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Trauma-Informed Co-Parenting: How A Shift in Compulsory Divorce Education to Reflect New Brain Development Research Can Promote Both Parents' and Children's Best Interests

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I. INTRODUCTION

Concerned about the health and emotional wellbeing of children adversely affected by their parents' divorce, legislatures throughout the United States have enacted laws requiring divorcing parents to attend co-parenting classes.¹ The goal of this state intervention in the post-divorce family is to ensure that parents learn ways to minimize conflict between them and harm to their children.² While thousands of parents take these classes structured as "opportunity" for education and resources about building parental skills,³ recent discoveries about brain development and function in medical research have demonstrated that individuals' history of trauma can have a profound impact on their emotional functioning, mental health, and physical welfare.⁴ Called a *hidden epidemic*,⁵ the negative long-

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¹ See Susan L. Pollet & Melissa Lombreglia, *A Nationwide Survey of Mandatory Parent Education*, 46 FAM. CT. REV. 375, 376 (2008).

² Andrew Schepard et al., *Preventing Trauma for the Children of Divorce Through Education and Professional Responsibility*, 16 NOVA L. REV. 767, 772 (1992).

³ Pollet & Lombreglia, *supra* note 1, at 379 (stating that the mandatory nature of the classes was described in one study as "mandating an opportunity" for parents).

⁴ Robert F. Anda et al, *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology*, 256 EUR. ARCH. OF PSYCHIATRY & CLINICAL NEUROSCIENCE 174, 180 (2005) ("Furthermore, the detrimental effects of traumatic stress on developing neural networks and on the neuroendocrine systems that regulate them have until recently remained hidden even to the eyes of most neuroscientists. However, the information and data that we present herein

term impact of childhood trauma reaches across generations.⁶ Without ensuring that co-parent education is adequately *trauma-informed*, those states with compulsory education are missing an important opportunity to help parents understand why they may be struggling, learn the role of unresolved prior trauma in their lives, obtain resources, and protect themselves and their children from recurring trauma.

Part I of this Article provides an overview of the advent and proliferation of statutorily mandated divorce education classes in the United States as well as their goals. Part II explores Adverse Childhood Experiences (ACEs) research that reveals how childhood trauma is associated with serious adult physical and mental illnesses, chronic disease, and risk for violent victimization.⁷ It also describes recent studies on the neurobiology of toxic stress and its impact on human development and wellbeing. Part III describes new data on parents' ACEs and co-parenting behaviors from a project entitled *Successful Co-Parenting After Divorce*, a university-sponsored online course that is part of a larger study on co-parenting issues.⁸ The data reveal that most of the parents in the study experienced multiple traumas in their childhoods. Data also reflected statistically significant relationships indicating that higher amounts of early trauma were correlated with higher amounts of conflict in the co-parenting relationship.⁹ Part IV proposes that current co-parenting training become trauma-informed, and describes the legislative and policy changes that can bring about a trauma-informed co-parenting education landscape. Recommendations include statutory changes in compulsory co-parenting, new family court rules, and evidentiary protections for documents that result from trauma-informed co-parenting education.

suggest that this veiled cascade of events represents a common pathway to a variety of important long-term behavioral, health, and social problems.”).

⁵ Jane Ellen Stevens, ACEs TOO HIGH NEWS, “*Silent Evidence*” *Worth Hearing About*, (May 30, 2016), <https://acestoohigh.com/2012/05/30/silent-evidence-worth-hearing/> (describing the insidious, widespread effects that childhood trauma may have upon adult health outcomes).

⁶ Danya Glaser, *Child Abuse and Neglect and the Brain—A Review*, 41 J. OF CHILD PSYCHOL. & PSYCHIATRY 97, 99 (2000) (explaining that some parents with a prior history of child abuse may be at an increased risk of abusing their own child).

⁷ *The ACEs Study*, CDC, http://www.cdc.gov/violenceprevention/acestudy/ace_brfs.html (last viewed May 5, 2016).

⁸ Fla. St. U., *Successful Co-Parenting After Divorce*, <http://coparenting.fsu.edu> (last visited Nov. 3, 2016).

⁹ See *infra* Part II.

II. DIVORCE AS A PUBLIC HEALTH ISSUE

Divorce has been described as a public health issue because of the large number of children and adults experiencing it;¹⁰ between 40 and 50 percent all first marriages end in divorce,¹¹ and many of these families have children.¹² Decisions about the care and custody of children were historically gender-based,¹³ with fathers having rights to their children as property through the eighteenth century¹⁴ and mothers in the nineteenth century presumed to be uniquely suited to be their children's caregivers and to serve their children's developmental needs.¹⁵ However, modern family law in both the United States and worldwide now emphasizes involvement by both parents in the lives of their children after divorce.¹⁶ Custody disputes about children of divorcing parents shifted when the federal Uniform Marriage and Divorce Act (UMDA) of 1970¹⁷ approved the "best interest standard," a case-by-case determination of what living arrangements would best meet the particular needs of the children involved.¹⁸ Today the best interest of the child standard,¹⁹ first implemented in California, is the law throughout the nation.²⁰

¹⁰ Schepard et al., *supra* note 2, at 768; *see also* Pollet & Lombreglia, *supra* note 1, at 375.

¹¹ Am. Psych. Ass'n, *Marriage & Divorce*, <http://www.apa.org/topics/divorce/> (last visited July 22, 2016).

¹² *See* Hal Arkowitz & Scott Lilienfeld, *Is Divorce Bad for Children?*, *SCI. AM. MIND*, March/April 2013, at 68 (2013), <http://www.scientificamerican.com/article/is-divorce-bad-for-children/>.

¹³ Women had very few rights, and fathers had ultimate authority over their children. J. Herbie DiFonzo, *From the Rule of One to Shared Parenting: Custody Presumptions in Law and Policy*, 52 *FAM. CT. REV.* 213, 214 (2014).

¹⁴ *Id.*

¹⁵ *Id.* By the mid-nineteenth century, maternal custody was presumed. Deborah Ahrens, *Not in Front of the Children: Prohibition on Child Custody as Civil Branding for Criminal Activity*, 75 *N.Y.U. L. REV.* 737, 751 (2000).

¹⁶ DiFonzo, *supra* note 13, at 214–15.

¹⁷ Unif. Marriage & Divorce Act § 308 (1973); CAL. CIV. CODE § 4801 (West 1976) (repealed 1993). The UMDA provided for an equal division of community property and made other substantive changes to improve the law, including increasing the emphasis on counseling and conciliation services. It also made a number of modifications designed to both make the divorce process less painful and to expedite the time necessary to secure a divorce. *See* Ovvie Miller, *California Divorce Reform After 25 Years*, 28 *BEVERLY HILLS B. ASS'N J.* 160 (1994).

¹⁸ *See, e.g.,* *Rosero v. Blake*, 581 S.E.2d 41 (N.C. 2003), *cert. denied*, 540 U.S. 1177 (2004) (abolishing a rule that automatically placed children born out-of-wedlock with their mother and replacing it with a "best interests" test for such children).

¹⁹ The "best interests of the child" standard requires consideration of "all relevant factors, including the child's health, safety, and welfare, any history of abuse by one parent

The UMDA also reflected the realization that divorce can be a painful process for all involved.²¹ Concerns about the impact of divorce on children have included children's "crisis-engendered reactions."²² Such emotional impacts can include deep sadness, anger, and distress over the child's future welfare; feelings of loss of the family structure; fear of losing a connection with both parents; desire for parents' reconciliation; and inability to concentrate at school.²³ Concerned about hostile custody battles between parents so contentious that legal decisions have used military terminology to describe them,²⁴ judges have supported a transformation of

against any child or the other parent, and the nature and amount of the child's connection with the parents." *Brown v. Yana*, 127 P.3d 28, 31 (Cal. 2006). *See Fox v. City of Tulare*, No. 1:11-CV-O520 AWI SMS, 2014 WL 3687735, at *11 (E.D. Cal. July 24, 2014) ("[A] child who is the object of a custody battle between biological parents is entitled to proceedings that use the "best interest of the child" legal standard.").

²⁰ Joan B. Kelly, *Future of Children: The Determination of Child Custody*, 4 CHILD. & DIVORCE 121, 128–37 (1994). Many states have laws that enumerate how the court is to determine what is in a child's best interest using factors such as the following:

(c) The capacity and disposition of the parties involved to provide the child with food, clothing, medical care or other remedial care recognized and permitted under the laws of this state in place of medical care, and other material needs. (d) The length of time the child has lived in a stable, satisfactory environment, and the desirability of maintaining continuity. (e) The permanence, as a family unit, of the existing or proposed custodial home or homes. (f) The moral fitness of the parties involved. (g) The mental and physical health of the parties involved. (h) The home, school, and community record of the child. (i) The reasonable preference of the child, if the court considers the child to be of sufficient age to express preference. (j) The willingness and ability of each of the parties to facilitate and encourage a close and continuing parent-child relationship between the child and the other parent or the child and the parents. (k) Domestic violence, regardless of whether the violence was directed against or witnessed by the child[.]

MICH. COMP. LAWS § 722.23 (2015).

²¹ Unif. Marriage & Divorce Act § 6 (1973) (eliminating the notion of fault in divorce in an "effort to reduce the adversary trapping of marital litigation," removing an "assignment of blame").

²² Andrew Schepard, *War and P.E.A.C.E.: A Preliminary Report and a Model Statute on an Interdisciplinary Educational Program for Divorcing and Separating Parents*, 27 U. MICH. J.L. REFORM 131, 140 (1993).

²³ *Id.*

²⁴ *See, e.g., Cristina Ortega, The Custody Wars: Why Children Are Losing the Legal Battle and What We Can Do About It*, 4 J. L. & FAM. STUD. 217, 218 (2002) (stating that child custody disputes can be a battlefield); Schepard, *supra* note 22, at 140; *see also Kirk v. Kirk*, 770 N.E.2d 304, 305, 307 (Ind. 2002) ("The parties were regularly locked in a litigation struggle over the next five years . . . [I]t is particularly difficult for a reviewing court to second-guess a situation that centers on the personalities of two parents battling for control of a child."); *Black v. Black*, 92 A.3d 688, 695 (N.J. Super. Ct. Ch. Div. 2013) ("For over thirty years after Newburgh, matrimonial litigants and attorneys have battled in court over college contribution issues, frequently and heavily focusing upon factor eleven, the

the divorce process.²⁵ This new philosophy emphasizes a less adversarial approach²⁶ to post-divorce parenting, with both parents co-parenting their children.²⁷

In an effort to make divorce less emotionally difficult, the UMDA emphasized counseling and conciliation services for divorcing individuals.²⁸ Terminology used to describe post-divorce parenting has pivoted from the terms custody and visitation to more cooperation-based language.²⁹ The new legal term “parenting time” is now used by many jurisdictions to encourage a shared parenting approach reflected in a “parenting plan,”³⁰ a term used in the majority of the states³¹ that describes

‘child’s relationship with the paying parent.’”; *Costley v. Benjamin*, No. M2004-00375-COA-R3-CV, 2005 WL 1950114, at *7 (Tenn. Ct. App. 2005) (“Sending the police to the Benjamin house became a pattern during this custody struggle.”).

²⁵ Eric S. Solotoff, *High Conflict Divorces: Parent Coordinators and Other Professions Enlisted to Help with Parenting Time Issues*, NY FAMILY LEGAL BLOG (Dec. 6, 2008), <https://njfamilylaw.foxrothschild.com/2008/12/articles/visitationparenting-time/high-conflict-divorces-parent-coordinators-and-other-professionals-enlisted-to-help-with-parenting-time-issues/>.

²⁶ See, e.g., Catherine M. Lee & John Hunsley, *Empirically Informed Consultation to Parents Concerning the Effects of Separation and Divorce on Their Children*, 8 COGNITIVE & BEHAV. PRACT. 85, 86 (2001) (stating the benefits of medication and other alternatives to litigation); see also Claire Huntington, *Repairing Family Law*, 57 DUKE L. J. 1245, 1281 (2008) (“The process of family law fuels the hate by pitting one family member against another in a win/lose battle.”); Brianna F. Issurdutt, *Child Custody Modification Law: The Never-Ending Battle for Peace of Mind*, 10 NEV. L. J. 763, 764 (2010) (“[C]hild custody law in Nevada has adjusted in an effort to provide more stability for families affected by divorce and custody battles.”).

²⁷ Cynthia Lee Starnes, *Lovers, Parents, and Partners: Disentangling Spousal and Co-Parenting Commitments*, 54 ARIZ. L. REV. 197, 234 (2012) (explaining that when parents divorce during their child’s minority, the marital relationship ends, but divorce does not end the co-parenting partnership, which endures until the child reaches majority).

²⁸ *Id.*; see also Miller, *supra* note 17, at 160.

²⁹ Weinberger Law Group, LLC, *Parenting Time vs. Visitation: What’s the Difference?*, WEINBERGERLAWGROUP.COM (May 31, 2016), <http://www.weinbergerlawgroup.com/blog/newjersey-child-parenting-issues/parenting-time-vs-visitation-whats-difference/> (stating that “[t]he more archaic and possibly more familiar term that was used in the past is ‘visitation.’ But, because a parent spending time with their own child is really time spent parenting the child and not just visiting with the child, the terms have evolved over time.”).

³⁰ See, e.g., Ariz. Supreme Ct., *Planning for Parenting Time: Arizona’s Guide for Parents Living Apart*, ARIZONA.GOV (2009), <http://www.azcourts.gov/portals/31/parentingtime/ppwguidelines.pdf>; Mass. Supreme Ct., *Massachusetts Model Parenting Plans*, MASS.GOV, <http://www.mass.gov/courts/docs/courts-and-judges/courts/probate-and-family-court/parentingplan.pdf> (last viewed July 2, 2016); Minn. Supreme Ct., *Minnesota Parenting Agreement Worksheet*, MNCOURTS.GOV. (2004), <http://www.mncourts.gov/documents/Parenting-Agreement-Worksheet.pdf>; Ind. Supreme Ct., *Indiana Parenting Time Guidelines*, IN.GOV, <http://www.in.gov/judiciary/rules/parenting/> (last viewed July 3, 2016).

³¹ LINDA D. ELROD, *CHILD CUSTODY PRACTICE & PROCEDURE* § 4:7 (2015) (“By court

how time and responsibilities concerning the child are to be divided.³² Divorcing parents are also often required in most states to attend mediation in an attempt to resolve their differences amicably.³³ The rise of parenting coordinators—individuals who help parents resolve disputes over parenting time and parenting plans³⁴—is also an innovation created to help divorcing parents resolve their disputes.

These efforts are largely designed to protect children from the “perpetual turmoil” that can result from protracted litigation and conflict.³⁵ Because of the adversarial environment of the family court process and the powerfully “emotional nature of divorce, child custody battles can turn *vicious*[.]”³⁶ According to one researcher, divorce can be “the single most traumatic experience” of a child’s life, with the potential to cause lasting psychological injury.³⁷ Studies show that children can be adversely affected by their parents’ conflict;³⁸ children exposed to high levels of

rule or statute, over half of the states now require the parties to submit a parenting plan in all or some types of custody cases.”).

³² See, e.g., MINN. STAT. § 518.175 (2015) (emphasizing that it is in the best interest of the child to maintain a relationship with both parents and that parenting time is a shared approach); OHIO REV. CODE ANN. § 3109.04 (LexisNexis 2015) (requiring that parents in shared parenting make decisions together after divorce).

³³ See Resource Center on Domestic Violence, *Custody Mediation Where Domestic Violence is Present*, NAT’L COUNCIL OF JUV. & FAM. CT. JUDGES (Jan. 24, 2014), <http://www.ncjfcj.org/sites/default/files/chart-mediation-dv-present.pdf> (last visited July 3, 2016) (displaying chart of states requiring mediation and listing whether there is an opt-out provision when domestic violence is present); see also Andrew Schepard, *An Introduction to the Model Standards of Practice for Family and Divorce Mediation*, 35 FAM. L.Q. 1, 10–12 (2001) (citing mediation as a way to reduce prolonged conflict which may cause damage to children and is recommended as part of the Family Law and Dispute Resolution Sections of the American Bar Association). But cf. Dennis P. Saccuzzo et al., *Mandatory Custody Mediation: Empirical Evidence of Increased Risk for Domestic Violence Victims and Their Children*, <https://www.ncjrs.gov/pdffiles1/nij/grants/195422.pdf> (finding evidence that compelled mediation puts victims of domestic violence at risk).

³⁴ Christine A. Coates, *The Parenting Coordinator as Peacemaker and Peacebuilder*, 53 FAM. CT. REV. 398, 400 (2015) (explaining that it is the parent coordinator’s responsibility to help parents create structures of co-parenting, such as parenting plans and calendars for parenting time).

³⁵ Lisa Haddad et al., *High-Conflict Divorce: A Review of the Literature*, 29 AM. J. FAM. L. 243, 243 (2016) (noting that for some, “the conflict continues, possibly never ending, trapping themselves and their children in a perpetual turmoil, causing deep and lasting scars”).

³⁶ Allison M. Nichols, *Toward a Child-Centered Approach to Evaluating Claims of Alienation in High-Conflict Custody Disputes*, 112 MICH. L. REV. 663, 664 (2012) (emphasis added).

³⁷ *Id.* (quoting Kathleen Coulborn Faller, *Child Maltreatment and Endangerment in the Context of Divorce*, 22 U. ARK. LITTLE ROCK L. REV. 429, 429 (2000)).

³⁸ Paul R. Amato, *Research on Divorce: Continuing Trends and New Developments*, 72

parental conflict are at greater risk for developing problems such as depression, anxiety, social and behavioral problems, and difficulties developing relationships in later life.³⁹ In the late 1970s,⁴⁰ courts⁴¹ and legislatures⁴² began to mandate that divorcing parents take classes to become educated about the effects of divorce and conflict on children.⁴³ The trend proliferated, with over a dozen states currently requiring all divorcing parents to take a divorce class,⁴⁴ other states recommending only the teaching of certain parenting skills to divorcing parents for the benefit of the child,⁴⁵ and still others leaving the decision of who is required to take the classes to the discretion of the family court judge hearing the case.⁴⁶ A few states have no requirement.⁴⁷

J. MARRIAGE & FAM. 650, 653 (2010) (noting that research has consistently shown that children with divorced parents score lower on emotional, behavioral, social, health, and academic outcomes than children with continuously married parents).

³⁹ See Gregory M. Fosco & John H. Grych, *Emotional, Cognitive, and Family Systems Mediators of Children's Adjustment to Interparental Conflict*, 22 J. FAM. PSYCHOL. 843, 843-54 (2008).

⁴⁰ See Eighth Cir. Fam. L. Advisory Grp., *A Brief Review of the History*, EIGHTH JUD. CT. OF FLA., <http://circuit8.org/web/family/flag/No%20Fault%20Divorce.pdf> (last visited Oct. 28, 2016). The first documented parent education class began in 1978 in Kansas. See *id.*

⁴¹ See Mass. Prob. & Fam. Ct. Order 4:08, MASS. CT. SYS. (Apr. 7, 2008), <http://mgctraining.mass.gov/courts/case-legal-res/rules-of-court/probate/pfc-orders/4-08.html> ("This court finds it in the best interests of the children to educate parents about emotional needs and effects of divorce and conflict on child behavior and development."); see also Ky. Ct. of Justice, *Divorce Education*, COURTS.KY.GOV (2016), <http://courts.ky.gov/courtprograms/divorceeducation/Pages/default.aspx> ("More than half of Kentucky's 56 judicial circuits have some form of Divorce Education that is mandated by the local courts.").

⁴² See, e.g., FLA. STAT. § 61.21(4) (2014) ("All parties to a dissolution of marriage proceeding with minor children or a paternity action that involves issues of parental responsibility shall be required to complete the Parent Education and Family Stabilization Course prior to the entry by the court of a final judgment.").

⁴³ See, e.g., N.Y. State Parent Ed. & Awareness Program, *Parent's Handbook*, NYCOURTS.GOV, <https://www.nycourts.gov/IP/parent-ed/pdf/ParentsHandbook.pdf> (last visited July 3, 2016) (stating that the program was designed to help parents gain a better understanding of what children are experiencing and to help reduce the stress of the breakup on the children).

⁴⁴ See, e.g., TENN. CODE ANN. § 36-6-408 (2015) (requiring parent educational seminar where a permanent parenting plan is or will be entered); UTAH CODE ANN. § 30-3-11.3 (LexisNexis 2015); WIS. STAT. § 767.401 (2015).

⁴⁵ See, e.g., IOWA CODE § 598.15 (2010) (recommending the teaching of parenting skills in conflict resolution for the benefit of the child).

⁴⁶ E.g., 750 ILL. COMP. STAT. ANN. 5/404.1 (LexisNexis 2016); KAN. STAT. ANN. § 23-3214 (2016); MD. CODE ANN., FAM. LAW § 7-103.2 (LexisNexis 2016).

⁴⁷ South Dakota and North Dakota are two states that do not mandate or recommend

The structure and content of divorce education classes have some variation, but overall the emphasis has been on education with efforts to avoid therapy interventions.⁴⁸ Many states have developed a list of content that must be part of these classes,⁴⁹ which typically take between four and nine hours.⁵⁰ Instructors are generally tasked with informing parents about the impact that divorce can have on children and providing a means to create parenting plans that describe the parents' responsibilities and time-sharing arrangements for the children.⁵¹ The statutory mandates generally refer to a more specific set of criteria that are established by rule.⁵² Other states list the general topics in the state law, and name who will certify the classes. Delaware, for example, provides that the "Parenting Education Course" shall be certified by the Department of Services for Children, Youth and Their Families to meet the goal of "educating divorce litigants on the impact on children of the restructuring of families."⁵³ The course, required for divorcing parents unless the judge deems it unnecessary,⁵⁴ must be at least four hours long and include information on the developmental stages of children, children's adjustment to their parents' separation, conflict management and dispute resolution, stress reduction for children, cooperative parenting, and guidelines for visitation.⁵⁵

Researchers who have collected and analyzed reports by parents who take the programs note that parents generally view those programs positively and believe that the classes are helpful to post-divorce

parenting classes for divorcing parents. For a full list of states, see Pollet & Lombreglia, *supra* note 1, at 375.

⁴⁸ Tali Schaefer, *Saving Children or Blaming Parents? Lessons from Mandated Parenting Classes*, 19 COLUM. J. GENDER & L. 491, 497 (2010) (noting that parenting classes "provide education, not therapy").

⁴⁹ See Pollet & Lombreglia, *supra* note 1, at 375 (stating that as of 2008, forty-six states have mandatory divorce education classes).

⁵⁰ See Tamara A. Fackrell et. al., *How Effective Are Court-Affiliated Divorcing Parents Education Programs? A Meta-Analytic Study*, 49 FAM. CT. REV. 107, 111 (2011) (stating that most parent education programs reviewed in the study were about four to nine hours in length).

⁵¹ Amanda Sigal et. al., *Do Parent Education Programs Promote Healthy Post-Divorce Parenting? Critical Distinctions and a Review of the Evidence*, 49 FAM. CT. REV. 120, 132 (2011) (explaining that most divorce education classes outlined goals pertaining to co-parenting, such as the division of time and responsibilities, and education of the impact of divorce-related events on children).

⁵² For example, the Florida Family Stabilization Course is mandated by statute but further defined by Rule 65C-32 of the Florida Administrative Code. FLA. ADMIN. CODE ANN. r. 65C-32 (2016).

⁵³ DEL. CODE ANN. tit. 13, § 1507 (2015).

⁵⁴ *Id.*

⁵⁵ *Id.*

adjustment.⁵⁶ However, criticisms of the programs often include concern that many parenting programs have not been thoroughly evaluated to determine whether they are effective in changing parents' behaviors and attitudes.⁵⁷ Other criticisms of the programs involve the mandatory nature of the classes perceived to place a "negative judgment" and blame on divorcing parents.⁵⁸

A specific concern is that without explicit safeguards for victims of domestic violence, victims compelled to take parenting classes are at greater risk because the courses emphasize that parents must cooperate with each other.⁵⁹ Perpetrators of domestic or intimate partner violence use their power and control over victims to coerce, threaten, and manipulate their victims, thereby severely reducing the amount of bargaining power that their partners have.⁶⁰ This produces an imbalance of power that, when added to the threats of harm and stalking behaviors common in domestic violence dynamics,⁶¹ creates a more formidable batterer. Thus empowered, a batterer can force the victimized parent to capitulate to parenting demands solely to keep more violence from occurring, regardless of whether or not the decisions are in the child's best interest.⁶² No real power to negotiate or compromise exists when domestic violence is present. What is commonly called "parallel parenting,"⁶³ rather than co-parenting, is often recommended in domestic violence cases.⁶⁴

⁵⁶ See Peter Salem et al., *Taking Stock of Parent Education in the Family Courts: Envisioning a Public Health Approach*, 51 FAM. CT. REV. 131, 131–48 (2013); see also Nancy Ver Steegh & Solveig Erickson, *Mandatory Divorce Education Classes: What Do the Parents Say?* 28 WM. MITCHELL L. REV. 889, 905–07 (2001).

⁵⁷ Salem, *supra* note 56, at 131.

⁵⁸ Schaefer, *supra* note 48, at 492.

⁵⁹ See, Evelyn Frazee *Sensitizing Parent Education Programs to Domestic Violence Concerns: The Perspective of the New York State Parent Education Advisory Board*, 43 FAM. CT. REV. 124, 130 (2005) (stating that for victims, engaging in cooperative parenting in a domestic violence or high-conflict situation may very well jeopardize the safety of the abused parent and that of the children).

⁶⁰ N.Y. Office for the Prevention of Domestic Violence, *Understanding Domestic Abusers*, <http://www.opdv.ny.gov/professionals/abusers/genderandipv.html> (last visited July 14, 2016) (describing the "coercive controlling violence" that results in a fixed imbalance of power); see also Kerry Loomis, *Domestic Violence and Mediation: A Tragic Combination for Victims*, 35 CAL W. L. REV. 355, 363–68 (1999).

⁶¹ CDC, *Intimate Partner Violence: Definitions*, CDC.GOV, <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html> (last updated July 20, 2016).

⁶² See Evelyn Frazee & Susan Pollet, *Doing No Harm While Doing Good: Minimizing the Threat of Domestic Violence While Optimizing the Benefits of Parent Education*, 49 JUDGES' J. 23, 24 (2010).

⁶³ Edward Kruk, *Parallel Parenting After Divorce*, Psych. Today (Sept. 1, 2013), <https://www.psychologytoday.com/blog/co-parenting-after-divorce/201309/parallel-parenting-after-divorce> (describing "parallel parenting" as an "arrangement in which

In addition to these concerns, the content of these classes does not require consideration or accommodation of parents' individual needs or differences.⁶⁵ This may be a result of the limited amount of time required to complete many of the courses. Whatever the explanation, no state requires that instructors offer parents a way to gauge their own individual challenges or obstacles to co-parenting as a component of the training. Such a gap may result in ineffective service delivery, especially in light of recent neurobiological studies showing the devastating impact that histories of early trauma can have on individuals' functioning⁶⁶ and research offering evidence that a substantial percentage of the population has suffered such trauma.⁶⁷

III. THE IMPACT OF CHILDHOOD TRAUMA ON PARENTING

Research known as "The Adverse Childhood Experiences" (ACE) studies⁶⁸ has provided confirmation that exposure to childhood trauma can have a profound impact on individual development, and lead to serious

divorced parents are able to co-parent by means of disengaging from each other, and having limited direct contact, in situations where they have demonstrated that they are unable to communicate with each other in a respectful manner").

⁶⁴ See Eighth Jud. Cir. of Fla., *Parallel Parenting Plans*, CIRCUIT8.ORG, http://circuit8.org/parallel_parenting (last visited July 14, 2016) (asserting that parallel parenting plans are appropriate for parents who do not get along, are highly reactive to each other, feel extremely uncomfortable in each other's presence, have an order of protection, or cannot cooperate in one or more major areas of parenting).

⁶⁵ This absence is reflected by the general course requirements for several types of parenting courses. See, e.g., Atrium Fam. Ctr., *Positive Parenting Through Divorce*, http://www.positiveparentingthroughdivorce.com/course_outline.htm (last visited July 14, 2016) (listing general types of information); Cobb Cnty., *Divorcing Parents Seminar, Cobb County*, https://cobbcounty.org/index.php?option=com_content&view=article&id=2193&Itemid=990 (last visited July 14, 2016) (noting that the purpose of the seminar is to "provide parents with information on topics including the divorce process and how it impacts children, developmental stages of children, communication skills, identifying when a child may need help, and realistic expectations about step families"); see also FLA. STAT. § 61.21(1)(c) (2015) (requiring an educational program with general information regarding the issues and legal procedures for resolving time-sharing and child support disputes, the emotional experiences and problems of divorcing adults, the family problems and the emotional concerns and needs of the children and the availability of community services and resources).

⁶⁶ See *infra* notes 68–108.

⁶⁷ See *infra* note 69 and accompanying text.

⁶⁸ Robert F. Anda et. al., *Building a Framework for Global Surveillance of the Public Health Implications of Adverse Childhood Experiences*, 39 AM. J. PREVENTATIVE MED. 93, 93–96 (2010) ("Sufficient amounts of data exist to show that ACEs are common and are associated with many public health problems.").

long-term physical, interpersonal, and mental health problems. The ACE studies also demonstrated that a significant proportion of the public—in most studies between 50% and 75%—have been exposed to traumatic events.⁶⁹ The groundbreaking ACE studies show that exposure to multiple traumas in childhood can create emotional and physical scars⁷⁰ so wounding that their insidious, widespread effects upon adult health outcomes are considered a major underreported source of adult health problems.⁷¹

Evidence of the impact of trauma is not new,⁷² but attention to it has recently increased. The science of childhood trauma has its roots in an accidental discovery. In the 1980s Dr. Vincent Felitti was operating an obesity clinic that was struggling to keep its patients from dropping out of treatment before completion.⁷³ Felitti began by interviewing 286 of the patients from his clinic who had dropped out, and discovered a high rate of early-life sexual trauma among them.⁷⁴ These results prompted Felitti to investigate the prevalence of childhood adversity and its association with adult illness among the general population, eventually leading to a research collaboration between Felitti and Centers for Disease Control epidemiologist Dr. Robert Anda.⁷⁵ They partnered with the Health

⁶⁹ Bonnie L. Green et al., *Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers*, 47 *FAM. MED.* 7 (2015) (citing Naomi Breslau, *Gender Differences in Trauma and Posttraumatic Stress Disorder*, 5 *J. GENDER SPECIFIC MED.* 34, 34–40 (2001)) (noting that the prevalence of exposure to traumatic events is 50–75% of the general population).

⁷⁰ See generally Robert Listenbee, Jr. et al., *Defending Childhood: Report of the Attorney General's National Task Force on Children Exposed to Violence*, TRAUMA-INFORMED CARE PROJECT (2012), <http://www.traumainformedcareproject.org/resources/CEV-Full%20Report%2012-12-12%20us%20attorney%20gen%20report%20on%20trauma.pdf> (noting that childhood trauma harms children's ability to mature cognitively and emotionally, scarring them physically and emotionally well into their adult lives).

⁷¹ Stevens, *supra* note 5.

⁷² Naomi Breslau, *Epidemiologic Studies of Trauma, Posttraumatic Stress Disorder, and Other Psychiatric Disorders*, 47 *CAN. J. PSYCHIATRY* 923, 923–24 (2002) (explaining that psychiatric interest in PTSD in the 1980's was focused primarily on veterans of the Vietnam War, with a more recent focus on the prevalence of trauma within the general population).

⁷³ *Id.* (stating that Dr. Felitti, then-chief of Kaiser Permanente's Department of Preventive Medicine in San Diego, couldn't understand why 55 percent of the 1,500 people who enrolled in his weight-loss clinic every year left before completing the program).

⁷⁴ Jane Ellen Stevens, *The Adverse Childhood Experiences Study—the Largest, Most Important Public Health Study You Never Heard of—Began in an Obesity Clinic*, ACES TOO HIGH NEWS, Oct. 3, 2012, <https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/> (stating that, in Dr. Felitti's initial study with 286 patients from his obesity clinic who were interviewed, most had been sexually abused as children).

⁷⁵ *Id.* (describing the sequence of events that led to Dr. Felitti being introduced to Dr.

Maintenance Organization (HMO) Kaiser Permanente⁷⁶ to conduct a large-scale, ongoing study evaluating how early negative experiences affected the adult physical and mental health outcomes and risk behaviors of over 17,000 participants.⁷⁷ The first wave of the original Kaiser Permanente study involved over 9,500 participants who were receiving medical services through the HMO and responded to a survey asking about adverse childhood experiences.⁷⁸ A 17-item surveys asked study participants about physical, emotional, and sexual abuse; physical and emotional neglect; parental divorce or death; parental incarceration; and mental illness and substance abuse in their childhood home.⁷⁹ In order to generalize the original results to more diverse populations,⁸⁰ the ACE study was replicated multiple times with different populations and settings, including with children in poor, urban areas⁸¹ and with juvenile offenders.⁸² Additionally,

Anda, and the subsequent development of the ACE study).

⁷⁶ *Id.* The article described the study as follows:

Kaiser Permanente in San Diego was a perfect place to do a mega-study. More than 50,000 members came through the department each year, for a comprehensive medical evaluation. Every person who came through the Department of Preventive Medicine filled out a detailed biopsychosocial (biomedical, psychological, social) medical questionnaire prior to undergoing a complete physical examination and extensive laboratory tests. It would be easy to add another set of questions. In two waves, Felitti and Anda asked 26,000 people who came through the department “if they would be interested in helping us understand how childhood events might affect adult health,” says Felitti. Of those, 17,421 agreed.

Id.

⁷⁷ Anda et al., *supra* note 4, at 176 (describing the collaborating institutions involved with the study, as well as the purpose of the study and the participant response rate over two waves).

⁷⁸ See also Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTATIVE MED. 245, 246–49 (1998) (describing the survey methods and the response rate of participants in the first wave).

⁷⁹ *Id.* at 248 (describing the different categories used to measure adverse childhood experiences, and the number of question items used to measure each category).

⁸⁰ Anda et al., *supra* note 4, at 178 (noting that 73% of women and 76% of men were white).

⁸¹ Nadine J. Burke et al., *The Impact of Adverse Childhood Experiences on an Urban Pediatric Population*, 35 CHILD ABUSE & NEGLECT 408, 409 (2011) (“We present data from youth who live in and around Bayview Hunters Point, a community that places them at high risk for exposure to ACEs.”).

⁸² Michael T. Baglivio et al., *The Prevalence of Adverse Childhood Experiences (ACE) in The Lives of Juvenile Offenders*, 3 J. JUV. JUST. 1, 6–7 (2014) (explaining how a secondary data analysis of Positive Achievement Change Tool assessment results was used to extrapolate the ACE scores of 64,329 juvenile offenders in the state of Florida for research purposes).

the study was conducted internationally in developing countries.⁸³ Different versions of the original ACE survey have been created that examine additional types of adverse childhood experiences, including bullying, poverty, and living in an unsafe neighborhood.⁸⁴

ACE scales are designed to measure cumulative childhood stress. Respondents are provided with a list of various traumatic experiences and one point is given to each affirmative response to each particular type of trauma experienced.⁸⁵ Researchers found that about two-thirds of adults surveyed in the initial study reported at least one ACE,⁸⁶ and that more than half of the study participants report one or more ACEs.⁸⁷ The correlation between increased numbers of ACEs and increased health problems is remarkably strong; as the number of ACEs rises, so does incidence of later health and behavioral problems.⁸⁸ The authors extracted these findings by analyzing the relationship⁸⁹ between ACE scores and subsequent health problems.⁹⁰ Having an ACE score of four or higher, for example, is linked with higher rates of adult alcoholism, sexually transmitted diseases, and intravenous drug use.⁹¹ In addition, high ACE scores put people at a greater

⁸³ Laurie S. Ramiro et al., *Adverse Childhood Experiences (ACE) and Health-risk Behaviors Among Adults in a Developing Country Setting*, 34 CHILD ABUSE & NEGLECT 842, 844 (2010), (“This study aimed to determine the interrelationship among adverse childhood experiences, health-risk behaviors and health outcomes in a developing country setting.”).

⁸⁴ David Finkelhor et al., *Improving the Adverse Childhood Experiences Study Scale*, 167 J. AM. MED. ASS’N PEDIATRICS 70, 72 (2013) (outlining the additional items used to assess adverse childhood experiences that were not included in the original ACE study).

⁸⁵ Felitti et al., *supra* note 77, at 248 (defining participants as exposed to a category if they responded “yes” to one or more of the questions in that category).

⁸⁶ Amy Anderson Mellies, *Impact of Adverse Childhood Experiences on Adult Health in Colorado*, 99 HEALTH WATCH 1 (2016) (“Results from the initial recruitment phase showed that ACEs are common, with nearly two-thirds of participants experiencing at least one type of ACE while growing up.”).

⁸⁷ Felitti et al., *supra* note 77, at 249 (stating that “more than half of respondents (52%) experienced ≥ 1 category of adverse childhood exposure.”).

⁸⁸ *Id.* at 250 (“finding a strong relationship between the number of childhood exposures and the number of health risk factors for leading causes of death in adults”).

⁸⁹ Olav Axelson, Francesco Forastiere & Mats Frederickson, *Assessing Dose-Response Relationships by Cumulative Exposures in Epidemiological Studies*, 50 AM. J. INDUS. MED., 217, 217 (2007) (citing Austin Bradford Hill, *The Environment and Disease: Association or Causation?* (1965)) (“If the occurrence of a disease increases with the degree of exposure, an increasing dose—response (or exposure-response) relationship is indicated, which facilitates the interpretation that the exposure is of causal importance for the development of the disease, a consideration included in the so called Hill ‘criteria’ or ‘viewpoints’”).

⁹⁰ *Id.* at 249 (stating that “[t]o test for a dose-response relationship to health problems, we entered the number of childhood exposures as a single ordinal variable (0, 1, 2, 3, 4, 5, 6, 7) into a separate logistic regression model for each risk factor or disease condition.”).

⁹¹ Felitti, *supra* note 77, at 250 (describing the dose-response relationships between

risk of developing heart disease, chronic lung disease, liver disease, skeletal fractures, and cancer.⁹² Having an ACE score of four or greater also leads to an increased risk of being diagnosed with symptoms of a mental health condition⁹³ such as hallucinations⁹⁴ and depression.⁹⁵ ACE scores of six or higher have been correlated with an average reduced life expectancy of twenty years.⁹⁶

Neuroscience explains how ACEs can have such a devastating impact. When a child is exposed to a traumatic experience, this exposure causes the child's developing brain to be flooded with stress hormones.⁹⁷ These hormones are correlated with impaired neurological functioning in high amounts.⁹⁸ Because individuals' brains are not fully developed until the

ACE scores of 4 or greater and corresponding health-risk behaviors).

⁹² *Id.*

⁹³ Valerie J. Edwards et. al., *Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results from the Adverse Childhood Experiences Study*, 160 AM. J. PSYCHIATRY 1453, 1456 (2003) ("Decrements in the mental health score occurred in a dose-response manner as the number of abuse types increased.").

⁹⁴ Charles L. Whitfield et. al., *Adverse Childhood Experiences and Hallucinations*, 29 CHILD ABUSE & NEGLECT 797, 803 (2005). Researchers assessed the relationship between ACE score and hallucinations separately for persons with and without substance abuse histories. *Id.* After adjusting for age, sex, race, and educational attainment, the researchers found an increase in the prevalence of hallucinations for both groups. *Id.*

⁹⁵ Daniel P. Chapman et al., *Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood*, 82 J. AFFECTIVE DISORDERS 217, 222 (2004) ("Cumulative exposure to ACEs generally assumed a stronger dose-response relationship with depressive disorders among women than men. However, the presence of ACEs was also associated with strong and significantly increased risks of both lifetime and current depressive disorders in men.").

⁹⁶ David W. Brown, *Adverse Childhood Experiences and the Risk of Premature Mortality*, 37 AM. J. PREVENTATIVE MED. 389, 393 (2009), ("People with six or more ACEs died nearly 20 years earlier on average than those without ACEs.").

⁹⁷ Anda, *supra* note 4, at 180 ("Extreme, traumatic or repetitive childhood stressors such as abuse, witnessing or being the victim of domestic violence, and related types of ACEs are common, tend to be kept secret, and go unrecognized by the outside world. Likewise, the fight-or-flight response among children exposed to these types of stressors, and the attendant release of endogenous catecholamines and adrenal corticosteroids are both uncontrollable and invisible.") (citation omitted).

⁹⁸ Glaser, *supra* note 6, at 104 (citing Amy F. T. Arnsten, *Development of the Cerebral Cortex: Stress Impairs Prefrontal Cortical Function*, 38 J. AM. ACAD. & ADOLESCENT PSYCHIATRY 220, 220-22 (1999); Dennis Charney et. al., *Psychobiological Mechanisms of Post-Traumatic Stress Disorder*, 50 ARCH. GEN. PSYCHIATRY 294, 294-305 (1993)). Charney and his co-authors noted:

In preclinical studies, stress has been shown to enhance the release and metabolism of dopamine in the prefrontal cortex, one of whose functions is to produce coping responses to stress. Raised levels of noradrenaline and dopamine are positively associated with dysfunction of the prefrontal cortex, whose functions also include the

third decade of life,⁹⁹ exposure to ACEs can actually interfere with the normal developmental process of the brain.¹⁰⁰ A part of the brain called the prefrontal cortex, which helps with “executive functioning”—a person’s ability to plan, organize, and filter out distracting stimuli¹⁰¹—can be damaged by excessive stress hormones.¹⁰² The impact that ACEs have on a child’s developing brain may impact the child’s physical and mental health,¹⁰³ as well as behavioral and social functioning.¹⁰⁴ Prolonged exposure to ACEs may have permanent negative impacts upon the development of a child’s brain¹⁰⁵ and may cause behavioral, social, and health problems.¹⁰⁶ Studies have demonstrated that exposure to ACEs may predispose a child towards developing mental health conditions such as depression and anxiety disorders.¹⁰⁷

planning and organizing of actions using working memory and the inhibiting of inappropriate responses and attention to distractions (“executive functions”).

Id.

⁹⁹ Peter B. Jones, *Adult Mental Health Disorders and Their Age at Onset*, 202 BRIT. J. PSYCHIATRY s5, s8 (2013).

¹⁰⁰ Yolanda P. Graham et al., *The Effects of Neonatal Stress on Brain Development: Implications for Psychopathology*, 11 DEVELOPMENT & PSYCHOPATHOLOGY 545, 558 (1999) (“It is likely that early abuse or neglect, especially chronic exposure, activates the HPA axis of infants, perhaps leading to permanent changes in their developing neurobiological systems.”).

¹⁰¹ Glaser, *supra* note 6, at 104 (describing the functions of the prefrontal cortex, and explains the specific role of executive functioning).

¹⁰² *Id.* (describing how elevated levels of neurotransmitters associated with reactions to stress may be correlated with dysfunction of the prefrontal cortex in ways that have negative impacts upon working memory and executive functioning).

¹⁰³ Amanda R. Tarullo & Megan R. Gunnar, *Child Maltreatment and the Developing HPA Axis*, 50 HORMONES & BEHAVIOR 632, 636 (2006) (“Child maltreatment clearly has complex, long-term effects on HPA function, which likely have deleterious implications for physical and mental health.”).

¹⁰⁴ Anda et al., *supra* note 4, at 180 (stating that the accumulation of negative effects of traumatic stress upon developing brain may lead to long-term problems with behavioral health and social functioning).

¹⁰⁵ Graham et al., *supra* note 99, at 558 (“It is likely that early abuse or neglect, especially chronic exposure, activates the HPA axis of infants, perhaps leading to permanent changes in their developing neurobiological systems.”).

¹⁰⁶ Anda et al., *supra* note 4, at 180. Anda stated that the detrimental effects of traumatic stress on developing neural networks and on the neuroendocrine systems that regulate them have until recently remained hidden even to the eyes of most neuroscientists. *Id.* However, the information and data that we present herein suggest that this veiled cascade of events represents a common pathway to a variety of important long-term behavioral, health, and social problems.

¹⁰⁷ Christine Heim & Charles B. Nemeroff, *The Impact of Early Adverse Experiences on Brain Systems Involved in the Pathophysiology of Anxiety and Affective Disorders*, 46 BIOLOGICAL PSYCHIATRY 1509, 1517–18 (1999) (“Together, these findings suggest that there

As victims of childhood trauma grow up and form their own relationships, another consequence of ACEs—especially abuse and neglect—may be dysfunctions and difficulties in intimate relationships.¹⁰⁸ Studies show that marital relationships may be undermined if one or both partners have a history of ACEs.¹⁰⁹ Individuals who have unresolved trauma may be unable to form and maintain healthy relationships.¹¹⁰ Moreover, they may display impaired judgment in their choice of partners and spouses.¹¹¹ Exposure to various forms of childhood maltreatment also increases the likelihood that victims will get divorced.¹¹² Being exposed to various forms of maltreatment may also predispose a person towards experiences of intimate partner violence;¹¹³ people who have been traumatized as children may be more likely to subconsciously reenact traumatic experiences in their adult intimate relationships.¹¹⁴ For those who are later re-victimized, these reenactments of trauma are not a calculated

may be an initial sensitization of the stress hormone system, representing a biological vulnerability for the development of depression and anxiety disorders.”).

¹⁰⁸ See Rebecca A. Colman & Cathy Spatz Widom, *Childhood Abuse and Neglect and Adult Intimate Relationships: A Prospective Study*, 28 CHILD ABUSE & NEGLECT 1133, 1139 (2004) (finding that child abuse and neglect were associated with an increased risk of relationship dysfunction among study subjects who had ever married or cohabitated).

¹⁰⁹ *Id.* (finding that male and female victims of child abuse and neglect in study experienced more dysfunction in marital relationships than control subjects).

¹¹⁰ See Green, *supra* note 69, at 7 (“Trauma survivors may be impaired in forming and maintaining trusting relationships . . .”).

¹¹¹ David Finkelhor & Angela Browne, *The Traumatic Impact of Child Sexual Abuse: A Conceptualization*, 55 AM. J. ORTHOPSYCHIATRY 530, 535 (1985) Finkelhor and Browne stated as follows:

Sexual abuse victims suffer from grave disenchantment and disillusionment. In combination with this there may be an intense need to regain trust and security, manifested in the extreme dependency and clinging seen in especially young victims. This same need in adults may show in impaired judgment about the trustworthiness of other or in a desperate search for a redeeming relationship.

Id.

¹¹² Colman & Widom, *supra* note 108, at 1135 (finding that physical abuse, sexual abuse, and neglect each increased risk for divorce).

¹¹³ Charles L. Whitfield et al., *Violent Childhood Experiences and the Risk of Intimate Partner Violence in Adults Assessment in a Large Health Maintenance Organization*, 18 J. INTERPERS. VIOLENCE 166, 176 (2003) (“Childhood physical abuse increased the risk of victimization among women and the risk of perpetration by men more than 2-fold; childhood sexual abuse increased these risks 1.8-fold for both men and women; and witnessing domestic violence increased these risks approximately 2-fold for women and men.”).

¹¹⁴ Jim Walker, *Unresolved Loss and Trauma in Parents and the Implications in Terms of Child Protection*, 21 J. SOC. WORK PRAC. 77, 80 (2007) (“Where psychoanalysis talks of the repetition compulsion, attachment therapists refer to narrative reenactment of the trauma. This is often most evident in the choice of a partner.”).

choice; instead, they result from having been raised in an environment where being victimized was a common and ongoing experience.¹¹⁵

In adults who have children, research suggests that parents struggling with the effects of unresolved trauma are more likely to act in ways that are harmful to their own children, and are at a higher risk of maltreating their children in manners similar to their own victimization.¹¹⁶ This phenomenon has been hypothesized as resulting from a parent's unconscious fear, anger, and memories of abandonment being triggered by a child's vulnerability and the demands of providing care to young children.¹¹⁷ Unresolved trauma increases the likelihood of a repeated cycle of violence; some parents with high exposure to ACEs may be more likely to neglect or abuse their children if they are not given the opportunity to resolve their traumatic experiences.¹¹⁸

In addition, parents who have suffered from trauma as children are at a higher risk of having children who experience disorganized forms of attachment.¹¹⁹ Dissociation—a state of numbed detachment from the present environment¹²⁰—interferes with parents' capacity to create secure

¹¹⁵ Whitfield, *supra* note 113, at 179–80. The article found:

Revictimization/retraumatization is usually experienced and learned inside the family and is nearly always associated with a low self-esteem and often with dissociation during the revictimization, both of which commonly come from the prior repeated trauma. Toward the end of her recovery work, one of our patients said, "If I believe that I am bad and unworthy, then I will more easily let others mistreat me."

Id.

¹¹⁶ See Walker, *supra* note 114, at 80 (citing Robert J. Neborsky, *A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing Attachment Theory Approach*, in HEALING TRAUMA: ATTACHMENT, MIND, BODY, AND BRAIN (Marron F. Solomon & Daniel J. Siegel eds., 2003)) ("Unresolved trauma leads to an increased likelihood that as a parent the person will treat their own child the same way they themselves were treated.").

¹¹⁷ See *id.* at 82 ("[I]t seems that whenever the abusive or neglectful parent finds himself in a relationship in which the child appears vulnerable or in a state of need, old unresolved childhood feelings of fear, anger, distress or abandonment are unconsciously activated.").

¹¹⁸ Glaser, *supra* note 6, at 99 (explaining that mothers who did not abuse their children were able to lucidly reflect on their experiences of abuse in a cohesive manner, in contrast to abusive mothers who presented with elevated levels of dissociation and whose recollections of their childhoods that were inconsistent with a history of abuse).

¹¹⁹ See Walker, *supra* note 114, at 80 (citing Mary Main & Erik Hesse, *Parents' Unresolved Traumatic Experiences Are Related to Infant Disorganised Status: Is Frightened and/or Frightening Behaviour the Linking Mechanism?*, in ATTACHMENT IN THE PRESCHOOL YEARS: THEORY, RESEARCH AND INTERVENTION 161-82 (Mark Greenberg, Dante Cicchetti, & E. Mark Cummings eds., 1990)) (asserting existence of "strong correlation" between unresolved loss and trauma and disorganised attachment in children).

¹²⁰ Allan N. Schore, *The Effects of Early Relational Trauma on Right Brain Development, Affect Regulation, and Infant Mental Health*, 22 INFANT MENTAL HEALTH J.

attachment bonds with their infants.¹²¹ Some researchers believe that the heightened risk of dissociation among children of parents who suffered serious ACEs may reflect a link between a parent's dissociation—a symptom of, and common coping mechanism for trauma¹²²—and the child's own.¹²³ Further, there is also a strong link between a parent's dissociation and his or her neglect of the child.¹²⁴

Secure attachment bonds between an infant and caregiver are based upon a complex interplay of biological and environmental factors.¹²⁵ In order to learn to regulate their own emotions, infants depend on the attuned responses of a caregiver.¹²⁶ If the caregiver is unresponsive to the infant because of earlier trauma, this lack of an attuned infant-caregiver interaction leaves a baby unable to regulate his or her own emotions—potentially inducing prolonged states of hyperarousal in the baby.¹²⁷ States of dysregulated arousal can be passed from a caregiver to the child, thus contributing to intergenerational cycles of attachment

201, 211 (2001) (“[Dissociation is a process] in which the child disengages from stimuli in the external world and attends to an ‘internal’ world. The child’s dissociation in the midst of terror involves numbing, avoidance, compliance, and restricted affect.”).

¹²¹ Nico Moleman et al., *The Partus Stress Reaction: A Neglected Etiological Factor In Postpartum Psychiatric Disorders*, 180 J. NERV. MENT. DIS. 271, 271 (1992) (describing how the dissociative experiences of a parent led to a failure to form attachments with their infants).

¹²² See Bessel A. Van der Kolk et al., *Dissociation, Somatization, and Affect Dysregulation: The Complexity of Adaption of Trauma*, 153 AM. J. PSYCHIATRY 83, 84 (1996) (describing dissociation as a symptom that is associated with trauma-related psychiatric diagnoses).

¹²³ See Schore, *supra* note 120, at 217–18.

¹²⁴ *Id.* at 218 (“The caregiver’s entrance into a dissociative state represents the real-time manifestation of neglect.”).

¹²⁵ Glaser, *supra* note 6, at 101 (citing Allan Schore, *The Experience-Dependent Maturation of a Regulatory System in the Orbital Prefrontal Cortex and the Origin of Developmental Psychopathology*, 8 DEV. PSYCHOPATH. 59 (1996)) (“The early mother-infant interaction is thus a biobehavioural system. In the brain of the infant who sees the responsive mother’s face, brain stem dopaminergic fibres are activated, which trigger high levels of endogenous opiates. These endorphins are biochemically responsible for the pleasurable aspects of social interaction and social affect and are related to attachment.”).

¹²⁶ *Id.* (citing B.A. Kolk & R.E. Fisler, *Childhood Abuse and Neglect and Loss of Self-Regulation*, 58 BULL. MENNINGER CLINIC 145 (1994)) (“The sensitive caregiver’s role is to modulate the infant’s arousal, which could also follow intense displeasure, fear, or frustration, by calming the infant and restoring her or him to a tolerable emotional state, free of anxiety.”).

¹²⁷ Allan Schore, *Relational Trauma and the Developing Right Brain*, 1159 ANNALS N.Y. ACAD. SCI. 189, 196 (2009) (“Instead of modulating, [abuse] induces extreme levels of stimulation and arousal . . . and . . . [without] interactive repair, the infant’s intense negative-affective states last for long periods of time.”).

trauma.¹²⁸ Such a dysfunction may predispose the child to an increased risk of aggression or hypervigilance later in life¹²⁹ Research conducted on the mental health problems of children in the juvenile justice system demonstrates that children in this system have higher rates of childhood trauma compared to children in the general population,¹³⁰ and have a greater likelihood of having suffered multiple forms of childhood trauma.¹³¹

Recent studies in neuroscience have challenged common longstanding beliefs that neural imprints laid down in the brain during critical periods of development are irrevocable.¹³² Instead, and despite the alarming fact that ACEs might cause significant damage to the developing brain, the brain has been viewed as somewhat plastic.¹³³ Thus, some of the damage may be reversible.¹³⁴ It is therefore important to develop prevention efforts aimed at breaking the cycles of intergenerational trauma. Many programs have been developed that focus on prevention and early intervention for

¹²⁸ *Id.* at 197 (citing R. Davidson et al., *Approach-Withdrawal and Cerebral Asymmetry: Emotional Expression and Brain Physiology*, 58 J. PERS. SOC. PSYCHOL. 330 (1990)) (“During the intergenerational transmission of attachment trauma, the infant is matching the rhythmic structures of the mother’s dysregulated arousal states. This synchronization is registered in the firing patterns of the stress-sensitive corticolimbic regions of the right brain, dominant for coping with negative affects.”).

¹²⁹ Glaser, *supra* note 6, at 101 (“In the absence of experiences of external modulation of affect, the infant brain is unable to learn self-regulation of affect, part of the process of ontogenesis. Such deficits may only become apparent later, when the child is expected to have matured for that particular task and these deficits may then become manifest by aggression or hypervigilance.”).

¹³⁰ Baglivio et al., *supra* note 82, at 2–3 (citing Carly B. Dierkhising et al., *Trauma Histories Among Justice-Involved Youth: Findings from the National Child Traumatic Stress Network*, 4 EUR. J. PSYCHOTRAUMATOLOGY 1483 (2013)) (“Prior research on adverse and traumatic experiences, as well as mental health problems of juvenile justice-involved youth, has revealed higher prevalence rates of adversity and trauma for these youth compared to youth in the general population.”).

¹³¹ *Id.* at 3 (“Furthermore, compared to youth in the general population, juvenile justice-involved youth have been found to have a greater likelihood of having experienced multiple forms of trauma, with one-third reporting exposure to multiple types of trauma each year.” (citation omitted)).

¹³² Richard J. Davidson & Bruce S. McEwen, *Social Influences on Neuroplasticity: Stress and Interventions to Promote Well-Being*, 15 NAT. NEUROSCI. 689, 691 (2012) (“One of the longest held notions of brain plasticity is that certain critical periods or windows exist in development, during which circuitry is laid down that lasts for the lifetime.”).

¹³³ *Id.* (“However, a more recent set of findings suggests that developmentally induced plasticity, at least certain kinds, can be reversed by re-opening those windows.”).

¹³⁴ Bruce S. McEwen & Linn Getz, *Lifetime Experiences, the Brain and Personalized Medicine: An Integrative Perspective*, 62 METABOLISM: CLINICAL & EXPERIMENTAL S20, S22 (2013) (“It is important to understand that the human brain possesses a life-long and clinically significant capacity for reversible, structural plasticity.”).

children.¹³⁵ Still, adults who have experienced ACEs—including those who become parents—can benefit from interventions.¹³⁶ Targeted interventions for parents to enhance brain function can include basic but transformative changes such as healthy lifestyles with less stress, good sleep habits, exercise, and nutrient-rich healthy eating.¹³⁷ Studies suggest that neural changes and even changes in the structure of the brain (especially the amygdala¹³⁸) may occur with these and other interventions, and result in positive changes in behavior.¹³⁹

¹³⁵ See NAT'L CHILD TRAUMATIC STRESS NETWORK, *Effective Treatments for Youth Trauma*, (2003), http://www.nctsn.org/sites/default/files/assets/pdfs/effective_treatments_youth_trauma.pdf (describing treatments that have been found to be effective for youth who have experienced trauma).

¹³⁶ Julian D. Ford & Christine A. Courtois, *Educational Resources and Evidence-Based Treatment for Adults*, ACAD. ON VIOLENCE & ABUSE (2015), http://www.avahealth.org/aces_best_practices/educational-resources-evidence-based-treatment---adults.html. The authors described the progression of intervention as follows:

There are a number of evidence-based approaches to psychotherapy for adults with ACEs histories, each of which guides the client through a progression of three phases: (1) safety and stabilization, (2) trauma processing, and (3) consolidation of therapeutic gains. The first and third phases are standard-of-care best-practice approaches for all psychotherapies, although they must be done with careful attention to the unique impact of ACEs.

Id.

¹³⁷ See McEwen & Getz, *supra* note 134, at S24. The authors identify several successful programs that are focused on preventing adverse childhood experiences and describing the return on investment of such programs in regards to individual and societal benefits, while giving the caveat that these programs are most successful when the family environment is already stable. *Id.* The authors then stress that interventions for those who have suffered from ACEs are beneficial as well, although they may require a greater investment in time and energy. *Id.* Social integration and social support, along with basic salubrious behaviors such as healthy eating, sleeping, and exercise habits are described as being not only beneficial, but even having potentially equal or superior positive effects as medications. *Id.*

¹³⁸ Christian Paret et al., *Down-Regulation of Amygdala Activation with Real-Time FMRI Neurofeedback in a Healthy Female Sample*, 8 FRONT. BEHAV. NEUROSCI. 1, 13 (2014) (citing Annete Beatrix Brühl, *Real-Time Neurofeedback Using Functional MRI Could Improve Down-Regulation of Amygdala Activity During Emotional Stimulation: A Proof-Of-Concept Study*, 27 BRAIN TOPOGRAPHY 138 (2014)) (“In particular, down-regulation of the amygdala as demonstrated in the current study and elsewhere may be helpful for disorders characterized by problems in emotion regulation and elevated amygdala activity such as borderline personality disorder. In these patients, training skills for emotion regulation is a decisive aspect of successful psychotherapies.”).

¹³⁹ Davidson & McEwen, *supra* note 132, at 692 (“There is a growing literature documenting functional and structural changes in the brain with specific interventions and training regimes. The behavioral evidence in support of such interventions and training provides a reasonable foundation for the exploration of neural changes that support these behavioral outcomes.”).

Such striking evidence of long-term detrimental impact of childhood trauma, the need for intervention, the potential cyclical recurrence of trauma on parents' children, and the potential for healing has been analyzed in many ways. Researchers have recognized that unresolved trauma has a high economic cost that has an effect upon various domains, including health care, workplace absenteeism and productivity, and mental health services.¹⁴⁰ Apart from the financial cost, trauma takes a high human toll as individuals and families suffer and cycle through the justice system repeatedly¹⁴¹—in family court cases, delinquency cases, dependency cases, and criminal cases.¹⁴² Such a powerful dynamic creates a compelling case for the justice system to alert individuals, families, and communities to the devastating impact of trauma and to devise ways to break its cycle.

IV. TRAUMATIZED PARENTS AND CHILDREN IN THE COURT SYSTEM

Although research about ACEs has existed since the late 1990s,¹⁴³ it is only recently that researchers, clinicians, and community leaders have

¹⁴⁰ Richard J. Gelles & Staci Perlman, *Estimated Annual Cost Of Child Abuse And Neglect*, PREVENT CHILD ABUSE AMERICA (2012), http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf (finding that the total direct and indirect cost of child maltreatment is \$78,405,740,013; adding two new categories of costs—indirect costs of early intervention (\$247,804,537) and emergency/transitional housing (\$1,606,866,538) thereby increasing the total costs to \$80,260,411,087).

¹⁴¹ See Baglivio et al., *supra* note 82, at 3 (“By extrapolating ACE scores from the e standardized assessment tool used within the Florida Department of Juvenile Justice (FDJJ), described below, we demonstrate that increased ACE scores correlate with increased risk to reoffend.”); see also Rose Patterson, *Trauma: Why it Matters to Florida Courts*, LINKEDIN (Apr. 11, 2016), <https://www.linkedin.com/pulse/trauma-why-matters-florida-courts-rose-patterson>; Gene Griffin & Sarah Sallen, *Considering Child Trauma Issues in Juvenile Court Sentencing*, 34 CHILD. LEGAL RTS. J. 1, 11 (2013) (citing Elizabeth M. Tracy & Pamela J. Johnson, *The Intergenerational Transmission of Family Violence*, in WORKING WITH TRAUMATIZED YOUTH IN CHILD WELFARE 113, 113–34 (Nancy Boyd Webb ed., 2005) (“It is not unusual to see families cycle through the court system.”)).

¹⁴² See Patterson, *supra* note 141.

¹⁴³ Anda et al, *supra* note 4, at 176. In describing the methods used in the ACE study, the author stated:

The study population was drawn from the HAC (Health Appraisal Center), which provides preventive health evaluations to adult members of Kaiser Health Plan in San Diego County. All persons evaluated at the HAC complete a standardized questionnaire, which includes health histories and health-related behaviors, a medical review of systems, and psychosocial evaluations which are a part of the ACE Study database. Two weeks after their evaluation, each person evaluated at the HAC between August 1995 and March 1996 (survey wave 1; response rate 70%) and June and October 1997 (survey wave 2; response rate 65 %) received the ACE Study questionnaire by mail. The questionnaire collected detailed information about ACEs

realized that adults who navigate a range of community systems such as medical organizations, social services, and the court system have suffered from trauma.¹⁴⁴ This involvement makes it imperative for the leaders of these systems to take an active role in developing methods that are sensitive to the needs of the traumatized individuals with whom they will interact. The term “trauma-informed”¹⁴⁵ changes the dialogue around trauma and trauma effects. It seeks to ask not “What Is Wrong with You?” but rather “What Happened to You?”¹⁴⁶ A national organization called the Trauma Informed Care Project provides guidance, ideas, and explanations of concepts to judges in “The Essential Components of Judicial Practice”:¹⁴⁷ “Many of the individuals who come into your courtroom have been severely injured as children, and their behaviors, although ineffective, are ways to maintain and cope with toxic stress.”¹⁴⁸

Thus, the goals of judicial practice should be to protect those who come before the court, recognize that many of them have experienced trauma that has made them vulnerable, treat those individuals with dignity and respect, and focus on their strengths.¹⁴⁹ Judges have been advised to educate

including abuse, witnessing domestic violence, and serious household dysfunction as well as health-related behaviors from adolescence to adulthood.

Id.

¹⁴⁴ See Denise E. Elliott et al., *Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women*, 33 J. COMMUNITY PSYCHOL. 461, 461–77.

¹⁴⁵ National Center for Trauma-Informed Care, *Trauma-Informed Approach and Trauma-Specific Interventions*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/nctic/trauma-interventions> (last updated Aug. 8, 2015). The agency suggests:

A program, organization, or system that is trauma-informed: 1. *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and, 4. Seeks to actively resist *re-traumatization*.

Id.

¹⁴⁶ TRAUMA INFORMED CARE PROJECT, <http://www.traumainformedcareproject.org> (last viewed May 18, 2016).

¹⁴⁷ Susan Wells & Jennifer Urff, *Essential Components of Trauma Informed Judicial Practice* (2013), http://www.nasmhpd.org/sites/default/files/JudgesEssential_5%201%202013finaldraft.pdf (last viewed June 13, 2016).

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* (Protect: “The goal is to guarantee physical and emotional safety for all individuals who appear in [one’s] court.” Respect: “Trauma-informed judicial interactions begin with . . . treating individuals who come before the court with dignity and respect.” Teach and Reinforce: Encouraging skill-building and competence by acknowledging strengths and underlying positive intent of behavior.)

themselves on trauma, its effects, and methods to encourage and support healing. In Florida, for example, there is a Family Court Tool Kit on Family and Child Development.¹⁵⁰ It educates judges and magistrates about ACEs and their impact to improve judicial decision-making and outcomes for children.¹⁵¹ However, it is also meant to be used widely by hearing officers who preside over family court cases as well as by court partners: mediators, attorneys, parenting coordinators, case managers, juvenile probation officers, and clerks who handle family court cases.¹⁵²

While the Tool Kit educates those who work in the court system, no equivalent training for parents and individuals involved in the court system is offered to educate them about the impact of trauma and the importance of resolving it. This important gap should be corrected. As courts around the country order divorcing parents to participate in parent education classes, they have an opportunity to insist that such classes be trauma-informed, to recognize that most parents have experienced trauma, to give parents some insights into the effect of adverse childhood experiences, and to offer parents opportunities to think about and resolve their prior trauma so that the problem is not repeated in the next generation of children. New research associated with the public curriculum “Successful Co-Parenting After Divorce”¹⁵³ provides data revealing a correlation between childhood trauma and various dimensions of co-parenting conflict.

The online training Successful Co-Parenting After Divorce is divided into three modules.¹⁵⁴ The first module explains the effects of divorce on children and parents and discusses basic family law concepts such as parenting time, sharing decision making about the children, and the economic impact of divorce.¹⁵⁵ The second module offers parents directions for developing new skills and strategies for successfully sharing responsibilities for their children; prominent among these are communication skills, conflict reduction, and negotiation.¹⁵⁶ The third module provides information about remarriage, describes the importance of stress reduction for parents, and offers information concerning child abuse, domestic violence, and community and faith-based resources.¹⁵⁷ Videos in

¹⁵⁰ See *Family Court Tool Kit: Trauma and Child Development*, FLORIDA COURTS, <http://www.flcourts.org/resources-and-services/court-improvement/judicial-toolkits/family-court-toolkit/> (last viewed May 18, 2016).

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Successful Co-Parenting After Divorce*, *supra* note 8.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

the training include advice to divorcing parents from adults whose own parents had divorced when they were young,¹⁵⁸ divorced individuals talking about their feelings and about the importance of co-parenting,¹⁵⁹ and actors portraying parents demonstrating hostile and then cooperative parenting communication.¹⁶⁰ For those who completed the full training (n = 156), most parents had positive attitudes about the training itself; 89% of participants reported that they had learned new skills from the training, and 91% reported that the training could help parents and families adjust post-divorce.¹⁶¹

At specific junctures throughout the training, participants are asked to complete voluntary, anonymous study surveys about their opinions, attitudes, beliefs, history, and behavior.¹⁶² Through pilot testing of the training conducted by an online data collection and analysis company, participants provided information about their co-parenting relationships, their wellbeing, and their children's wellbeing.¹⁶³ Participants were also asked whether they had experienced certain childhood traumatic experiences when they were under the age of eighteen using the World Health Organization's Adverse Childhood Experiences International Questionnaire (ACE-IQ).¹⁶⁴ Parents were asked about the frequency with which they experienced a variety of traumas; if they answered any in the affirmative, regardless of the frequency, they were considered to have experienced the given ACE.¹⁶⁵ This is the manner in which ACE studies are typically conducted and presented.¹⁶⁶

Table 1 below demonstrates that many parents who took the curriculum during the pilot testing phase reported experiencing trauma as children. More than half of the sample reported experiencing each of the following forms of childhood trauma: physical abuse, emotional abuse, household

¹⁵⁸ Institute for Family Violence Studies, *Advice to Parents from Children of Divorce*, YOUTUBE (Aug. 28, 2015), <https://www.youtube.com/watch?v=qZrAYif2cOw>.

¹⁵⁹ Institute for Family Violence Studies, *The Truth about Divorce*, YOUTUBE (Aug. 31, 2015), <https://www.youtube.com/watch?v=UD5epM2aiN0>.

¹⁶⁰ Institute for Family Violence Studies, *Talking to Your Co-Parent: Two Examples to Consider*, YOUTUBE (Sept. 23, 2015), <https://www.youtube.com/watch?v=eN4mwa8e-OE>.

¹⁶¹ See generally Karen Oehme, *Successful Co-Parenting Pilot Data*, FLA. STATE UNIV. INST. FOR FAMILY VIOLENCE STUDIES (June 1, 2016), <http://familyvio.csw.fsu.edu/wp-content/uploads/2016/06/Co-Parenting-Study.pdf>.

¹⁶² *Successful Co-Parenting After Divorce*, *supra* note 8.

¹⁶³ *Id.*

¹⁶⁴ World Health Organization, *Adverse Childhood Experiences International Questionnaire (ACE-IQ)*, WHO.INT, http://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/ (describing the ACE questionnaire).

¹⁶⁵ *Id.*

¹⁶⁶ See generally Baglivio et al., *supra* note 82.

intimate partner violence, the death or divorce of at least one parent, bullying, and community violence. Additionally, over a third of the sample reported experiencing each of the following forms of childhood trauma: contact sexual abuse, mental illness of someone in their household, and physical neglect. Moreover, over a quarter of the sample experienced having a substance abuser in the household.

*Table 1: ACEs of parenting taking online co-parenting curriculum*¹⁶⁷

Adverse Childhood Experiences (ACEs) of parents taking online co-parenting curriculum	Yes (%)	No (%)
Physical Abuse	62.7	37.3
Emotional Abuse	73.7	26.3
Contact Sexual Abuse	39.2	60.8
Alcohol or drug abuser in household	28.2	71.8
Incarcerated household member	14.1	85.9
Mental Illness household member	35.3	64.7
Household Intimate Partner Violence	72.9	27.1
Parental divorce or death of parent	65.5	34.5
Emotional neglect	15.7	84.3
Physical neglect	33.7	66.3
Bullying	73.3	26.7
Community violence	68.6	31.4
Collective violence	21.6	78.4

Table 2 displays parents who participated in the pilot training, separated into groups based upon the number of ACEs experienced. Although the number of women in this sample (215) outnumbered the men (40), a comparable proportion of men and women were in each group. Approximately three quarters of parents who took the course had experienced four or more ACEs. Further, over 43% of participants experienced seven or more ACEs. The pervasiveness of this trauma calls for intervention and education to help parents learn to resolve their trauma.

¹⁶⁷ Oehme, *supra* note 161, at 23.

Mandatory co-parenting classes provide a prime opportunity to undertake such efforts.

Table 2: ACEs of study participants by segment¹⁶⁸

Number of ACEs	Total (n = 255)	Men (n = 40)	Women (n = 215)
0-3	65 (25.5%)	12 (30.0%)	53 (24.7%)
4-6	79 (31.0%)	12 (30.0%)	67 (31.1%)
7 or more	111 (43.5%)	16 (40.0%)	95 (44.2%)

The preliminary data from the Successful Co-parenting After Divorce study, presented here, investigates for the first time the association between these traumatic experiences and specific co-parenting behaviors. In order to advance the knowledge base on co-parenting and to protect families, a series of inferential analyses was conducted to expand understanding of the relationship between ACEs and co-parenting behaviors. Parents were therefore asked about their relationship with their former partners, using a newly developed measure—currently being validated—called the Multidimensional Co-parenting Measure for Dissolved Relationships (MCS-DR) to assess four dimensions of the post-divorce co-parenting relationship: *Support*, *Overt Conflict*, *Self-Regulated Covert Conflict*, and *Partner-Regulated Covert Conflict*.¹⁶⁹

Support is a co-parenting dimension that involves cooperation and assistance between parents in the responsibilities of childrearing.¹⁷⁰ This instrument includes items that assess the degree to which parents ask each other for advice and help in childrearing decisions, and the extent to which the former spouse is a resource to the other parent in raising the child.¹⁷¹ The remaining three sections of the instrument—*Overt Conflict*, *Self-Regulated Covert Conflict*, and *Partner-Regulated Covert Conflict*—represent three dimensions of conflict that have frequently been subsumed under a single global assessment of conflict in prior literature concerning co-parenting.¹⁷² However, some researchers have suggested

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 18–21.

¹⁷¹ *See id.*

¹⁷² *See* Cheryl Buehler et al., *Interparental Conflict Styles and Youth Problem Behaviors: A Two-Sample Replication Study*, 60 J. MARRIAGE & FAM. 119, 120 (1998).

that a more nuanced conceptualization of conflict is needed, specifically distinguishing between co-parents' overt and covert conflict.¹⁷³ *Overt Conflict* involves direct or openly conflictual behaviors, such as conversations between parents that are "tense and/or sarcastic" and parents' criticizing or belittling their former partner.¹⁷⁴ Covert conflict involves indirect forms of conflict that either are communicated passively or through alternative sources including the child (e.g., "triangulation" or "triangling").¹⁷⁵ Two forms of covert conflict are measured with the MCS-DR,¹⁷⁶ differentiating between behaviors that parents themselves engage in and behaviors that they perceive their former partner engaging in. *Self-Regulated Covert Conflict* includes items that assess behaviors such as asking the child about the former partner's personal life, and a parent's trying to persuade the child that he or she is better than the other parent.¹⁷⁷ *Partner-Regulated Covert Conflict* includes items that assess if the former spouse is sending messages through the child, and if a parent asks the child about the other parent's personal life.¹⁷⁸

The relative presence (or absence) of each of these co-parenting dynamics has implications for the adjustment of both parents and children to the divorce process, as well as for the overall wellbeing of parents and children after divorce.¹⁷⁹ For instructors who provide divorce education courses, the nature and quality of existing co-parenting relationships can be an important consideration in helping divorcing parents move forward after divorce. Conversely, parents receiving only generic co-parenting information (such as that required by statute) will find the course of limited utility. The new scale helps parents gain insights into the kinds of co-parenting behaviors they are experiencing. It can also be important for

¹⁷³ See *id.*

¹⁷⁴ Karen Oehme, *The Multidimensional Co-Parenting Scale for Dissolved Relationships*, FLA. STATE UNIV. INST. FOR FAMILY VIOLENCE STUDIES (June 1, 2016), <http://familyvio.csw.fsu.edu/wp-content/uploads/2016/06/MCS-DR-Scale.pdf>

¹⁷⁵ Oehme, *supra* note 174, at 1; Buehler, *supra* note 172, at 120. Triangulation occurs when parents have poor boundaries and engage others in their conflicts. Cheryl Buehler & Deborah P. Welsh, *A Process Model of Adolescents' Triangulation into Parents' Marital Conflict: The Role of Emotional Reactivity*, 23 J. FAM. PSYCHOL. 167, 167–68 (2009). The term is frequently used to describe an unhealthy parental bond with a child. *Id.* In a conflicted divorce, it can mean putting the child in the middle of a dispute. *Id.*

¹⁷⁶ See Oehme, *supra* note 161, at 18; Oehme, *supra* note 174, at 1.

¹⁷⁷ Oehme, *supra* note 174, at 1.

¹⁷⁸ *Id.*

¹⁷⁹ See Bonnie L. Barber & David H. Demo, *The Kids Are Alright (at Least, Most of Them): Links Between Divorce and Dissolution and Child Well-Being*, in HANDBOOK OF DIVORCE AND RELATIONSHIP DISSOLUTION 289, 289–312 (Mark A. Fine & John H. Harvey eds., 2006); see also W. Kim Halford & Susie Sweeper, *Trajectories of Adjustment to Couple Relationship Separation*, 52 FAM. PROC. 228, 228–43 (2013).

instructors and parents alike to understand that parents' experiences may vary. After all, it is not uncommon for parents to engage in seemingly contradictory co-parenting behaviors: e.g., those who exhibit a *Mixed* co-parenting relationship containing high levels of both conflict and support.¹⁸⁰ Providing parents with brief instruments that give them information about how much support and conflict exist in their co-parenting relationship and suggestions for improving or strengthening their co-parenting may be an important next step in co-parenting program development.

Results of analyses examining co-parenting dimensions in light of parents' ACEs are displayed in Table 3 below.

Table 3: One Way ANOVA results comparing MCS-DR constructs by participant ACEs¹⁸¹

MCS-DR Factors	0-3	4-6	7 or More
	ACEs M (SD)	ACEs M (SD)	ACEs M (SD)
Support	3.72 (1.42) _a	3.63 (1.32) _a	3.80 (1.41) _a
Overt Conflict	2.72 (1.29) _a	3.35 (1.34) _b	3.40 (1.40) _b
Self-Regulated Covert Conflict	1.73 (0.75) _a	1.99 (0.83) _{ab}	2.10 (1.01) _b
Partner-Regulated Covert Conflict	2.23 (1.09) _a	2.51 (1.13) _{ab}	2.75 (1.25) _b

These pilot data suggest a connection between the number of ACEs experienced by parents and certain dimensions of co-parenting evaluated in the MCS-DR scale.¹⁸² *Support* was the only co-parenting factor not to

¹⁸⁰ See ELEANOR E. MACCOBY & ROBERT H. MNOOKIN, DIVIDING THE CHILD: SOCIAL AND LEGAL DILEMMAS OF CUSTODY 234 (1992) (describing the typologies of co-parenting behaviors).

¹⁸¹ Oehme, *supra* note 161, at 24. Subscripts that vary across columns denote significant differences at a 0.05 p-value or lower for One Way ANOVAs across groups using 5,000 bias-corrected bootstrapped samples and a Least-Squares Difference Post-Hoc Test.

¹⁸² Table 3 displays results of a series of One Way Analyses of Variance (ANOVAs) to examine group differences for each of the four MCS-DR dimensions (support, and different types of conflict) across the segmented ACEs classifications described above. Specifically, ANOVAs allow researchers the capability to compare more than two conditions and is

significantly vary as a function of the number of ACEs experienced by participants. Those with three or fewer ACEs experienced lower *Self-Regulated Covert Conflict* and *Partner-Regulated Covert Conflict* than those with seven or more ACEs. Those with three or fewer ACEs experienced statistically significantly lower levels of *Overt Conflict* than both those experiencing between four and six ACEs and those with seven or more ACEs.

Table 4 highlights results from a series of linear regressions conducted to determine if the number of ACEs a parent had experienced was significantly related to any of the dimensions of the MCS-DR.¹⁸³ Linear regressions are used to examine how various independent variables—e.g., support, overt conflict—account for variation in a given dependent variable.¹⁸⁴ As was observed in Table 3, *Support* did not correlate with the number of ACEs a parent experienced. However, *Overt Conflict*, *Self-Regulated Covert Conflict*, and *Partner-Regulated Covert Conflict* were all significantly correlated with the number of ACEs parents had experienced.¹⁸⁵ With many of the parents studied having experienced a high number of ACEs, there is some evidence that as the number of parents' ACEs' increases so do the levels of various forms of co-parenting conflict. Still, despite the statistically significant findings, additional factors need be explored to further our understanding of the relationship between ACEs and co-parenting behaviors. As a first glimpse into the association between ACEs and varying co-parenting behaviors, these new data offer additional hope for improving the quality of co-parenting relationships. Because reducing conflict is such an important part of co-parenting, it makes sense that parents be exposed to information about resolving their own trauma histories to help them fashion a healthier future.

preferred over the use of multiple t-tests. ANDY FIELD, *DISCOVERING STATISTICS USING SPSS 348* (3d ed. 2009). Such analyses, therefore, provide us insights regarding the equality of means across groups. *Id.* After such initial comparisons, post-hoc tests are used to identify which groups differ from one another using a series of contrasts providing further detailing how each factor (e.g., overt conflict) compares across groups (e.g., ACEs). *Id.* Using bias-corrected bootstrapped sampling methods are among the techniques used by researchers to test for significant group differences. See generally BRADLEY EFRON & ROBERT J. TIBSHIRANI, *AN INTRODUCTION TO THE BOOTSTRAP* (1993).

¹⁸³ Oehme, *supra* note 161, at 24.

¹⁸⁴ FIELD, *supra* note 182, at 198.

¹⁸⁵ Independently ACEs accounted for approximately 3% of the variance in each of the co-parenting dimensions for which it was significantly related. Significant coefficients are determined using 5,000 bias-correct bootstrapped samples and 95% confidence intervals. **p* < .05.

Table 4: Regression analyses for co-parenting behaviors based upon number of ACEs¹⁸⁶

Variables	Support	Overt Conflict	Self-Regulated Covert Conflict	Partner-Regulated Covert Conflict
Number of ACEs (β)	.02	.18	.18	.17
Adjusted R ²	.00	.03	.03	.03

V. TOWARD TRAUMA-INFORMED EDUCATION FOR CO-PARENTS

The most powerful people for reducing ACE scores in the next generation are parenting adults. Parents have the most opportunity and the most potential for changing the trajectory of the public's health for generations. But parents must actually know about ACEs and their effects in order to realize this potential.¹⁸⁷

Many researchers believe that individuals can benefit from learning how childhood trauma might be contributing to current relationship¹⁸⁸ or health problems.¹⁸⁹ Nevertheless, our proposal to policymakers to ensure that compulsory co-parenting classes for divorcing parents are trauma-informed comes with an important caveat. Any legislative or judicial mandates to make co-parenting training trauma-informed should contain specific language intended to prepare parents for the sections that will be addressing trauma. We believe that this language, which could be written into a state's administrative code that provides detail to the statutory mandate, will serve several purposes. First, it will prepare parents to assess whether they are able to engage with material addressing trauma before questionnaires about ACEs are actually administered. Thus, parents will have a meaningful opportunity to opt out of the inquiry. Second, the language will provide parents with resources if they experience discomfort. Third, it will ensure

¹⁸⁶ Oehme, *supra* note 161, at 24.

¹⁸⁷ REGION X ACE PLANNING TEAM, THRIVE WASH., NEAR@HOME: ADDRESSING ACES IN HOME VISITING BY ASKING, LISTENING, AND ACCEPTING 9 (2d ed. 2016), <https://thrivewa.org/wp-content/uploads/NEARatHome.pdf> [hereinafter NEAR@HOME].

¹⁸⁸ See Colman & Widom, *supra* note 107 ("Among those individuals who had ever married or cohabitated, child abuse and neglect were also associated with an increased risk of relationship dysfunction.").

¹⁸⁹ See Felitti, *supra* note 77, at 250 ("We also found a significant (P less than .05) dose-response relationship between the number of childhood exposures and the following disease conditions: ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health.").

uniform use of standardized instruments throughout the jurisdiction. Finally, it will provide parents with information about how to build resiliency so that trauma does not become intergenerational.

A. Crafting Sensitive Trauma-Informed Classes

Ensuring that the parenting education mandate is trauma-informed includes recognition that classes must be sensitive to the shame and guilt that individuals often feel when reflecting upon their trauma histories.¹⁹⁰ In turn, this shame may cause parents to avoid discussing or acknowledging past experiences of trauma—a course that could increase the risk of intergenerational transmission of trauma.¹⁹¹ However, when parents learn that painful experiences are common to many people, the experience may be *normalized* and made less painful or embarrassing to consider.¹⁹² In addition, when parents are given information about the prevalence of trauma,¹⁹³ symptoms of trauma,¹⁹⁴ and coping strategies to resolve

¹⁹⁰ See Deborah A. Lee et al., *The Role of Shame and Guilt in Traumatic Events: A Clinical Model of Shame-Based and Guilt-Based PTSD*, 74 BRIT. J. MED. PSYCHOL. 451, 451–52 (2001) (“[W]hile fear is often a dominant affect in the formation and maintenance of PTSD, other affects such as anger, shame, guilt and sadness are frequently associated with the traumatic event . . . Indeed[,] imaginal exposure conducted in a manner where no account is taken of the patient’s shame, guilt or anger may serve to worsen the post-trauma reactions.”).

¹⁹¹ See NEAR@HOME, *supra* note 187, at 10. The team noted:

When we avoid talking about ACEs, we may inadvertently be sending a message that people should be ashamed of their childhood experiences. Shame can increase risk of intergenerational transmission because it reinforces one of the pathways for transmission: avoidance. A parent may re-create the emotional conditions of past adversity without consciously choosing this path for her children. People need to have an opportunity to appropriately and voluntarily share information about their personal histories as a part of a healing process.

Id.

¹⁹² See Rosanne McBride, NAT’L INST. ON DRUG ABUSE, TALKING TO PATIENTS ABOUT SENSITIVE TOPICS: TECHNIQUES FOR INCREASING THE RELIABILITY OF PATIENT SELF-REPORT—HANDOUT (2010), https://www.drugabuse.gov/sites/default/files/sensitive-topics-handout_0.pdf. Using the concept of universality, along with language that normalizes experiences of trauma, may be important factors in helping to prepare individuals to be able to discuss sensitive topics. See *id.*

¹⁹³ See Christopher Wildeman et al., *The Prevalence of Confirmed Maltreatment Among US Children: 2004 to 2011*, 168 J. AM. MED. ASS’N PEDIATRICS 706, 709 (2014). Between 2004 and 2011, approximately one in eight children in the United States were confirmed to be maltreated from birth to 18 years of age. See *id.*

¹⁹⁴ See U.S. Dep’t of Health & Hum. Servs. Child Welfare Info. Gateway, *What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms* (2013), <https://www.childwelfare.gov/pubpdfs/whatiscan.pdf>.

trauma,¹⁹⁵ such information may reduce the stigma of victimization and give parents hope that such trauma will be resolved and not replicated with a new generation of victims.¹⁹⁶

Instructors must take care to offer ACE scales and other instruments as optional tools that parents can use. Parents should be told that the process of exploring ACEs and other sensitive issues is voluntary and that family courts will never compel parents to explore their trauma histories as part of such classes. Instead, parents should be informed that the classes offer an *opportunity* for them to learn about new research that links individuals' childhood traumatic experiences to adult problems.¹⁹⁷ Thus, parents should always be able to decline to review the information about childhood histories of trauma in the class.¹⁹⁸ It is virtually inevitable, of course, that some parents will not exercise this prerogative. However, for many who choose to learn about this information, the exposure may prove invaluable. Moreover, even some of those who initially elect not to review the information may, upon later reflection, decide to explore their histories. Monitoring patterns of response will form an important part of conducting and reforming trauma-informed co-parenting training.

¹⁹⁵ See Substance Abuse & Mental Health Servs. Admin., *Coping with Traumatic Events*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Aug. 25, 2011), <http://media.samhsa.gov/MentalHealth/TraumaticEvent.aspx?from=carousel&position=1&date=3112011> (providing resources, strategies, and advice for coping with trauma).

¹⁹⁶ See NEAR@HOME, *supra* note 187, at 9 ("Parents who know the impact of ACEs and have a chance to reconstruct personal narrative about their lives can make meaning from their experiences and intentionally choose a more protected developmental path for their children. They also report feeling more self-worth and fulfillment in their lives.").

¹⁹⁷ See *id.* ("Because ACEs can affect emotional state, behavior, and illness, adult history of ACEs can affect the climate inside a family or household."); see also Charles B. Nemeroff, *Paradise Lost: The Neurobiological and Clinical Consequences of Child Abuse and Neglect*, 89 NEURON 892, 892 (2016) ("In the last decade, a remarkable concatenation of research findings has accumulated supporting the hypothesis that exposure to early untoward life events (early life stress [ELS]) in the form of child abuse and/or neglect is associated with a marked increase in vulnerability to major psychiatric and other medical disorders including major depression, bipolar disorder, post-traumatic stress disorder (PTSD), alcohol and drug abuse, and perhaps even schizophrenia, as well as obesity, migraines, cardiovascular disease (CVD), diabetes, and others.").

¹⁹⁸ Research suggests that while some individuals do experience symptom relief after talking about trauma, others respond with an exacerbation of symptoms. Lindsay Bicknell-Hentges, & John J. Lynch, *Everything Counselors and Supervisors Need to Know About Treating Trauma 2* (March 2009) (unpublished manuscript), https://www.counseling.org/docs/disaster-and-trauma_sexual-abuse/everything-counselors-and-supervisors-need-to-know-about-treating-trauma_bicknell-hentges-lynch.doc?sfvrsn=2 (citing Alexander C. McFarlane & Bessel A. Van Der Kolk, *Trauma and Its Challenge to Society*, in *TRAUMATIC STRESS: THE EFFECTS OF OVERWHELMING EXPERIENCE ON MIND, BODY & SOC'Y* 24–26 (1996)).

Offering information about ACEs does not transform classes into therapy sessions; on the contrary, classes should be consciously designed to be educational rather than therapeutic. Class leaders can make it clear that they do not provide mental health services while still offering referrals to those individuals who may want to speak to a mental health counselor, clergy member, or community support group.¹⁹⁹ Offering parents the ability to stop answering questions at any time and reminding parents of community resources—their own physicians, community health clinics, or other local resources provide information on mental health and wellness issues—should be an integral part of co-parenting classes. One way of preparing parents to think about prior trauma is using trauma scenarios or vignettes²⁰⁰ that explore an imagined person’s childhood trauma, highlighting the strengths exhibited by the person’s adapting to life after that experience.²⁰¹ It is important to tell parents what kinds of events might “trigger” a person’s re-experiencing of trauma as an adult,²⁰² but at the

¹⁹⁹ Janice Carello & Lisa D. Butler, *Potentially Perilous Pedagogies: Teaching Trauma is Not the Same as Trauma-Informed Teaching*, 15 J. TRAUMA & DISSOCIATION 153, 158 (2013) (discussing a study which stated that 14% of students who wrote about past traumatic experiences felt retraumatized, which included “feeling anxious, panicky, depressed, or suicidal—feelings serious enough to warrant clinical attention (citing JEFFREY BERMAN, RISKY WRITING: SELF-DISCLOSURE AND SELF-TRANSFORMATION IN THE CLASSROOM 236 (2001))).

²⁰⁰ See Christopher M. Layne et al., *The Core Curriculum on Childhood Trauma: A Tool for Training a Trauma-Informed Workforce*, 3 PSYCHOL. TRAUMA: THEORY, RES., PRAC. & POL’Y 243, 245 (2011). In describing the benefits of using case vignettes in clinical practice, the author stated:

The Core Curriculum uses detailed case vignettes of trauma-exposed youth and families, combined with problem-based learning methods, to promote two primary learning aims: (a) to enhance the development of foundational trauma-related conceptual knowledge, and (b) to accelerate the acquisition of trauma-informed clinical reasoning and clinical judgment. Vignettes are presented in segments to simulate gathering, organizing, drawing meaning from, and making decisions based on information in professional practice[.]

Id.

²⁰¹ SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., TREATMENT IMPROVEMENT PROTOCOL (TIP) SERIES NO. 57, TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES 8 (2014), https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf_NBK207201.pdf (“Although many individuals may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.”).

²⁰² See Elliott, *supra* note 144, at 472 (Parents “should be educated about the common vulnerabilities of trauma survivors, such as retraumatization being triggered by a child’s age or behavior, and supported in finding ways to take care of their own feelings as well as those of their children.”).

same time to provide them with reason to believe that these experiences need not defeat their goal of effective parenting.

B. The Necessity of Confidentiality

Those who choose to learn about childhood trauma and its links to adult problems must be protected from disclosure of sensitive information about themselves. Statutes should be amended to maintain the confidentiality of a parent who reveals traumatic exposure as part of participation in a class or pursuant to an automated (online) system. Legislatures have long adopted exceptions to public record laws²⁰³ and carved out exceptions to the collection of evidence in court proceedings for a host of reasons.²⁰⁴ The expectation of confidentiality for protected communication is essential to facilitating the free and honest flow of information. To encourage parents to reflect on their own histories of trauma, responses to questions about ACEs and any paperwork or statements relating to that trauma must be confidential and not subject to discovery.

While several statutes already recognize the need for confidentiality and privileges to protect parents who take parenting classes, these should be expanded where necessary to preserve the confidentiality of all records or forms filled out by parents to effectuate the purposes of the parenting classes. For example, Section 61.21 of the Florida Statutes, which authorizes the Department of Children and Families to approve a class for divorcing parents to educate, train, and assist them on the consequences of divorce for parents and children, states:

[I]nformation obtained or statements made by the parties at any educational session required under this statute shall not be considered in the adjudication of a pending or subsequent action, nor shall any report resulting from such educational session become part of the record of the case unless the parties have stipulated in writing to the contrary.²⁰⁵

Other states, such as Minnesota, make it clear that statements made by a party during a parent education program are inadmissible as evidence for

²⁰³ See, e.g., CAL. GOV'T. CODE § 6254; FLA. STAT. §§ 119.071, 119.0711; GA. CODE ANN. § 50-18-72; TENN. CODE ANN. § 10-7-504.

²⁰⁴ See, e.g., FED. R. EVID. 404(a)(1) ("Evidence of a person's character or character trait is not admissible to prove that on a particular occasion the person acted in accordance with the character or trait."); 407 ("When measures are taken that would have made an earlier injury or harm less likely to occur, evidence of the subsequent measures is not admissible to prove: negligence; culpable conduct; a defect in a product or its design; or a need for a warning or instruction."); 409 ("Evidence of furnishing, promising to pay, or offering to pay medical, hospital, or similar expenses resulting from an injury is not admissible to prove liability for the injury.").

²⁰⁵ FLA. STAT. § 61.21(8).

any purpose—including impeachment—and specify that parent education instructors may not be subpoenaed or called as witnesses.²⁰⁶ Maryland adds a prohibition on releasing any “reports” obtained from a parenting seminar.²⁰⁷ Similarly, West Virginia protects the confidentiality of parents who participate in divorce education sessions and restricts information that can be provided to the court to the number of sessions that the parent completes.²⁰⁸ New York requires a larger amount of demographic data to be reported: evaluation forms, the number of participants in each class by gender, a list of referral sources, names of the presenters, and the location of the training.²⁰⁹ These data are presumably sought for purposes of evaluating the trainings themselves rather than to focus on any individual participant.

In recognition of the importance of open and honest communication,²¹⁰ records of other proceedings involving former partners and their children are inadmissible. For example, Illinois protects statements made by parents in family court conferences, with exceptions for new allegations of abuse or neglect.²¹¹ Many states extend the privilege to litigants’ communication with mediators,²¹² social workers, and counselors.²¹³ There are, however, exceptions to privileged communications, including known or suspected child maltreatment²¹⁴ Under our recommendation to provide parents with

²⁰⁶ See MINN. STAT. § 518.157(5); see also N.J. STAT. ANN. § 2A:34-12.7 (“All communications made by any program participant during the course of attending the ‘Parents’ Education Program,’ . . . are confidential and shall not be admissible as evidence in any court proceeding.”).

²⁰⁷ MD. CODE ANN., FAM. LAW § 7-103.2(e) (2015).

²⁰⁸ See WV. R. PRAC. & PROC. FAM. CT. RULE 37a(f) (“[A] parent education presenter shall maintain the confidentiality of all parent education sessions and records . . . [and] shall not be subpoenaed or called to testify . . .”).

²⁰⁹ See N.Y. STATE PARENT EDUC. ADVISORY BD., PROPOSED GUIDELINES, STANDARDS & REQUIREMENTS FOR PARENT EDUCATION PROGRAMS (2003).

²¹⁰ See ILL. S. CT. R. 942, Committee Comments (adopted Feb. 10, 2006) (stating that confidentiality was needed to ensure open and honest discourse).

²¹¹ See ILL. S. CT. R. 942(e).

²¹² See, e.g., ILL. S. CT. R. 905(c).

²¹³ See, e.g., OHIO REV. CODE ANN. § 2317.02(G)(1) (LexisNexis 2015); see also Ike Vanden Eyke & Emily Miskel, *The Mental Health Privilege in Divorce and Custody Cases*, 25 J. AM. ACAD. MATRIM. L. 453, 463 (2013) (citing Roth v. Roth, 793 S.W.2d 590, 592 (Mo. Ct. App. 1990)).

²¹⁴ Bruce G. Borkosky & Mark S. Thomas, *Florida’s Psychotherapist-Patient Privilege in Family Court*, 87 FLA. B. J. 35, ¶ 8 n.20 (2013) (citing FLA. STAT. § 39.204 (2012)). In Florida, exceptions to privileged communication include any communication involving the perpetrator or alleged perpetrator in any situation involving known or suspected child abuse, abandonment, or neglect. See *id.* at ¶ 8. Other exceptions to privileged communications under Florida Statutes include Baker Act proceedings; when the communication is subsequent to a court-ordered evaluation; or when the patient relies on his or her condition

information about ACEs, it is conceivable that individuals may seek out physical or mental health treatment because of a realization that their past trauma may be affecting their current wellbeing. State laws recognize the longstanding privilege between a patient and his or her physician/psychiatrist and will generally not allow medical records to be released even if a parent is seeking custody of a child.²¹⁵ However, in an abundance of caution, we recommend that states add language to their codes to the effect that records, statements, or other evidence created at or derived from parenting classes are not admissible in court proceedings.

VI. CONCLUSION

The very purpose of mandatory co-parenting classes for estranged partners has always been to help parents address the challenges of caring for children under strained and complicated circumstances. These classes, however, will not fully serve their function without acknowledging and incorporating recent research showing the destructive impact that parents' adverse childhood experiences can have on their ability to raise their children both individually and cooperatively. Instruction that is not sufficiently *trauma-informed* increases the likelihood that parents will fail to grasp and respond to the role of unresolved prior trauma in their lives. Without steps to mitigate the effects of early trauma, parents run a substantial risk of subjecting their children to their own traumatic experiences.

To prevent such cycles of intergenerational trauma, this Article proposes that states revise current co-parenting training to ensure that it is properly trauma-informed. The legislation itself should be crafted both to ensure

as "an element of the patient's claim or defense" (known as the "shield and sword rule"). *Id.* at ¶ 14, n.41 (citing *Davidge v. Davidge*, 451 So. 2d 1051, 1052 (Fla. 4th Dist. Ct. App. 1984)).

²¹⁵ See Eyke & Miskel, *supra* note 213, at 464 (citing *Roper v. Roper*, 336 So.2d 654, 656 (Fla. Dist. Ct. App. 1976)) (discussing how under Florida law a party's mental condition does not automatically become an element of a child custody case); see also Courtney Waits, *The Use of Mental Health Records in Child Custody Proceedings*, 17 J. AM. ACAD. MATRIM. L. 159, 165 (2001) (citing *Kinsella v. Kinsella*, 696 A.2d 556 (N.J. Ct. App. 1994)) (describing New Jersey's three prong test for allowing access to a parent's medical records: "a 'legitimate need' must be present for the evidence to exist, the relevancy and materiality to the issue before the court, and the moving party must demonstrate that the information to which they are seeking access 'cannot be secured from any less intrusive source.'"); *Clark v. Clark*, 371 N.W.2d 749, 753 (Neb. 1985) ("[W]hen a litigant seeks custody of a child in a dissolution of marriage proceeding, that action does not result in making relevant the information contained in the file cabinets of every psychiatrist who has ever treated the litigant. The determination as to the admissibility of the evidence to which the waiver applies is to be initially entrusted to the sound discretion of the trial court.").

that all such training is sensitive to the trauma that many parents have suffered and to avoid exacerbating the rancor often found in family court litigation. Thus, parents should be offered the opportunity to reflect on their own histories of trauma, and be made aware of the existence and value of information on the persistent effects of early trauma. Likewise, statutes should prescribe sweeping confidentiality of documents arising out of parents' participation in training activities. Such features will aim to assure parents that trauma-informed education is designed to be neither coercive nor invasive. Rather, it seeks to help parents reduce the lingering force of trauma in their lives and avert its presence in their children's.

