sex offender for 25 years for having sex with his nearly 15-year-old girlfriend. The couple married in April, 2009, but he remained on the offender registry until November 2009 when a Michigan appeals court ruled that his registration requirement was cruel and unusual punishment (*People of the State of Michigan v. DiPiazza*, 2009). In March 2008, ABC’s 20/20 aired John Stossel’s interview with Frank Rodriguez, who as a 19-year-old high school senior was convicted of assaulting a minor after engaging in “consensual sex” with his 15-

year-old girlfriend, a freshman. Today he and his former underage victim are married and have four daughters, but he will remain on the sex abuse registry in Texas for life.

Setting a Research Agenda: Pressing Questions for Social Science Researchers

Little research has examined the prevalence, characteristics, and consequences of statutory relationships. Moreover, there is a need to empirically test the assumptions behind and questions raised by existing and burgeoning laws governing statutory relationships. Research topics include:

1. Many states have attempted to discern statutory relationships between youth close in age from other child sexual abuse cases by enacting “Romeo and Juliet” provisions (e.g., Georgia, Florida) or by specifying minimum age requirements for a teen to be considered a victim or an older partner to be considered a perpetrator of statutory rape. The last review of statutory rape laws is outdated (Glosser, Gardiner, & Fishman, 2004) and continued modification of laws has led to drastic discrepancies in possible legal punishments for statutory rape across states. What are the legal consequences of engaging in statutory rape and do youth and adults understand these consequences?
2. Hines and Finkelhor’s (2007) extensive review of statutory relationships concludes that more research is needed to better understand (a) youth’s development of sexual knowledge, (b) sexual decision-making abilities, and (c) statutory relationship dynamics. What age are youth competent to consent to sex? How should researchers examine this with respect to literature on transferring youth to adult court and adolescents’ competence to make abortion decisions?

3. How many youth engage in statutory relationships, and how often is the perpetrator relatively close in age versus significantly older? Research has been criticized for selection effects and biased estimates of the incidence of statutory relationships. Population based surveys (e.g., National Survey of Family Growth) often ask only about youth's first sexual relationship; youth might engage in statutory relationships after their first sexual experience.
4. Do laws deter statutory relationships? Do youth and young adults understand the consequences of engaging in statutory relationships? If so, do they engage in such relationships anyway?
5. How does the public view statutory relationships? What age differences between couples are perceived as acceptable and unacceptable by youth and adults from all backgrounds, and how do these perceptions compare to what we know about adolescent developmental knowledge about sex?
6. When are statutory rape laws enforced or not enforced? Are they enforced fairly? Compared to men, are women less likely to be charged and convicted of statutory rape? Compared to heterosexual couples, are homosexual couples more likely to be convicted? In Kansas, 18-year-old Matthew Limon was sentenced to 17 years in prison for performing consensual oral sex on a male a month short of 15-years old. Under Romeo and Juliet laws, the sentence for oral sex would have been 15 months in prison had the younger partner been female. In light of *Lawrence v. Texas* (2003), Limon's sentence was eventually reversed, but not until it reached the Kansas Supreme Court for a second time.
7. How different is statutory rape (i.e., minor has seemingly consensual sex with an adult) from underage prostitution (i.e., minor has seemingly consensual sex with an adult and receives money)? Why in one case is the minor a victim yet in the other he/she is a criminal and can be legally punished?

Future research on these pressing questions will provide much-needed answers to help shape lay, scientific, and legal responses to the complex issues surrounding statutory relationships. Moreover, research might help to inform policy makers as they strive to protect adolescents from sexual exploitation and adults from unjust prosecution and punishment.

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Students! You are invited to attend:
**The Section on Child Maltreatment
and Division 37**

**Meet a Mentor:
Connecting with Mentors
in Practice & Policy**

Friday, August 13, 7 to 7:50 pm.

See program for location details.

For more information, contact:

Jenelle Shanley, PhD

*Section of Child Maltreatment Program Chair
Jenelle-Shanley@ouhsc.edu*

You are invited to attend:
**The Section on Child Maltreatment
and Division 37**

Social Hour

Friday, August 13, 6 to 6:50 pm.

See program for location details.

Co-sponsored by:

Committee on Children, Youth, and Families
Division 43 Family Psychology

For more information, contact:

Jenelle Shanley, PhD

*Section of Child Maltreatment Program Chair
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**Look for these Sessions at the Upcoming APA Annual Convention
in San Diego, California, August 12-15, 2010**

Thursday, August 12:

- 1 – 1:50 p.m. Symposium: *Experiences of Child Caregivers*
- 3 – 3:50 p.m. Symposium: *Community-Based Child Mental Health Care*

Friday, August 13:

- 8 – 8:50 a.m. *Evidence-Based Practices to Prevent Child Maltreatment*
(Room 31C of the San Diego Convention Center)
- 9 – 9:50 a.m. Symposium: *Child Sexual Exploitation*
- 11 – 11:50 a.m. Poster Session: Child and Family Research, Policy,
and Practice – I
- 12 – 12:50 p.m. Invited Address: *Evidence-based Practices to Prevent
Child Maltreatment*
- 2 – 2:50 p.m. Invited Address: *Summit on Young Children's
Mental Health*
- 3 – 4:50 p.m. Division 37 Business Meeting and Section Presidential
Address: *Human Trafficking of Children*
- 5 – 5:50 p.m. Invited Address: Nicholas Hobbs Award and Distinguished
Contribution to Child Advocacy Award
- 6 – 6:50 p.m. Division 37 and 43 Social Hour
- 7 – 7:50 p.m. *Meet a Mentor: Connecting with Mentors in Practice
and Policy*

Saturday, August 14:

- 9 – 9:50 a.m. Symposium: *ICD/DSM Revisions*
- 11 – 11:50 a.m. Poster Session: Child and Family Research, Policy,
and Practice - II
- 12 – 12:50 p.m. Symposium: *Improving the Well-Being of Children
and Families*
- 2 – 2:50 p.m. Symposium: *Challenges and Opportunities in Rural and
Small Community Practice*
- 4 – 4:50 p.m. Symposium: *Refugee Child and Family Resilience*

Sunday, August 15:

- 9 – 10:50 a.m. Symposium: *Ethnicity, Culture, and Child Maltreatment*
- 11 – 11:50 a.m. Symposium: *Trials and Tribulations of Translational
Research*

Hope to see you at the 2010 APA 118th Annual Convention!

San Diego Convention Center
San Diego, CA
August 12th - 15th, 2010

To find more convention information and register: <http://www.apa.org/convention/index.aspx>

ATTENTION Section Members!

If you have recently published an article, or have other exciting news (e.g., featured on a radio show, etc.) that you would like to share with other Section members, email the information to: Amie Lemos-Miller at amielemos@hotmail.com. The announcement will be included in a future edition of the Section's newsletter.

Call for Articles

Interested in contributing to the Section's Newsletter? Manuscript submissions should be relevant to the Section's focus on child maltreatment research, treatment, assessment, and policy. Manuscripts should generally be between 600-1300 words. Contact Amie Lemos-Miller (amielemos@hotmail.com) if you would like to contribute a manuscript.

Section Members' Recently Published Articles

Russell, B. S., Trudeau, J., & Britner, P. A. (2008). Intervention type matters in primary prevention of abusive head injury: Event history analysis results. *Child Abuse & Neglect: The International Journal*, 32(10), 949-957.

*For additional information on Section activities you can also visit our website at http://www.apa.org/divisions/div37/child_maltreatment/homepage.html

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