
Monitored Visitation Guidelines from CAPSAC

California Professional Society on the Abuse of Children

an independent affiliate of the American Professional Society on the Abuse of Children

Purpose

Family reunification is one of the legislatively mandated goals of the California Dependency Court. After allegations of sexual abuse or a sustained petition, an appropriate plan can assist the Court in reunifying the family in a timely and successful manner. Premature or poorly planned visitation can impede a family's reunification process. The rights of families are best served by a coordinated visitation and reunification plan.

A goal of Family Court is to assist families with children to transition in the best possible manner to a different family structure. When there are allegations of sexual abuse in Family Court proceedings, the safety of the child is essential to maintain while providing for the rights of the parents.

This document is offered to assist decision makers, in cases when sexual abuse allegations appear reasonably credible in Family Court or there is a prima facie case in Dependency Court, to determine when monitored visits should be ordered.

This document was written by a multidisciplinary task force of the California Professional Society On The Abuse of Children (CAPSAC). It is an update of a document produced in 1993 by a task force of the CAPSAC-L.A. Board. P.O. Box 55427 Sherman Oaks, CA 91413 Phone (818) 788-1605 Fax (310) 375-0613.

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The following are guidelines and are not intended to serve as a rigid blueprint for practice nor are they intended to establish a legal standard to which professionals must adhere. Rather, the guidelines provide a model of desirable professional practice.

A. Important Points Related to Monitored Visits

1. What happens in the initial contacts between an (alleged) child victim and an (alleged) perpetrator after allegations of sexual abuse have come to light is central to their ongoing relationship and future healthy reunification. A step-wise process is in the best interest of the child. (See Section B and Charts I and II, pages 7-8.)
2. Bonding occurs within the first days and hours of a child's relationship to his or her parents. The attachment relationship between a parent and child develops over the lifetime of a child. A period of investigation resulting from allegations of abuse will not disrupt a healthy attachment between a parent and a child.
3. It is well established that child abuse has at its core the issue of the power and influence of the perpetrator over the victim. While monitored visits prevent the continuation of the physical activity of the sexually abusive relationship of the perpetrator to the victim, monitoring may not forestall the emotionally abusive relationship. Emotional abuse and sexual intrusion are the hallmarks of sexual abuse. The emotional damage of sexual abuse far outlasts any physical damage.

4. A child who has alleged abuse may require a period of time to feel protected, to understand each person's responsibility related to abuse, and to develop self-protection skills prior to visiting the (alleged) abuser. Some reasons abused children may want immediate visits with the person they alleged abused them include the following: a) see if the person is angry; b) ask for forgiveness for making the allegations; c) get gifts; d) assuage other family member's anger at the (alleged) victim; e) express their love and caring for the person; f) see if the person is all right.
5. The influence of a perpetrator on a child victim during visitations is substantial. The perpetrator's influence on the child may not be recognized by a monitor. A child can be influenced by the physical movements, glances, smell or clothing of an offender which may trigger traumatic memories. Certain foods, toys, books or other things brought by the perpetrator may have strong negative connotations for the child or be subtle reminders of the emotionally controlling aspects of the relationship from which the child struggled to get away. The offender's influence may eventuate in the child recanting the allegations. A child may not feel supported, believed or that allegations of sexual abuse are serious if, without preparation, he or she simply starts visits and telephone calls with the person by whom he or she was (allegedly) abused. A process needs to occur before visits begin. (See Section B and Charts I and II, pages 7-8.)
6. Because premature visits of offenders with their victims impedes the perpetrator's progress in treatment, Senate Bill 3560 was sponsored by the California Coalition on Sexual Offending, a multidisciplinary group of service providers to sexual offenders. Sections 1202.05 and 5154.2 of the California Penal Code now state that incarcerated offenders may not have visits with their victims who are under 18 years of age. The Director of Corrections will only allow visits when the Juvenile Court, pursuant to sections 362.6 of the Welfare and Institutions Code, finds that such visits are in the best interest of the child.
7. The parental alienation syndrome applies in custody disputes when no abuse has occurred and one parent overtly or covertly vilifies the other parent to a child, who thereafter deprecates that parent.

Parental alienation is not a valid issue when a parent has been sexually, physically or emotionally abusive (per Richard Gardner, M.D.). The concept is often misinterpreted and misapplied to the anger and distrust a child, as well as the nonmolesting parent, evidences toward an abusive parent. In cases where the nonmolesting parent is protective of the abused child/ren, anger at the (alleged) perpetrator is natural. In cases where the nonmolesting parent's allegiance is to the (alleged) perpetrator and not the (alleged) victim, the child victim's mental health is in jeopardy.

B. The Decision to Order Therapeutic Contacts, Eventuating in Monitored Visits

1. Chart I (page 7) provides a schematic of the process involved in deciding when to order visits in the Dependency Court. Chart II (page 8) provides a schematic of the process involved in deciding when to order visits in Family Court.
2. There should be no visits ordered until child protective services, mental health workers, family court services, or expert panel member have submitted a report for the review of the judicial officer. The report (Section C) will indicate when it is in the best interest of the child to have visits with the (alleged) perpetrator.
3. When available, the child and (alleged) perpetrator should have separate contact with mental health professionals in the interim between the allegations and the beginning of visits. Included in the treatment goals is preparing the child and (alleged) perpetrator for therapeutic contact. (See Section D.)
4. The first visits ordered are for therapeutic contact. It is expected that a mental health professional, child protective services worker, or evaluator who knows both the (alleged) perpetrator and child will be present at the initial therapeutic contacts. The meetings should be held in the child therapist's office or a neutral

location.

Therapeutic contact differs substantially from monitored visits. During therapeutic contacts the person guiding the contact actively engages in assisting the (alleged) perpetrator and the child to reengage in a relationship. In these therapeutic contacts, the professionals assist in: a) discussing the allegations; b) discussing issues of adult responsibility when abuse occurs; c) discussing any secrets, threats or other pressure felt by the child; d) defining the altered relationship between the child and parent regarding physical contact during visits (See attached CAPSAC Guidelines for Monitored Visits, p. 13.); f) discussing areas of concern for the child and the (alleged) perpetrator, past, present and future; g) talking about emotional, sexual and physical boundaries; h) setting the stage for future open communication; i) assisting in any helpful dialog between the parties.

During therapeutic contacts the child is supported in what he or she wishes to say to the (alleged) perpetrator regarding the allegations or other matters. The (alleged) perpetrator need not acknowledge any statements made by the child regarding the allegations (if the allegations have been denied) but is asked to listen to and not contradict or question the child. The child is told that the (alleged) perpetrator will listen even if he or she disputes the child's veracity. This session is not used to determine the truth of allegations and all parties should have this explained ahead of time. (See attached CAPSAC Guidelines for Monitored Visits, pp.9 -11.)

This therapeutic contact is supportive of the child and is used to provide understanding of the relationship between the child and the (alleged) perpetrator and to state the reasons for the court requirement of monitoring.

Without discussion regarding the allegations of abuse, a child victim may develop self-defeating behavior repeatedly seen in battered spouses. Battered spouses can engage in a continuous cycle of returning to the batterer with neither partner adequately acknowledging the abuse, only to leave and return again after subsequent abusive incidents.

5. Therapeutic contacts will give way to suitably monitored visits unless the outcome of these initial contacts contraindicates such visits. In that case, the professionals assisting in the therapeutic contacts will make recommendations to the court regarding further preparation of the child and the (alleged) perpetrator for healthy contact.

6. A suitable monitor is a professional monitor or someone known and trusted by the child, who believes the court was correct to order monitored visits and is willing and capable of protecting the minor, that is, has adequate assertion skills and influence over the (alleged) perpetrator that he or she will conform to the rules of the visit as imposed by the monitor. (See attached CAPSAC Guidelines for Monitored Visits, pages 9-14.)

C. Information Required from Mental Health Professionals/Child Protective Services/Family Court Services/Expert Panel Members to Assist in Determining When to Begin Therapeutic Contacts

1. Report on Child

- a. Is the child clear about issues related to responsibility when an adult molests a child?
- b. Can the child talk about the (alleged) sexual abuse without significant anxiety, shame or guilt? Will the child be able to state his/her feelings to the (alleged) perpetrator? If not, can the child listen while a mental health professional talks about the (alleged) abuse to the (alleged) perpetrator in order to set the stage for the visits?

- c. If the child is highly sexualized, will meeting with the (alleged) perpetrator exacerbate the condition?
- d. What are the child's feelings about visiting the (alleged) perpetrator? What statements has the child made? Is the child allowed by the nonmolesting parent to experience his or her own emotions regarding the allegations and the (alleged) offender? Are the child's feelings about meeting with the (alleged) perpetrator unduly influenced by the needs of the nonmolesting parent or other family members?
- e. Is the child likely to be highly distressed by the visits? If so, will this be detrimental to the child's emotional health?
- f. If the child wants to visit with the (alleged) perpetrator, who will be present to assist the child in talking about the (alleged) abuse and any other relevant issues? This could be the child's therapist, counselor, or social worker. The person must be someone with whom the child is comfortable and who can speak about the (alleged) abuse in a therapeutic manner.
- g. Does the (alleged) perpetrator play an integral role in the developing mental health of the child? What has been the quality of the attachment between the child and the (alleged) perpetrator? Is the child going to suffer from not visiting with the (alleged) perpetrator? If the child wants to visit with the (alleged) perpetrator, are the child's motivations in the best interests of his/her recovery from the (alleged) abusive relationship? In what way will the child profit from the visit?
- h. Are there any concerns about the victim's relationship to siblings, the nonmolesting parent or extended family members? Are safety measures necessary for contact of the (alleged) victim with other family members?
- i. Provide future treatment goals, a proposed timetable for resuming contact, and any other information which will help the judicial officer make the decision when to begin therapeutic contact between the child and (alleged) perpetrator.

2. Report on (Alleged) Perpetrator

- a. With the understanding that there is no requirement to agree or appear to agree with the allegations, will the (alleged) perpetrator allow the child or the mental health professional working with the child to freely discuss the allegations or the contents of a sustained petition in the initial therapeutic contact?
- b. If the child has said "no" to visits, is the (alleged) perpetrator able to understand the child's apprehension or concerns?
- c. Is the (alleged) perpetrator acting in a retaliatory manner or demanding his/her rights to visits, regardless of the child's statements and/or emotional and behavioral condition?
- d. How much progress has the (alleged) perpetrator made in being able to understand and act on behalf of the best interests of the child? Is the (alleged) perpetrator ready to behave in a way which will enrich, rather than potentially further harm, the child's relationship to him/her?
- e. What is the level of insight of the (alleged) perpetrator? Does the (alleged) perpetrator take responsibility for any negative or problematic behaviors toward the child and/or other people significant to the child?
- f. Does the (alleged) perpetrator understand ways in which people may violate the emotional, sexual and physical space of the child? Can the (alleged) perpetrator articulate what the child alleges

happened? If the (alleged) perpetrator denies the (alleged) sexual abuse, can he or she discuss abuse issues hypothetically, that is, how might a sexually abused child feel?

g. Does the (alleged) perpetrator understand and agree to follow the rules regarding physical contact and verbal interactions with the child during the therapeutic contacts and monitored visits? (See attached CAPSAC Guidelines for Monitored Visits, page 10.) Does the (alleged) perpetrator see people's need for physical and emotional space and boundaries?

h. If the (alleged) offender blames the nonmolesting parent for the allegations, can he or she see the need to forego this battle with the other parent when interacting with the child?

i. Provide future treatment goals, a proposed timetable for resuming contact, and any other information which will help the judicial officer make the decision when to begin therapeutic contact between the child and (alleged) perpetrator.

3. Report on the Nonmolesting Parent

a. Is the nonmolesting parent sufficiently aware of how the (alleged) abusive relationship was able to occur without detection? Has the nonmolesting parent become aware of and assumed responsibility for whatever part he or she may have played in the (alleged) abuse?

b. Describe the nonmolesting parent's assignment of blame for the abuse. How does the nonmolesting parent see the role/function of each family member in the (alleged) abuse?

c. How have the nonmolesting parent and the family adjusted subsequent to the allegations or the sustained petition of sexual abuse? Are there adequate protections in place for nonmolested siblings?

d. Is the nonmolesting parent adequately prepared to support the child and transport the child to therapeutic contacts with the (alleged) perpetrator?

e. If the child's therapist believes the child is ready to begin therapeutic sessions with the (alleged) perpetrator, is the nonmolesting parent in agreement? If not, describe the issues and what movement is being made toward their resolution.

f. If the child is outside the home and the (alleged) perpetrator and nonmolesting parent are living together or friendly, how does this affect the initial therapeutic interactions? Who should be present? Is the nonmolesting parent sufficiently protective of the (alleged) child victim and other siblings?

g. What are the nonmolesting parent's feelings about the (alleged) victim visiting the (alleged) perpetrator? What statements has the nonmolesting parent made? Is the child allowed by the nonmolesting parent to experience his or her own emotions regarding the allegations and the (alleged) offender? Are the child's feelings about meeting with the (alleged) perpetrator unduly influenced by the needs of the nonmolesting parent or other family members?

h. Provide future treatment goals, a proposed timetable for resuming contact, and any other information which will help the judicial officer make the decision when to begin therapeutic contact between the child and (alleged) perpetrator.

4. Report on the Minor's Caretaker (if not the nonmolesting parent)

a. If the child's therapist believes the child is ready to begin therapeutic sessions with the (alleged) perpetrator, is the child's caretaker in agreement?

- b. Is the child's caretaker adequately prepared to support the child and transport the child to therapeutic contacts with the (alleged) perpetrator? If not, provide a proposed plan for preparing for the visits.
5. Report from Child Protective Services (If applicable)
 - a. Describe the role and goals of all therapists and other community supports working with family members.
 - b. Provide the results of CPS assessment of all family members. Are there other victims in the family? How are the siblings of the (alleged) victim reacting to the allegations and to their sibling?
 - c. Include as attachments letters from the all therapists involved with any family member. If there are no other mental health providers, the CPS worker should answer the questions outlined in Section C 1-4.
 - d. Make recommendations regarding when it is in the best interest of the child to start therapeutic contact leading to monitored visitation for the (alleged) child victim.
 - e. Make recommendations regarding visitation for the siblings of the (alleged) victim.
 - f. Suggest an appropriate treatment plan and case plan for the family.
 - g. In the event that there are no auxiliary therapeutic professionals, the CPS worker should propose an alternate means of proceeding with therapeutic contact, monitored visits and eventual family reunification.

D. Therapy For The Parties

1. If the (alleged) perpetrator, due to denial of the allegations is not in sex offender specific therapy, he/she should be in therapy working on:
 - a) an empathic response to his/her child's belief regarding the (sustained) allegations;
 - b) preparation for monitored visits;
 - c) impulse control, problem solving and conflict resolution;
 - d) understanding healthy physical and emotional relationships between adults, and between adults and children;
 - e) the dynamics of sexual abuse and its effects on the child/victim, siblings, nonmolesting parent and family unit ;
 - f) developmentally appropriate parenting roles and responsibilities related to child/victims and siblings;
 - g) healthy emotional, physical and sexual boundaries between adults and children and
 - h) if the (alleged) perpetrator thinks all fault for the allegations lies with the nonmolesting parent, how he or she plans to control this when with the (alleged) victim.
2. The nonmolesting parent generally requires a separate therapist from the child to assure that any competing needs of the nonmolesting parent, and the child are accurately identified and worked through.

The role of the nonmolesting parent is important in the reunification of the family. If the nonmolesting parent is supportive of the child, regular contact with this parent, in preparation for successful reunification will be important. If not supportive of the child, all visits should be closely monitored.

3. Mental health professionals who work with the (alleged) perpetrator, nonmolesting parent, siblings and the (alleged) victim should be ordered to be in regular contact with one another throughout the therapy process. (The task force is aware that if there are parallel proceedings in Criminal Court that the psychotherapist-patient privilege may be at issue.) Regular contact with child protective services is also essential, if they are involved.

E. [Charts I](#) and [Chart II](#).

1. These charts reflect the suggested decision making process for ordering visitation in cases where allegations of sexual abuse appear reasonably credible in Family Court or there is a prima facie case in Dependency Court. The pertinent sections of this document are referred to in the charts.

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**CHART I
 DECISION MAKING PROCESS FOR ORDERING
 VISITATION WHEN THERE IS A PRIMA FACIE CASE
 OF SEXUAL ABUSE IN DEPENDENCY CASES**

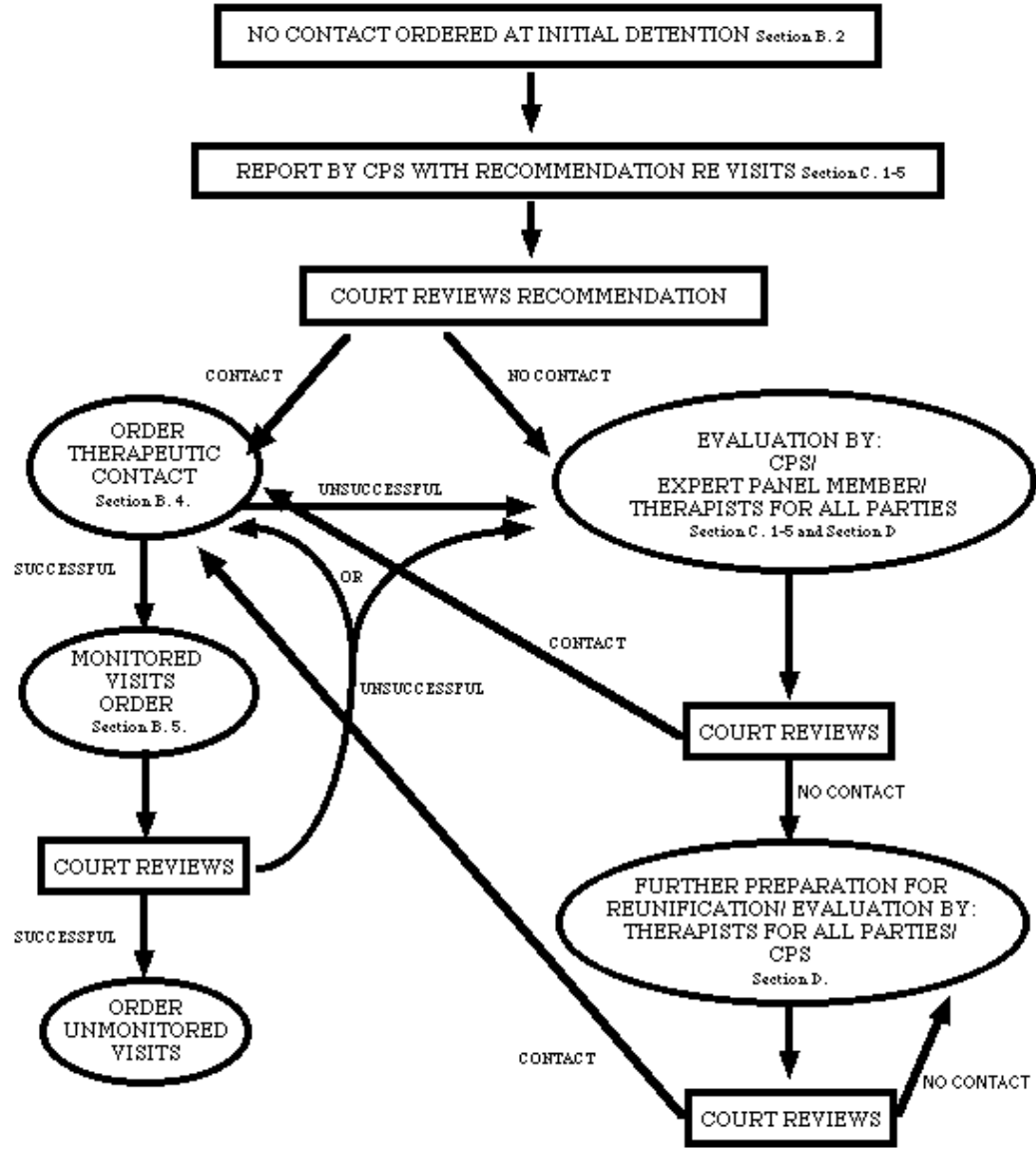


CHART II
DECISION MAKING PROCESS FOR ORDERING VISITATION
WHEN SEXUAL ABUSE ALLEGATIONS APPEAR
REASONABLY CREDIBLE IN FAMILY LAW CASES

