THE IMPACT OF CHILD PHYSICAL & SEXUAL ABUSE ON SUPERVISED VISITATION

CHAPTER 3

Introduction

Many of the children referred to supervised visitation programs by the Department of Children and Families, a Community Based Care agency (CBC), and/or the court have been physically and/or sexually abused. Both physical and sexual abuse not only result in physical injuries to the child but also have emotional, behavioral, and societal consequences that impact the provision of supervised visitation services. Visit monitors must have an understanding of these consequences in order to provide appropriate services.

In most cases of this type, DCF or the CBC has temporary custody of the children and works with the family to ensure pre-reunification case planning. In some cases, DCF works to terminate parental rights due to the severity of the abuse, the failure of the parents to follow through on their case plan, or other factors. Some children referred to supervised visitation may be in relative placement outside of the home, living in emergency shelter, or staying with foster parents.

Overview

This chapter provides current information and research findings about child physical and sexual abuse in order to assist visit monitors in their roles. For more comprehensive information on child sexual abuse, however, visit monitors should refer to the manual Child Sexual Abuse Referrals: A Curriculum for Supervised Visitation Providers published by the Clearinghouse on Supervised Visitation.

Objectives

Upon completion of this chapter, a visit monitor will be able to:

1. Identify types of physical and sexual child abuse;
2. State the prevalence of child physical abuse based upon the most current research findings;
3. Recognize risk factors and mediating factors for child physical abuse;
4. Discuss the developmental impact of physical abuse upon child victims;
5. State the prevalence of child sexual abuse based upon the most current research findings;
6. Recognize risk and mediating factors for child sexual abuse;
7. Discuss the developmental impact of child sexual abuse on child victims;
8. Assess the impact of abuse experiences on supervised visitation;
9. Identify role of visit monitors in observing visits involving child physical and sexual abuse; and
10. Prepare a child for visits, monitor visits, and follow-up visits.

Snapshots

Physical Abuse

● The third annual National Incidence Study of Child Abuse and Neglect found that boys had a greater risk of emotional neglect and of serious injury than did girls.

● Children of single parents had a 77% greater risk of being harmed by physical abuse and an 80% greater risk of suffering physical injury from abuse or neglect than did children living with both parents.

● A child’s age and gender are related to the rate of maltreatment, but race is not.

● Sixty-two percent of abused children were abused by their birth parents.

● Studies have found abused children to be 25% more likely to experience depression, teen pregnancy, low academic performance, drug use, and mental health problems than non-abused children.

● Data from the National Child Abuse and Neglect Systems reported an estimated 1,400 child fatalities in 2002.

● Of these fatalities, children under one year of age accounted for 41% of deaths.

Child Sexual Abuse

● Girls are sexually abused three times more often than boys.

● Twenty-five percent of sexually abused children were assaulted by a birth parent.

● Between one in three and one in four adult women report that they were sexually abused as children.
Types of Physical and Sexual Abuse

Physical and sexual abuse vary by type and severity. Physical abuse ranges from bruising to choking to brain trauma, and sexual abuse ranges from exposure to pornography to fondling to anal or vaginal penetration. Table 3.1 presents types of physical and sexual maltreatment along with descriptions or examples. It is derived from the State of Florida, Department of Children and Families’ Child Abuse Allegation Matrix.

Table 3.1
Types & Examples of Physical & Sexual Abuse

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Description/Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruises, welts</td>
<td>Injuries resulting from bleeding within the skin when skin is discolored but not broken.</td>
</tr>
<tr>
<td>Cuts, punctures, bites</td>
<td>A cut or break in the skin caused by an object or teeth.</td>
</tr>
<tr>
<td>Burns/scalds</td>
<td>Tissue injury resulting from exposure to heat or chemicals.</td>
</tr>
<tr>
<td>Dislocation of bones</td>
<td>Displacement of a bone from its joint.</td>
</tr>
<tr>
<td>Bone fractures</td>
<td>Broken bone: simple, compound, complicated or spiral.</td>
</tr>
<tr>
<td>Internal injuries</td>
<td>No visible injury to organs in chest or abdomen.</td>
</tr>
<tr>
<td>Skull fracture, brain or spinal cord damage, intracranial hemorrhage</td>
<td>Broken bone in skull, injury to nervous system, Shaken Baby Syndrome.</td>
</tr>
<tr>
<td>Asphyxiation, suffocation</td>
<td>Choking, smothering, or drowning which interfere with oxygen intake.</td>
</tr>
<tr>
<td>Deadly weapon</td>
<td>Injury caused by or threatened through a deadly weapon such as a knife or gun.</td>
</tr>
<tr>
<td>Beatings and/or excessive corporal punishment</td>
<td>Striking a child resulting in temporary or permanent disfigurement or impairment of a body part or death.</td>
</tr>
<tr>
<td>Sexual battery (incest)</td>
<td>Sexual battery or sexual intercourse with a child by a blood relative who is responsible for the child's care (includes anal, vaginal, penile penetration, placing an object in a child's anus or vaginal oral sex – fellatio, cunninglingus, anal-lingus).</td>
</tr>
<tr>
<td>Sexual battery (not incest)</td>
<td>Sexual battery or sexual intercourse with a child by a person not related to the child by blood but who is responsible for the child's welfare (step-parents) or who is an adult household member.</td>
</tr>
</tbody>
</table>
### Table 3.1 (cont’d)
Types & Examples of Physical & Sexual Abuse

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Description/Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual molestation</td>
<td>Sexual conduct with a child when such contact is used to arouse or sexually gratify the abuser. May include voyeurism, showing a child pornography, having a child masturbate while adult watches or vice versa, exposure of genitals, fondling, frontage, digital penetration, breast sucking, tongue kissing, or sexual contact with animals.</td>
</tr>
<tr>
<td>Sexual exploitation</td>
<td>Use of a child for sexual arousal or sexual gratification for profit. May include allowing a child to participate in or watch pornography or engage in prostitution.</td>
</tr>
</tbody>
</table>

**Sexual battery under Florida Statues is defined as oral, anal, vaginal penetration by or in union with the sexual organ of another, or the anal or vaginal penetration of another by any object.**
Exercise
Responding to Child Physical & Sexual Abuse

Instructions: Using newsprint and markers, list types of physical and sexual abuse that have been referred to the supervised visitation program in the past or that have appeared in the newspaper or on television. For example, monitors might list a case in which a parent burned a child’s hands on the stove-top, or an incident in which a parent was accused of taking pictures of a sexually-posed child.

Next, discuss the following questions:

- What feelings do you think you will have to overcome to be able to facilitate visits between abusive parents and their children?
- Do you feel supervised visitation services should be offered to these families? Why or why not?
- How might your feelings as a visit monitor interfere with your ability to be respectful in observing visits?
- How might a non-abusing parent or foster parent respond emotionally?
- Many workers identify the following reactions: fear, anger, feeling overwhelmed, disgusted, anxious, ambivalent, depressed, frustrated. Do you have any of these feelings about monitoring child sexual abuse cases?

Risk Factors
of Child Physical & Sexual Abuse

Research on the causes of child physical and sexual abuse typically examines factors from four systems: 1) the child, 2) the family, 3) the community in which the child lives, and 4) the larger social system. Each of these is discussed below.

Child Risk Factors

Children are not responsible for the abuse they experience, but research does indicate that certain characteristics of children may increase their risk for abuse. These characteristics include the following:

- Premature birth, birth anomalies (defects), low birth weight, exposure to toxins in utero;
- Temperament – especially if the child is difficult or slow to engage with the parent;
- Physical, cognitive, or emotional disabilities;
- Chronic illness – seizure disorders, cystic fibrosis, etc.;
- Childhood trauma;
- Anti-social peer group;
- Age (younger children at greater risk for physical abuse); and
- Child aggression, behavioral problems, attention deficits.

**Parental or Family Risk Factors**

Research has found that certain characteristics of a child’s family may also increase the risk for child physical or sexual abuse. These include:

- Substance abuse by parent;
- Domestic violence;
- High parental conflict;
- Social isolation;
- Family structure (single-parent, large number of children in home, step-parent or parent’s live-in partner);
- Parental mental illness;
- Separation/divorce;
- Age (younger parents are more likely to be physically abusive);
- Poor parenting skills (unrealistic expectations of child, disregard of child’s needs, negative perception of child, over-control of child, and poor boundaries); and
- Emotional & behavioral characteristics (anger and control problems, depression/anxiety, low frustration tolerance, low self-esteem, poor impulse control, lack of trust, or rigidity).

**Community Factors**

A number of community factors have been associated with child maltreatment as well. These include:

- Low socioeconomic level of community/neighborhood;
- Inadequate schools;
- Poor accessibility to or availability of health care, child care, social services;
- High unemployment;
- Youth gangs; and
- Exposure to institutional racism or gender bias.
Societal Factors

Research on child maltreatment also acknowledges the impact of larger societal factors on the prevalence of child physical and sexual abuse. These may include:

- Societal acceptance of violence as evidenced by the media or in entertainment;
- Religious views that support non-interference by public entities in child-rearing practices; and
- Lack of agreement by society as a whole about the definition of child abuse, the prevalence of abuse, or even consensus on appropriate interventions and treatments.

Mediating or Protective Factors for Child Physical & Sexual Abuse

Research conducted in the past decade acknowledges that there are mediating and protective factors within children, families, communities, and societies which help reduce the risks of child maltreatment, build family capacity, foster resiliency, and reduce the impact or consequences of abuse. These factors help explain why some children with the risk factors previously presented become abused and other children do not. They also help us understand why some child victims suffer long-term consequences, while others with the same risk factors do not. (This is not an exhaustive list. Factors do not imply causality.)

Child Protective or Mediating Factors

- Good health;
- No problems during pregnancy or birth;
- Above-average intelligence;
- Hobbies or outside interest;
- Good peer relationships; and
- Personality factors (good coping skills, social skills, easy temperament, self-esteem, internal control).

Parental/Family Protective or Mediating Factors

- Warm parent-child relationships;
- Supportive family environment;
- Extended family support;
- Advanced parental education;
• Household rules/structure;
• Parental monitoring of children;
• Good parental coping skills;
• Strong parenting skills; and
• Non-violent family environment.

Community/Societal Protective or Mediating Factors

• Stable socio-economic status in community;
• Accessible health care, child care, and social services;
• Low unemployment;
• Safe housing;
• Good schools and educational opportunities;
• Supportive adults outside of family; and
• Faith-based institutions or other social networks.
Instructions: If doing this exercise as a group, assign participants to groups of three to four people. If having trainee read the manual on his/her own, have him/her write reactions or responses for review by a supervisor. Ask trainees to read the following case examples and identify which risk factors are present.

Case One: A father with developmental disabilities has charges of sexual battery pending, but has been allowed to visit his six-year-old daughter. The mother also has developmental disabilities but was awarded custody. The family lives in a rural community with no transportation; the nearest healthcare facility is twenty miles away.

Case Two: A father is ordered to have access to his eight-year-old daughter and ten-year-old son at a visitation center. The parents are involved in a bitter custody dispute with a history of high parental conflict. There are allegations of sexual abuse, domestic violence, and substance abuse against both parents.

Case Three: A mother and father are referred to your program to visit their five children whom they have been accused of abusing. The children were kept in cages at their home and, when found, were severely malnourished with physical evidence of old and new injuries. Three of the children are developmentally delayed and another has significant mental health problems. The mother has a history of depression. The father is an immigrant who comes from a culture that values authoritarian discipline and dominance over women.

Consequences of Physical and Sexual Abuse for Children

Physical and sexual abuse of children causes physical health, psychological, behavioral, and intellectual consequences, which are presented below. Visit monitors should also remember that the protective or mediating factors discussed in the previous section may reduce the impact of these consequences in some child victims.

Physical Health Consequences

Broken bones, burns, Shaken Baby Syndrome, failure to thrive, and genital damage are all examples of the physical impact of child physical or sexual abuse. The severity of the abuse can have both short-term and long-term consequences. Abuse can lead to blindness, learning and developmental delays or disabilities, sleep disturbances, hyperactivity, and recurring chronic health conditions. Sexually-abused children may be at risk for sexually transmitted diseases. Additionally, children may be at risk for HIV/AIDS if their sexual abuse entailed rectal, anal, oral, or vaginal exposure to HIV-positive body fluids.
Psychological or Emotional Consequences

Poor emotional health is typically a consequence of child maltreatment. This can be manifested in a variety of ways, including panic disorders, post-traumatic stress disorder, attachment disorder, cognitive disorders (language delays, poor motor skills, limited intellectual functioning), or social difficulties (aggressiveness, fighting, poor peer relations, problems in school, etc.). Children who have experienced abuse often appear emotionally “needy.”

Behavioral Consequences

In a study conducted in 1997, children were found to be 25% more likely to experience delinquency, teen pregnancy, drug use, and have mental health problems if they had been abused. The National Institute on Drug Abuse (2000) found that two out of three clients in drug treatment had been abused as children.

Societal Consequences

Communities and larger societal systems (courts, child welfare agencies, law enforcement agencies) experience consequences of child abuse, too, including increased caseloads and increased demand on public services such as jails and emergency rooms.

Reactions of Parents, Children and Staff

Parents (both those who are abusive and those who are not), children, and staff may have reactions or concerns about scheduled supervised visits in cases of physical or sexual abuse. These are discussed below.

Reactions of Parents

- Either parent may have anger, sadness, apprehension, or anxiety about the visit.
- Parents may be distressed at seeing injuries to the child that have resulted from their abuse. They may try to minimize or ignore the injuries or blame some other party for them.
- Parents may minimize or deny that their actions were abusive – they may try to force the child to recant the allegations or convince the visit monitor to agree that they are “good” parents.
- Parents may also experience psychosomatic complaints before a visit: headaches, stomach problems, tiredness, etc.
- Parents may be physically or verbally aggressive toward visitation staff.
- Non-abusing parents may have been engaged in losing court battles trying to confirm the abuse and have given up in the process. These parents may appear “worn-down” not only by the child's abuse but also by the child's recanting or the lack of support from family or social systems.
Reactions of Foster Parents or Relatives

Foster parents or relatives who bring an abused child to a visit may also have concerns:

- Anxiety about potential adverse effects of the visit on the child;
- Concern that the staff cannot keep the child safe;
- Anticipation that the child will experience emotional or behavioral problems following the visit; and,
- Anxiety that the parent will seek them out and harm them.

Reactions of Children

Among the reactions to supervised visitation experienced by children are concerns about physical health, psychosomatic reactions, developmental issues, and behavioral reactions.

- **Physical Health Concerns**
  A child may experience ongoing repercussions of physical or sexual abuse such as scars, disfigurement, pain, difficulty in urination, or difficulty in speaking that may impede the visit. Children who have experienced sexual abuse may have specific concerns related to their sexual orientation (if abused by a same-sex parent) or concerns about their sexual development. Female children who have been sexually abused may have concerns that they are pregnant or concerns about carrying a pregnancy to term if the abuse has resulted in a pregnancy. Children whose abuse has resulted in scarring or disfigurement may be embarrassed or feel shame or feel guilt around their parents or other visiting families.

- **Psychosomatic Concerns**
  A child who has experienced abuse and who is now having emotional reactions to the abuse may respond with psychosomatic symptoms when informed that he/she will see an abusive parent. The child may report headaches, stomachaches, or feeling tired before, during, or after a visit.

- **Developmental Concerns**
  A physically or sexually abused child may have a number of developmental concerns that impact the visit including attachment issues (refusing to leave a foster parent to visit a parent), feelings of loss of control, vulnerability, impulse control, suicidal ideation or attempts, interpersonal concerns involving loss, self-blame, betrayal by the parent and/or the visit monitor, or intrapersonal issues (fear, trauma, anxiety, depression, flat affect, loss, or grief).

- **Behavioral Concerns**
  Children may manifest avoidant and/or aggressive behavior – refusing to go into the visit, fighting with visit monitor or other staff, or cursing. A child may also manifest sexualized behaviors toward other children, the visiting parent, or staff if there is a history of sexual abuse.
Reactions of Staff

Abusive parents present particular issues for visit monitors. The success of a visit may depend on the skill and education of the visit monitor as well as the nature and severity of the abuse, the age of child, the response of the family system, the case management plan for the family, and other factors.

Visit monitors assigned to parents who have been physically or sexually abusive to their children must be aware of their own feelings toward the parents and not allow these feelings to interfere with their ability to monitor the visit. At the same time, however, visit monitors must be fully aware of the impact of prior abuse experiences upon the child and his/her reaction to the visit and the potential for the child to be re-victimized during a visit with a parent.

Visit monitors may have been victims of child sexual abuse. If they have not addressed their own experiences of victimization, they may have difficulty effectively and objectively observing cases involving child sexual abuse. Program directors should be sensitive to this possibility and offer visit monitors the option of refusing certain types of cases without requiring them to reveal details of their personal histories.

Preparing a Physically or Sexually Abused Child for a Visit

Before scheduling a visit between a physically and/or sexually-abused child and his/her abusive parent, a number of factors must be considered, including the child’s concerns regarding her/his safety and protection, feelings of the child toward the parent and the visit itself, needs and wishes of the child, and the child’s willingness to interact appropriately with the parent seeking visitation.

Other factors that require attention by the visit monitor are a full understanding of the status of any protective service investigation that might be underway. Specifically, the monitor should be aware if the investigation is ongoing, if abuse has been founded/unsubstantiated, or if DCF is moving toward termination of parental rights. These issues are important for pre-visit planning.

Strategies for Preparing a Child for Visitation

If the child has visible injuries or scars from the physical abuse the visit monitor may want to:

- Explore the child’s embarrassment or thoughts about the injuries.
- Use role-play to practice responses if questioned about the injuries from other children, parents, or staff.
- Understand or anticipate parents’ reactions to seeing scars or injuries caused by parental abuse.
To address emotional concerns of a child anticipating contact with an abusive parent, a visit monitor may:

- Help the child express his/her fear, anger, or anxiety about seeing the parent. Anticipate that some children may exhibit temper tantrums, be argumentative, or refuse to discuss a pending visit.

- With older children and adolescents, the visit monitor should explore potential risk for self-harm, mutilation, or suicidal attempts/thinking.

- Visit monitors should educate foster parents or relatives caring for the child to anticipate possible acting-out behavior before or after a visit with an abusive parent.

- Help the child recognize her/his ambivalence toward the abusing parent – i.e. acknowledge both feelings of love and hate. Abused children express strong attachment and loyalty to the parents who have abused them. At the same time, they may express fear over continuing harm and rejection by the parent.

- Offer a nurturing environment where children can experience unconditional positive regard.

- Help the child express, either verbally or through play activities, his/her feelings about the visit.

- Initiate interventions that allow the child to “manage” or “control” the visits: for example, choosing to end a visit by using a pre-arranged signal with the visit monitor, or cooperatively setting parameters for physical contact.

- Educate the child about the parent’s responsibilities, the role of the visit monitor, and the role of the foster parent.

- Inform the child about the structure of the visit: where it will take place, who will be present, how long it will last, and if it will take place again.

- Put responsibility for the abuse on the abuser – never make the child think it was his or her fault!

**Monitoring Visits Involving Child Physical or Sexual Abuse**

Visit monitors observing and facilitating visits between an abusive parent and child can engage in a number of techniques to assist the visit:

- Anticipate a range of emotional reactions by both the parent and child such as detachment, depression, anger, or guilt.

- Insure that the parent in no way assigns “blame” or responsibility for the abuse to the child nor tries to minimize or deny that the abuse occurred.

- Anticipate that children, even those who have been severely abused by a parent, may ask when they can return home if they are living in an out-of-home placement.

- Anticipate that children may plead with their parents that they will be “good” if they can return home.

- Allow the child, if he or she chooses, to discuss the abuse, the status of her/his injuries, and treatment that he or she has received. Do not allow the parent to minimize the injuries.
• Do not express alarm if the child engages in sexualized behavior if he or she has experienced sexual abuse. At the same time, do not assume that a child who is referred because of allegations of sexual abuse will always engage in sexualized behavior. Do not assume that abuse did not occur simply because the visit is unremarkable.

• Look for evidence of fear in the child during visits. For example, the child may fear that the parent will be abusive, retaliate for disclosure of the abuse, or fear that something else will occur.

• While it is unlikely that a parent will physically or sexually abuse a child during a visit, it is not unheard of. Be visually aware of any contact between a parent and child and be sensitive to physical “triggers” that may remind the child of the abuse. Listen for coded messages.

• Recognize behaviors that may be sexually arousing for the parent: holding the child on the lap, prolonged lip kissing, etc.

• Be sensitive to emotionally abusive statements made to the child by the parent during visits such as, “I can’t hug you, it would be called abuse.”

• Intervene at any point during the visit by redirecting the parent or terminating the visit if the child becomes tearful, frightened, anxious, obviously distressed, or begins acting out or exhibiting regressive behavior such as urinating on him/herself. In some cases, a short time-out may allow the visit to resume, but in others, the visit should be terminated.

• Allow the child to signal when he or she becomes uncomfortable with anything that is happening during the visit. This can be a code word or physical sign, such as asking to get a drink of water.

**Following a Visit**

• Allow the child an opportunity to express his/her feelings about the visit either verbally or through play activities.

• Review with the child the schedule for further visits.

• Discuss suggestions the child may have for making the visit better or more comfortable/tolerable.

• Discuss with the foster parent (or other caregiver picking up the child after a visit) any concerns or problems that arose during the visit that may affect the child later in the day.

• Prepare the foster parent or caregiver for possible regressive behavior (bedwetting, sleep disturbance, sucking thumb, withdrawal) or aggressive behavior (angry, fighting, breaking things, defiance, sexual acting out) following a visit.

• Follow program protocols for having custodial parent or foster parent report back to staff any unusual behaviors or problems.
Mandatory Reporting of Child Abuse

Florida Statutes 39.201 states that any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report it to the Florida Child Abuse Hotline. If a visit monitor suspects abuse or neglect, it must be reported by calling 1-800-96-ABUSE. Supervised visitation programs have exceptions to their confidentiality policies for child abuse and neglect. Programs also should have protocols for making hotline calls.

Supervised Visitation
in Cases of Termination of Parental Rights

In some cases of physical or sexual child abuse, the Department of Children and Families works to terminate parental rights. This is a legal process whereby parents have voluntarily relinquish their parental rights because they have recognized their inability to provide care, or the court has terminated their parental rights without their consent because of abuse or neglect.

When this is the outcome of a case, a supervised visitation program may be ordered to allow the parents an opportunity to see their children for a final time. Depending upon the age of the child and the circumstances around the termination, some parents may use this opportunity to accept responsibility for their actions and to let the children know that they are loved and are not responsible for either the abuse or the termination. In other cases, parents may express great hostility, remorse, or grief during the visit. Visit monitors need to be prepared for a range of reactions from both children and parents if the visit is to be the final time the family will be together. Whenever possible, a mental health professional should be involved to assist staff with these difficult final visits. They are sometimes called “goodbye visits.”
**Exercise**

*Instructions:* Read the following case studies of families who received services from supervised visitation programs. Discuss or express in writing how these visits should have been handled.

*Case One:* A father is visiting his five-year-old daughter. During the visit, he picks her up and holds her over his lap as if she were an infant. The visit monitor notices that the child seems uncomfortable – she is squirming and pushing away from her father. The visit monitor intervenes and removes the child from the father’s lap. The monitor then observes that the father appears to be sexually aroused. The child asks to go to the toilet by herself. When she comes out of the bathroom, the visit monitor discovers that the girl has had a bowel movement and spread it on the walls of the stall.

*Case Two:* Two sisters, ages eight and ten, are in state custody due to sexual exploitation and abuse. The parents had received money from the father’s employer for allowing him to have sex with the girls. The father requested that the court allow him visitation at the local supervised visitation program. Initially, the visits went well, but later the girls began to show signs of re-victimization. The ten-year-old would fall into a deep sleep immediately after the visit and the eight-year-old would stand in the hallway and urinate on herself after the visits.

*Case Three:* A father was ordered into supervised visitation with his four-year-old daughter due to allegations of child sexual abuse. The father claims the mother is making false allegations to gain custody. During a visit, a visit monitor observes the father holding a stuffed toy near his genitals and having his daughter try and bite the toy as part of a game.

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**QUIZ**

1. Describe child, family, community, and societal risk factors associated with child physical and sexual abuse.

2. Describe mediating factors associated with reducing the impact of child physical and sexual abuse.

3. Discuss physical health consequences and the emotional, behavioral, and societal consequences of child abuse.

4. Identify techniques to employ in preparing a child for a visit with an abusive parent.

5. Identify techniques to employ while monitoring visits.

6. Identify reactions that foster parents or caregivers might notice in a child following a visit.