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REFERENCES

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WHY WE NEED TO TALK ABOUT TRAUMA IN PUBLIC HEALTH NUTRITION

When you consider the word trauma in relation to food, health and eating what does it conjure up? In what ways is trauma relevant to dietetic practice? What does it even mean? In this article, I briefly introduce the concept of trauma as used in public health, social justice activism and counselling.

UK DIETETICS TODAY

Public health, social justice activism and counselling are three overlapping arenas that are germane to dietetic discourse and practise. Here I talk about those arenas in relation to trauma, plus I explore irritable bowel syndrome to highlight why we need to talk about trauma. I've not written a step-by-step guide to consultation - in the space available, this would become a tick box activity and as such, it would miss the point that the topic, including its erstwhile absence from dietetic discourse, deserves lengthy consideration. Instead, I've written an overview that flags up why we need to integrate trauma physiology into our practice. I hope it conveys the urgent need for conversation and action.

Shortly after starting work as a community dietitian, I began to suspect that I was missing something important about health, something that couldn't be pinned down to eating or exercise. Take prejudice: surely racism harmed health. I had no vocabulary for this, no biochemistry of discrimination to draw on from my dietetic education. So I searched a clinical database for 'racism' and 'heart disease'. The results made such an impact on me that I can still recall the first papers I read. One investigated racism and waist circumference;[1] another asked, *'Does racism harm health? Did child abuse exist before 1962?';*[2] a third introduced me to Michael Marmot's work on status syndrome and the social determinants of health.[3]

I was shocked, including by my ignorance, and by the fact that the ramifications of knowing that it was only by stepping outside of my professional conditioning on knowledge creation that I learnt pathways linking racism, classism and abuse with 'lifestyle' disease. I began to think of health in terms of both self-care and social justice. As part of this awakening, I came to realise that understanding the concept of trauma was crucial to my work as a dietitian with individuals and groups, and for addressing health inequalities.

TRAUMA - DEFINITION AND PROCESS

In everyday conversation, we may refer to distressing or extremely trying events as traumatic. In a therapeutic context, trauma refers to extreme stress exposure resulting in a body response that prioritises immediate survival over longevity. Common causes and categories of trauma are recognised. One way of grouping the causes of trauma is given in Table 1 overleaf.

A key point is that trauma is defined by somatic experience and not by the event itself. Not everything that is highly stressful is traumatic. That said, some events are irrevocably traumatic - rape, child abuse and neglect, for instance.

In other cases, two people may share an experience that traumatises one and not the other. Thus, two children may undergo the same series of invasive interventions for an illness, leaving only one of the children traumatised.

Table 1: Categories of trauma (examples are not exhaustive and may overlap)

Violation of body integrity: accident, disaster, sexual and physical abuse, medical intervention, violence, assault, diagnosis, torture, war
Threat to sense of self and/or relational safety: sexual and physical abuse, shaming, coercion, diagnosis, group oppression, household substance misuse, refugee camps
Loss: bereavement, relationship breakdown, incarceration, adoption, moving
Neglect: developmental, emotional and physical needs unmet
Trauma can be experienced in different ways, for example, directly, indirectly, vicariously, acutely, chronically and insidiously.

Table 2: Hallmarks of trauma

Core features of traumatic experience in adulthood are that it often involves a disrupted sense of self, in tandem with the experience of a lack of control and overwhelm, i.e. powerlessness. Horror and terror are often hallmarks.
In childhood, primary carer relationships strongly impact neuronal growth, such that lack of safety and nurture have a neurophysiological impact causing developmental trauma. Left untreated, this can have life-long detrimental consequences.
A traumatic experience is one that overwhelms a person's physiological/ psychological capacity to process the event in a health-prolonging manner.

Another example is witnessing a disaster: one person shakes violently as they watch; the second person stands nearby and does not shake and, in fact, seems oddly numb.

Why the different responses? In essence, trauma involves a lack of integration.

The child who was not traumatised had reliable, nurturing caretakers and - in somatic terms - the stress they experienced was tolerable and could be integrated. The experiences did not have a deleterious effect on the child's physiology or sense of self. In terms of physiological regulation, they did not tip over homeostatically to 'a point of no return.' The traumatised child did not have this support and, somatically speaking, stress became toxic. They exceeded what their body could handle within the parameters of homeostasis.[4]

What about the adults? The person who shook is processing the stress-emotion fall-out on the spot. They still need time to fully absorb what just happened, but their physiological sense-making system stayed connected and they remained present to events in real time. The memory is stored as a coherent narrative. The person who stood beside them was unable to process the somatic impact in a health-prolonging way and, instead, their body dealt with the stress-emotions complex in a survival-sustaining way.

We are less likely to be traumatised by adverse events when we have been brought up to believe ourselves worthy of love and respect and we view the world as a safe place. Hand in hand with these criteria, we are likely to have had our basic material and relational needs met, such as the need for food and secure attachment. As a result, our nervous systems, memories, endocrine and immune systems developed along particular health-promoting pathways. As adults we have a strong sense of coherence. In other words, we have an abiding sense of confidence that we will be able to cope with things, predicated on a core sense of self-worth and expectations of a safe world.

Our biology is influenced by our biography. When we are traumatised, we are more likely to experience disaster as traumatic than if our biology is not shaped by trauma.

TRAUMA AND ADVERSE CHILDHOOD EVENTS (ACES)

There is a growing awareness of the association between adverse childhood events, or ACEs, and adult health. The strong link between ACEs and lifelong risk for adverse life events and poor health coutcomes testifies to the huge significance of early - developmental - trauma. This is relevant because high ACE scores are strongly linked with many conditions that bring patients to our

clinics, such as diabetes, heart disease, eating disorders, IBS and mental health problems.

It is important to acknowledge that trauma impacts metabolic health regardless of eating and exercise habits. This means that public health campaigns which emphasise lifestyle change as a route to significant population health improvement are way off the mark. They rely on cherry-picked science to promote a neoliberal political agenda that embeds health inequalities.

In other words, lifestyle does not explain the link between ACEs/trauma and poorer health. This is not the same as saying behaviours makes no difference. It is saying that current dietetic discourse misrepresents the role of lifestyle in determining health outcomes.

Trauma impacts body responses and behaviours through interlinked pathways. The use of food for emotional regulation may be seen in comfort eating, comfort dieting and eating disorders. There may also be substance abuse, extreme exercise and other trauma-wrought behaviours. These behaviours are symptoms of distress and dysregulation and are also resourceful coping strategies, so that a mechanistic approach to behaviour change is likely to be counter-productive.

The single most effective thing we can do to ameliorate and prevent trauma as a profession is to refuse to be complicit any longer in the cultural silence. Ignoring trauma leads to shame, stigma, isolation and pseudo-science. By educating ourselves on trauma and speaking up about its impact we contribute to social and scientific change.

As practitioners, it is imperative that we adopt a trauma-informed approach. This means practising in a way that recognises the impact of trauma on people's bodies, behaviours, beliefs and capacity for learning, planning and change. The traumatised child lives through a body and belief system shaped to respond to events as if the world and the people in it are unsafe. Without intervention, these deep-rooted feelings and habitual responses persist even when external circumstances change.

A TRAUMA-INFORMED APPROACH TO IRRITABLE BOWEL SYNDROME

Can you list a few causes of IBS? We'll come back to this later.

At a FODMAPs training day I attended, run by dietetic specialists, we were given case studies to work through. For one patient, let's call her Sally, IBS symptoms returned after childbirth. We were given a formula for working through anthropometry, biochemistry, diet and so on, to help us in our response. Perhaps you know it. I volunteered to share my answer in the feedback session. I'd not said much, when a nearby colleague helpfully interjected to steer me in the right direction: it's not so much that she thought I was answering the question wrongly, rather that my answer was so far removed from what we'd been told was right that she thought I was answering the wrong question. You see, I didn't think the answer lay in a sweep of Sally's diet history to change eating frequency and food type. It seemed hugely significant that Sally's symptoms had returned after birth because there is a strong and consistent relationship between IBS and childhood abuse - and also between IBS and domestic (intimate partner) violence - and it is known that childbirth itself can trigger flashbacks and other symptoms of PTSD.

The case study of eating patterns suggested that Sally was spiralling towards chaos. Now was really not the time to jump in with wholemeal bread. A more humane - trauma-informed - response would involve listening and bearing witness, building trust and helping someone make sense of what was going on. The dietetic intervention would use a body-aware and compassion-centred approach to demystify experiences and give a context for dietary change. Focusing on nutrient profile at the expense of exploring Sally's relationship with food and self-care, the meaning of her IBS and the context of her distress, inhibits body-mind healing and exacerbates symptoms.

The global healthcare impact of IBS is huge. It accounts for more doctor visits than diabetes or hypertension (in the US).[5] What do you think causes IBS? A USA study asked internal medicine physicians, family practice physicians and gastroenterology physicians this question. Gastroenterology physicians were most likely to state that prior infection

and a history of abuse were the causes of IBS.[6] In a review of the field, one author considers the trauma-IBS link thus:

> *'The pathophysiological features that explain this association relate to stress-mediated brain-gut dysfunction and can range from altered stress-induced mucosal immune function, to impaired ability of the central nervous system, to downregulate incoming visceral or somatic afferent signals. For gastroenterologists and other healthcare providers, it is important to understand when to inquire about an abuse history and what to do with that information."*[4]

To be clear, I am not suggesting that dietitians ask about abuse history. As things stand with our training and professional norms, this could be highly damaging. I am, however, suggesting that we need to educate ourselves about trauma and change our practice accordingly.

In fact, the causal role of trauma in IBS had been mentioned in the morning session of the FODMAPs training. Yet, the information was not integrated into the treatment model, which, consequently, used a non-scientific methodology. Instead, foods were reduced to constituent nutrients and dietary change was framed as a mechanistic endeavour. This default 'trauma-ignored' model is harmful because it entrenches disconnect and because it disregards the relational dimensions of healthcare. It was a strange experience to be surrounded by experts talking about gut disorders, but ignoring trauma. It was as if no one else in the room had ever woken themselves screaming.

MOVING BEYOND A POST-TRUTH DIETETICS

Professional narratives have real-life consequences. It is putting it mildly to say that doing what we have always done will not serve our patients or students well. For as long as it cements the cultural bias that silences trauma, dietetic practice contributes to systems of thought and practise that perpetuate personal and social trauma. This has implications for human rights, health outcomes and suffering, ethical practice and professional reputation.

Whether we intend it or not, the refusal to acknowledge trauma makes us adversaries in the struggle for social justice. Our adherence to positivism as a scientific paradigm ensures that we perpetuate the (neoliberal) belief that public health is largely a matter of lifestyle, education and willpower. The selective use of data to side-step the metabolic impact of racism, abuse, ACEs, poverty, other oppression and privilege, is post-truth 'science'. How did we arrive here? Is there anything in the answer, about professional socialisation and leadership for example, which might improve future organisational knowledge-creation?

The reality is that life is traumatic for many. We have a surfeit of evidence for this from Black Lives Matter and #MeToo, through to hate crimes, fat shaming, Grenfell Towers and welfare suicides. Either we continue to gate ourselves off from difficult truths and undertake research and CPD in a post-truth-science hermetic bubble, or we open our hearts to suffering - our own and others' - and commit to develop an ethical, relevant, trauma-informed profession. If healthcare is not trauma-informed then it is trauma-ignored. Trauma-ignored practice is not evidence based: it is not science, but science fiction.

WHAT NOW? STARTER IDEAS FOR CONVERSATION AND ACTION

Find out what any unfamiliar words mean, e.g. neoliberal, positivism, relational, reductionist. Are the concepts they describe useful to furthering your understanding and do you agree with the way they are used here? If not, why not? How would you paraphrase the text they appear in?

Do a PubMed search for key words around childhood diabetes and trauma/emotions. Are there any surprises? What does this mean for your practice? How will you use the information? Are there any ethical issues raised for your team/profession?

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