Adverse Child Experiences (ACEs)
Review & Critique

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Introduction

Understanding how children react to, and heal from, physical and psychological trauma is at the center of many conversations regarding the allocation of social services in the United States. Trauma-informed care has become an integral part of both state and federal social service policies addressing issues tied to child welfare. At its core, trauma-informed care approaches medical care from the perspective that every person has experienced some form of violence over the course of their lives, and those experiences have had an impact on their long-term health and well-being (Walkey and Cox 2013, Muskett 2014). However, there exists a tension between the ideology that informs trauma-informed care and the research models and intervention strategies employed to identify and serve survivors of trauma. The objective of many trauma-informed care projects is to create interventions to prevent trauma, or to focus on individual behavior modifications in the aftermath of trauma. While preventing trauma and providing care for survivors of trauma is important, a number of variables needs to be taken into consideration when creating programming designed to address trauma. Individuals and families coping with trauma who are unable to change or modify behaviors or lifestyles due to institutional barriers and/or existing structural social inequality run the risk of losing access to much-needed resources or face family separation. Trauma-informed care models that focus too heavily on the biological and neurological impact of trauma also leave little room to discuss the numerous ways in which environment and social inequality contribute to, or even create, trauma.1

About ACEs

The Adverse Childhood Experiences, or ACEs, framework has been adopted by many health-related disciplines in order to identify points of clinical and public health intervention, as well as explain a broad range of health and wellness concerns. Based on multi-disciplinary research conducted in the mid-1990s, ACEs have been used to explain concerns related to illness, behavior, and society. Studies using the ACEs model are currently linking childhood experiences to adult health conditions such as heart and lung disease, diabetes, obesity, addiction, and serious mental illness, including suicide. ACEs are also being used to connect childhood trauma with social issues, including but not limited to, economic precarity, chronic unemployment, incarceration, intimate partner violence, and teen pregnancy. Although the idea that childhood experiences inform adult behaviors has been part of health-related research for decades, there is a need to critically examine how the ACEs model is deployed and how the information collected from ACEs survey instruments is analyzed and shared. There is concern that what ACEs was designed to do in the 1990s, and how ACEs survey instruments and findings are used in the 2010s and 2020s are not aligned. Data that is designed to be relational but is interpreted as causational strips those living with trauma of their agency. It also runs the risk of ignoring how

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1 The following paper discusses the Adverse Childhood Experiences (ACEs) model. There are currently a large number of studies that have focused on the ways in which ACEs affects neuroplasticity and long-term brain development in children. It should be noted research focusing on neural pathways are a newer addition to ACEs research and are not part of the original ACEs study or the current ACEs protocol outlined by the CDC.
healthcare gaps and social service benefits cliffs are the products of structural violence\(^2\) rather than personal failings. Many of the phenomena observed and recorded in ACEs studies can also be explained using frameworks that focus on structural and institutional inequality.

Oppression and poverty are forms of violence that can also be used to frame different types of trauma-informed care. This paper provides a brief overview of the following themes: 1) Understanding the history of the ACEs model and examining how it has been used to determine diagnoses and interventions 2) Exploring how the ACEs model has transformed since the 1990s and investigating how this model is used to guide research that informs domestic social policy, 3) Argue that poverty and social inequality are also forms of violence that can produce outcomes similar to, or the same as, ACEs and 4) Document work being done that considers how ACEs can be used as part of larger projects that address social inequality.

The ACEs model was first introduced in a scholarly journal article titled *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults* (1998). The study was a partnership between the Centers for Disease Control (CDC) and Kaiser Permanente with assistance from researchers at southern California universities. The project’s stated goal was to better understand how childhood exposure to physical and sexual abuse and household dysfunction could be used to inform risky health behaviors in adults (Felitti et al. 1998). From 1995 to 1997, this multi-dimensional, large cohort study collected self-reported data from more than 17,000 clients using the Kaiser healthcare system in California. Data collection for the original ACEs project consisted of two questionnaires, two for women and two for men. Featured questions were broken into two themes: household history and health appraisal. The study identified ten ACEs: physical, emotional, and sexual abuse, physical and emotional neglect, substance abuse, mental illness, incarceration, poor treatment or abuse of mother, and parental separation or divorce.

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\(^2\) Structural violence is an intellectual framework that focuses on the way political, social, economic, and legal institutions create and/or reinforce social inequality. As an analytical tool, structural violence examines how long-term patterns of social exclusion and discrimination affect people’s ability to access vital resources including food, housing, healthcare and medicine, and living wage employment (Farmer 2009).
Analyzed data was organized into two categories: Abuse and Household Dysfunction. Abuse was defined as an individual childhood experience and included physical, psychological, and sexual abuse. The Household Dysfunction category included questions pertaining to children’s observations of the health and social behaviors modeled by adults in their households. These questions focused on mental illness and suicide, substance abuse, incarceration, and the number of times a child witnessed interpersonal violence in their household. Analysis in both categories focused heavily on how children’s relationships with their mothers, and their mothers’ health behaviors, shaped the number of ACEs they identified as adults. For example, the original ACEs study directly links a child’s exposure to physical and emotional violence either by their mother, or by their mother’s intimate partner, as an indicator of high ACEs scores as an adult. Although other family and household members could be responsible for abuse, the mother was considered the pathway through which children experienced abuse.

Researchers concluded they observed a strong correlation between the number of ACEs respondents identified and their level of good health and well-being as adults. They argued that there was evidence indicating childhood experiences had a direct impact on adult behaviors such as drinking, smoking, and overeating – which in turn contribute to numerous chronic health problems ranging from hypertension to heart disease and possibly cancer. They also concluded that childhood trauma created sustained feelings of anxiety and distrust as adults. This may manifest as chronic anxiety and depression disorders, or lead to distrust in doctors, authority figures, and the law. The researchers did make note that further studies needed to be conducted in order to determine how environmental factors, such as toxic contamination in homes, might influence the number of ACEs respondents reported. Recommendations stated that pediatricians, social workers, and clinic and hospital staff working with children should learn to administer ACEs surveys in order to encourage early interventions for households they identify as abusive or neglectful.

ACEs Adaptations
In the mid-late 2010s, the CDC modified and reintroduced an expanded version of the ACEs model that could be used by a wide variety of disciplines. The language used to describe trauma has changed, and the categories have been revised in order to take into account household dynamics in the twenty-first century. Instead of focusing exclusively on the mother’s role in shaping childhood wellness, the abuse and neglect categories have been expanded to include extended family and fictive kin who are part of individual households. The original categories were reframed as Abuse, Household Challenges, and Neglect. The revised CDC protocol now conceptualizes data collected in ACEs surveys under two headings: risk factors and protective

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3 A full discussion of both the CDC/Kaiser study and current ACEs resources are available on the CDC website under the Violence Prevention Heading.
https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
factors. Points of reference for both risk and protective factors are thought to occur at the individual, household, and community levels. ACEs research largely continues to focus on individual behaviors and interventions. Pediatricians, healthcare workers, and social workers are still encouraged to use the ACEs criteria to evaluate children they suspect live in households with a high number of risk factors.

In many ways the original ACEs study is a product of the social and economic environment that dominated the United States at the time of its conception. The study was conducted during a time when the intellectual ideologies that guided domestic social policy were tied to the idea that individual behaviors were the strongest determinant to predict success or failure. This pattern of behaviors, widely known as personal responsibility, placed the duty of good health, economic prosperity, and social contentment on an individual’s ability to secure their own resources. In terms of poverty, the personal responsibility model asserts that people who are unable to become economically prosperous lack knowledge and an understanding of how to achieve wealth.

Individuals who were not able to modify their lifestyles or follow educational models that promote economic prosperity and wealth are viewed as lazy, resistant, or non-compliant. This social philosophy served as the framework for many large-scale changes to domestic social policy in the 1990s. The most influential and long-lasting policy to come out of this era of social reform is The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), more commonly known as welfare reform or the Welfare Reform Act of 1996. PRWORA ushered in significant changes to the allocation of social services, limited the types of resources available through SNAP and WIC programs, and instituted time limits for individuals and families enrolled in these programs (Collins and Mayer 2010, Morgen et al. 2010).

Workfare also became an important part of mid-1990s social service reforms. Workfare programs instituted weekly and monthly work requirements for individuals enrolled in social service programs that provided food assistance. Although workfare was designed to create job opportunities that would help workers eventually find living wage employment, there was a number of issues within the program that created barriers for participants. Jobs available to workfare clients rarely paid a living wage, and workers were almost never placed in positions that could lead to advancement or higher wages. The wages made by workfare clients were also leveraged against the services they received in other state and federal programs. For example, workfare clients who also received housing assistance were frequently paid less than their non-workfare colleagues because it was assumed the wages workfare clients earned did not need to contribute to their housing costs (Roberts 2008, Morgen 2001). Individuals and families receiving food and housing assistance were also more likely to be using Medicaid. The increased privatization of Medicaid programs at the state level, and states’ ability to decide whether or not to accept federal Medicaid funds, have also left some of the poorest states in the nation without safety nets to provide a wide range of health services to poor communities (Bailey et al. 2017, Glassman 2017).
Critiques of ACEs

From a methodological perspective there is a growing body of literature critiquing the effectiveness of the ACEs model across diverse populations. The demographic for the original ACEs study was overwhelmingly older, white, and had achieved some level of post-secondary education. This population is significantly different than the impoverished neighborhoods and communities of color that are frequently the focus of ACEs studies conducted in the 2010s and 2020s. Researchers who critique the use of ACEs protocols argue that former and current survey instruments do not produce results that accurately represent the communities being surveyed.\(^4\) There is also a growing concern that using risk factors identified through ACEs research could result in long-term harm in populations where the concepts of community, neighborhood, and family are conceptualized differently than the 1990s framework (Dowd 2019, Harris et al. 2017).\(^5\) These critiques largely focus on expanding the definition of trauma to include the impact of chronic poverty on health and the importance of understanding racial and ethnic discrimination as a form of trauma.

Population

Western European researchers question whether data collected through ACEs questionnaires should be used as a free-standing evaluation tool since the ACEs model creates limited opportunities to understand difference across a population. They also believe that poverty should be a more integrated part of the discussion around high occurrences of ACEs (Finkelhor 2018, Gillies et al. 2019). Researchers in Canada and Australia argue that using ACEs in indigenous populations does not take into account how indigenous people define and organize family and community differently than predominantly white cohorts. They also argue that ACEs does not thoughtfully address how the historical trauma produced from displacement, genocide, and slavery creates additional barriers for indigenous people and people of color (Luther 2019). Since the ACEs model focuses on individual experiences within a specific clinical context, it also does not take into account how both current and historical trauma can be

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4 The original ACEs population consisted of both men and women. While women accounted for approximately 55% of ACEs respondents, the sex difference between men and women was not significant. Respondents also tended to live in large urban and suburban areas, were 75% white, and 75% had achieved some post-secondary education. Forty percent of respondents had received a four-year college degree; 85% of respondents were over 40 years of age, with the largest sample consisting of respondents over 60 years of age. Since there is such a vast difference in the original research population and many current research populations, many researchers question whether ACEs is the best tool to determine a course of action in communities affected by structural inequalities such as racism, language barriers, ableism, and poverty. Critics argue that although some ACEs studies do include discussions of economic insecurity or discrimination, these factors are not given as much consideration as responses regarding behavior fitting into established risk categories.

5 Since much of the programming related to ACEs research is new, there are few studies that have examined the short-term impact of this ACEs-informed programming. Critics are hesitant to predict outcomes of programming that has not produced long-term evaluations, but question whether programming aimed at increasing protective factors for children may also increase child removal from poor households. Since ACEs models do not fully take into account the effects of poverty as a form of violence, there is concern that indicators of poverty could be misinterpreted as personal choices.
shared between members of a marginalized group. Legal scholars in the United States express concern that without additional data collection techniques to provide context, ACEs results could be used to separate black children and youth from their families (Dowd 2018). Providing ACEs results without additional information may also increase the likelihood that black youth could become targets for the criminal justice system and face an increased risk of incarceration from a young age (Bateson et al. 2019).

Poverty
Chronic poverty can also be used to explain many of the risk factors identified by ACEs. Household demographics, parental education levels, neighborhood safety, and unemployment can be explained by exploring how institutional inequality creates and maintains high levels of economic and social insecurity for the poor. Poor people are more likely to develop multiple chronic illnesses, have poorer outcomes at time of diagnosis, and are more vulnerable to premature death caused by treatable illnesses (Mullings and Wali 2000, Adair 2002, Geronimus 1992, 2004, Pohlman and Becker 2006). Access to consistent, reliable healthcare, including preventative care, is tied to access to health insurance. The most recent census data indicates that employers cover approximately 56% of Americans (Berchick et al. 2018).6 7 People living at or below the poverty line overwhelmingly use Medicaid or other public sector healthcare resources, such as emergency rooms, to meet their primary care needs (Becker 2007, Boehm 2005, Rylko-Bauer and Farmer 2016). When public sector programs are streamlined, the first cuts are frequently made to mental health and substance dependency programs. ACEs identify mental health and substance use issues as risk factors for children in need of interventions. Interventions that focus on acute care may provide initial relief but are not sustainable. Access to consistent healthcare, coupled with other markers of poverty, including food and/or housing insecurity, and economic precarity means that the poor live in physically and emotionally chaotic, toxic environments (Mullings 2002, Checker 2008, Bell 2020). A shrinking living wage labor force, fewer healthcare plans with comprehensive preventative care, an almost non-existent social safety net system, and growing benefits cliffs leave people in poverty with limited options to leave impoverished conditions, even with programming that focuses on intervention and education.

A discussion of poverty must include a more compassionate and comprehensive explanation for many outcomes predicted by ACEs. Creating protective measures that focus on education, parenting skills, and exercises in building social networks and financial literacy do not take into account how different aspects of poverty work in tandem and build on each other to reify established structural barriers. Without reliable transportation it is challenging to maintain regular employment. Without a good work history, it is impossible to move into jobs that pay better wages and obtain benefits such as paid sick leave and health insurance. Housing programs can assist enrollees with initial housing, but a regular household income and affordable rent are key to helping the poor access and keep secure housing (Riccio and Deitch 2019). Food insecurity

6 These numbers do not reflect the number of people throughout the United States who are underinsured.

7 State of Kentucky in 2019 insurance coverage: 47% employer based, 26% Medicaid, 15% Medicare, 4% individual purchase, 2% military, and 6% uninsured (Kaiser Family Foundation).
affects performance levels at both school and at work (Ayala and Meier 2017). The current, renewed focus on streamlining SNAP benefits and placing additional mandates on SNAP recipients means that fewer resources are being directed towards initiatives addressing hunger (Mason 2020).

Social Justice

ACEs are frequently used to assess programming that examines the relationships between youth and the criminal justice system (Bonner et al. 2019). Poverty and incarceration have a complicated relationship. Poor people are more likely to be incarcerated, especially those living in communities of color (Guinier and Torres 2002, Alexander 2012). Since parolees are responsible for the cost of services they received while incarcerated, as well as fees attached to parole, they frequently leave prison already in debt (Resnik and Marcus 2020). Felony convictions have a dramatic impact on the jobs available to poor parolees, since they are required to report former felonies on job and school applications, and background checks are standard in most hiring procedures, even for minimum wage jobs. The effects of poverty are relational, and parolees struggling to find and maintain regular employment also experience food and housing concerns. A felony conviction, regardless of the circumstance, can create lifelong social and economic barriers. Lack of employment and housing opportunities, stereotyping of felons, imprisonment linked to minor offenses, cost-prohibitive legal services, and state and federal laws that present harsher sentences and penalties for repeat offenders ensure that poor people who have been incarcerated will continue to live in poverty.

Law enforcement, healthcare operators, and social service providers all use ACEs-driven data to document the cost of interventions designed to treat or combat trauma-related illnesses. Investing in community building initiatives and supporting anti-poverty legislation are more sustainable ways to combat ACEs. While ACEs as an independent research tool raises a number of questions about the circumstances surrounding data collection and the way data is analyzed, using ACEs with other evaluation tools can better inform social service organizations and non-profits working to provide resources for and opportunities to residents in underserved communities. By incorporating ACEs surveys into larger research agendas or program goals, ACEs data can be given context that could aid program designers working with children and youth across diverse environments. This type of programming focuses on the community aspect of ACEs and seeks to create trauma-informed care that addresses structural and institutional inequalities in specific communities. These projects build on the people and resources in the community to bring about change, rather than focus solely on education or intervention.

Mobilizing Action for Resilient Communities (MARC) is one such program. Comprised of fourteen community projects across the United States, MARC seeks to better understand the impact ACEs have on both local and state populations. MARC uses the term trauma-informed change to think about trauma-informed care as a complicated place-specific process. MARC partners are comprised of projects conducted at the regional, state, city, and community/neighborhood level. Each program identifies community-specific issues, and then creates programming around those issues. Each partner focuses on issues important to their
specific community. Programming addressing primary school education, support for children with special needs, healthcare for families with chronic health needs, the arts, and facilities for families facing addiction are a few examples of projects designed by program partners. The end goal is to not only design programming that can lead to sustainable change, but to also create a public repository of information to share with each other and other programs interested in instituting similar visions. MARC puts into practice many of the ideologies put forth in early ACEs research while honoring the voices of survivors of trauma and allowing them to guide trauma-informed change.

Conclusion

The ACEs model is one of the most popular models used in behavior research today. Many of the interventions designed to combat adult ACEs do not address the underlying problems tied to inequality and run the risk of legally and financially penalizing people who are unable to get out of a cycle of poverty. Unfortunately, some of the programs designed to address poverty actually intensify the experience of being poor by focusing on individual patterns and behaviors that cannot change unless poor people have access to economic resources. In some cases, focusing on ACEs instead of addressing the large number of issues that contribute to systemic poverty, policy makers continue to blame poor people for being poor. The effects of poverty are relational. Asking poor people to modify their health or economic behaviors without also providing an infrastructure to achieve physical, emotional, and economic security is not going to change the outcome. Multiple factors related to labor, health, housing, and food security all have to be addressed simultaneously in order to address poverty. In order for systems-involved people to become economically and legally autonomous, they must be able to find economic security. That security cannot come from modifying behavior if the origins of poverty are not addressed. ACEs modeling can play an important role in identifying community needs but cannot fulfill that need of its own. ACEs needs to be part of a more comprehensive plan of action if it to serve as a good and accurate evaluation tool for human relationships.
THE TRUTH ABOUT ACES

WHAT ARE THEY?

ACEs are Adverse Childhood Experiences

HOW PREVALENT ARE ACES?

The ACE study* revealed the following estimates:

**ABUSE**

- Physical Abuse: 26.3%
- Sexual Abuse: 20.7%
- Emotional Abuse: 10.9%

**NEGLECT**

- Emotional Neglect: 34.9%
- Physical Neglect: 6.8%

**HOUSEHOLD DYSFUNCTION**

- Household Substance Abuse: 26.3%
- Parental Divorce: 23.3%
- Household Mental Illness: 19.4%
- Mother Treated Violently: 12.7%
- Incarcerated Household Member: 4.7%

Of 17,000 ACE study participants:

- 39% have experienced 0 ACES
- 29% have experienced 1 ACE
- 14% have experienced 2 ACES
- 12% have experienced 3 ACES
- 9.5% have experienced 4 ACES
- 5% have at least 1 ACE

WHAT IMPACT DO ACES HAVE?

As the number of ACES increases, so does the risk for negative health outcomes.

Possible Risk Outcomes:

**BEHAVIOR**

- Lack of physical activity
- Smoking
- Alcoholism
- Drug use
- Minced work

**PHYSICAL & MENTAL HEALTH**

- Severe obesity
- Diabetes
- Depression
- Suicide attempts
- STIs
- Heart disease
- Cancer
- Stroke
- COPD
- Broken bones

rwjf.org/aces

*Source: http://www.cdc.gov/ncbddd/aces.htm
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About the researcher  
Elizabeth New received her master’s and PhD in Medical Anthropology at the University of Kentucky. Dr. New’s research interests have largely explored racial health disparities, the barriers poor women face accessing social service programs, gender inequality, economic and housing insecurity, and the relationship between poverty and state and federal social service policies and programs. Her Master’s research examined the social barriers and stereotypes both Appalachian born healthcare workers and low-income eastern Kentucky residents experienced navigating Kentucky’s Medicaid and SNAP programs. Her dissertation research examined how chronically ill, working poor and working class African American women built social and economic networks in order to support each other and access healthcare resources during the first phases of the ACA. In addition, Dr. New has taught classes pertaining to her research interests in the departments of Anthropology, Gender and Women’s Studies, and Appalachian Studies at the University of Kentucky as well as community and liberal arts colleges in the region. She currently consults with KCADV on projects that explore domestic violence from an anti-poverty perspective.  

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