DISCUSSION PAPER

The Interplay of Community Trauma, Diet, and Physical Activity:

Solutions for Public Health

Howard Pinderhughes, PhD, University of California, San Francisco School of Nursing

August 7, 2017

Diet- and activity-related illnesses—such as heart disease, stroke, cancer, and type 2 diabetes—can shorten life spans and adversely impact quality of life. Over the past 15 years, the public health field has made important progress in addressing these illnesses by shifting the focus from individual behavior to the broader social and economic forces that shape health [1]. There is now widespread agreement among experts in the field that in order to improve health outcomes and reduce the impact of these illnesses, we must pursue strategies, practices, and policies that are multifaceted, comprehensive, and focused on community- and institutional-level change [1].

There is a growing understanding that community conditions—the places where we live, work, and play—have a significant impact on our health and that adverse community experiences (community trauma) affect our food and activity behaviors. Advances in understanding the connection between adverse childhood experiences and health [2] have revolutionized the field of trauma-informed care [3], which has now become an important standard practice in communities across the country. But we must also seek to illuminate how adverse *community* experiences impact healthy eating and activity, and to develop integrated solutions. Adverse community experiences are destructive factors—such as racial, residential, and economic segregation; violence; structural racism and discrimination; intergenerational poverty; and public and private disinvestment—that traumatize entire communities. For example, experiencing and witnessing community violence can negatively impact the ability to eat healthfully and be active. Violence and fear of violence reduce social interactions that would otherwise contribute to community cohesion, thus reducing support for healthy eating and active living [4]. The pervasive presence of community trauma can become a significant barrier to efforts to improve population health and health equity, including those that address eating- and activity-related diseases. When people don't feel safe in their communities, they are less likely to walk to the grocery store, use local parks, access public transportation, and let their children play outside. Healthy food retailers and recreation businesses are less likely to invest in communities perceived as unsafe.

An analysis of the production of health inequities across multiple determinants of health revealed that adverse community factors—which decrease opportunities for healthy eating and activity—are rooted in structural violence in the form of government policies and business practices [5]. These policies and practices have led, for example, to the overconcentration of unhealthy food outlets in communities of color and communities with low to average household incomes [6]. In the case of food retail, public policies such as those of the Federal Housing Administration incentivized suburban homeownership, which resulted in white middle-class flight to the suburbs and a concentration of poverty in the inner cities [7]. Supermarkets, grocery stores, and many other businesses followed the white middle-class population in migrating to the suburbs. This flight (along with financial policies and practices, including redlining) left a void for unhealthful food outlets to fill [7,8]. The high cost and scarce availability of land in dense urban areas contributed to the migration

of businesses out of the cities and resulted in loss of jobs and tax revenues [9], and has influenced decisions about the siting of grocery stores and supermarkets [10]. Additionally, there has been limited availability of loans for local residents in underserved neighborhoods so that they might open businesses that sell and promote healthy food options [7]. These adverse community experiences have resulted in limited economic opportunities for residents and a poor food system in which chain restaurants and stores fill the gap with less healthy or unhealthful food options.

According to two recent Prevention Institute reports, strategies that address community trauma in highly impacted communities are well aligned with those that increase access to healthy foods and opportunities for physical activity [4,11]. By building on indigenous knowledge, expertise, and leadership, these strategies are already working in communities across the country. For example:

- **Creating safe spaces** enables community members to get the most use out of public resources, including those that support good nutrition and physical activity. Factors such as access to safe spaces for play, housing quality, transportation, and neighborhood "walkability" affect the choices people make on a day-to-day basis. An example project is Bridge Housing [12], a model for strengthening community in trauma-affected neighborhoods by integrating affordable housing with social services.
- **Promoting community development and employment** provides remedies to underlying inequities that contribute to violence. The point of these efforts is to ensure everyone in a community has equitable access to quality education, living-wage jobs, and environments free of oppression and bias (such as racism and sexism), among other factors. For example, Roots of Success [13], an educational program, prepares youth and adults who come from communities heavily impacted by poverty, unemployment, and environmental injustice for environmental careers and for improving conditions in their communities. This preparation impacts economic development and employment, which in turn can have a positive impact on levels of community trauma, food sources, and opportunities for physical activity.
- **Fostering social cohesion** helps residents feel included, gives them a sense of ownership, and promotes social order and community participation. By bolstering social networks, residents increase their mutual trust and willingness to intervene on behalf of one another. They become more involved in activities that build community, such as community gardens, healing circles, and restorative justice programs. An example project is the Rosebud Sioux Tribe's Defending Childhood initiative [14], which builds on families' strengths and needs by focusing on cultural traditions and ceremonies.

Conclusion

All people and communities deserve equal opportunities to be healthy and safe, but we know such opportunities aren't distributed evenly. To improve health outcomes and reduce the disproportionate impact of diet- and activity-related illnesses, it's essential to facilitate a deeper understanding of the underlying factors—including adverse community experiences—that profoundly and inequitably influence health and health equity outcomes for entire communities.

For these efforts to truly improve health at a community level, we must increase health practitioner and stakeholder awareness of actions that allow communities to heal from community trauma, protect against community trauma, and prevent community trauma in the first place. This is a worthy goal in and of itself and also creates a strong foundation for the improved nutrition and physical activity that leads to better mental and physical health.

References

1. Centers for Disease Control and Prevention and Prevention Institute. 2013. *A practitioner's guide for advancing health equity.* Atlanta, GA: US Department of Health and Human Services. https://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf
2. Shonkoff, J. P., A. S. Garner, B. S. Siegel, M. I. Dobbins, M. F. Earls, L. McGuinn, J. Pascoe, D. L. Wood, Committee on Psychosocial Aspects of Child and Family Health, and Committee on Early Childhood, Adoption, and Dependent Care. 2012. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 129(1):e232-e246.

3. Marsac, M. L., N. Kassam-Adams, A. K. Hildenbrand, E. Nicholls, F. K. Winston, S. S. Leff, and J. Fein. 2016. Implementing a trauma-informed approach in pediatric health care networks. *JAMA Pediatrics* 170(1): 70-77.
4. Cohen, L., R. Davis, V. Lee, and E. Valdovinos. 2010. *Addressing the intersection: Preventing violence and promoting healthy eating and active living.* Oakland, CA: Prevention Institute.
5. Davis, R., S. Savannah, E. Yañez, D. Fields-Johnson, B. Nelson, L. Parks, R. Do, A. Macaysa, and R. Rivas. 2016. *Countering the production of health inequities: A framework of emerging systems to achieve an equitable culture of health.* Oakland, CA: Prevention Institute.
6. Mack, R. 1997. Bringing down the walls of state preemption: California cities fight for local control of alcohol outlets. *Berkeley Journal of African-American Law and Policy* 3(1): 295-324.
7. Barker, C., A. Francois, R. Goodman, E. Hussain. 2012. *Unshared bounty: How structural racism contributes to the creation and persistence of food deserts.* New York, NY: American Civil Liberties Union and New York Law School. Available from: http://www.racialjusticeproject.com/wp-content/uploads/sites/30/2012/06/NYLS-Food-Deserts-Report.pdf (accessed May 18, 2017).
8. Kwate, N. O. A. 2008. Fried chicken and fresh apples: Racial segregation as a fundamental cause of fast food density in Black neighborhoods. *Health and Place* 14(1):32–44. doi: 10.1016/j.healthplace.2007.04.001.
9. Teitz, M. B., and K. Chapple. 1998. The causes of inner-city poverty: Eight hypotheses in search of reality. *Cityscape: A Journal of Policy Development and Research* 3(3):33-70.
10. Feldstein, L. M. 2012. Zoning and land use controls: Beyond agriculture. *Maine Law Review* 65(2): 467-490.
11. Pinderhughes, H., R. Davis, and M. Williams. 2016. *Adverse community experiences and resilience: A framework for addressing and preventing community trauma.* Oakland, CA: Prevention Institute.
12. Bridge Housing. 2017. *Resident and Community Services.* http://www.bridgehousing.com/what-we-do/resident-community-services (accessed June 23, 2017).
13. Roots of Success. 2017. *Environmental Literacy Curriculum.* https://rootsofsuccess.org (accessed May 18, 2017).
14. Defending Childhood. 2013. *Rosebud Sioux Tribe's Defending Childhood Initiative.* https://sites.google.com/site/rstdefendingchildhood (accessed May 18, 2017).

Suggested Citation

Pinderhughes, H. 2017. The interplay of community trauma, diet, and physical activity: Solutions for public health. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/the-interplay-of-community-trauma-diet-and-physical-activity-solutions-for-public-health.

Author Information

Howard Pinderhughes, PhD, is Chair of the Department of Social and Behavioral Sciences at the University of California San Francisco, and a board member of Prevention Institute.

Conflict-of-Interest Disclosure

None disclosed.

Disclaimer