Childhood Food Insecurity
Viewed Through the Lens of Developmental Trauma
Reshaping the Future of Dietetics
Through Trauma-Informed Care

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December 4, 2025

Food insecurity (FI) is defined as limited or uncertain access to adequate food, with low food security involving reduced diet quality and very low food security involving disrupted eating patterns and reduced intake.[1] Contributing factors include financial hardship, unstable employment, limited access to nutritious food, inadequate social support, and family-composition stressors that disproportionately affect low-income and racially marginalized households.[2] In 2023, 13.5% of U.S. households were food insecure, with higher prevalence among households with children (17.9%), single mothers (34.7%) and fathers (22.6%), Black adults (23.3%), Hispanic adults (21.9%), and households below 130% of the federal poverty level.[1] Despite adults protecting their children through restriction themselves, 8.9% of FI households reported that a child had experienced hunger, skipped meals, or gone an entire day without eating.[1,2]

Childhood FI functions as a distinct developmental adversity with consequences extending beyond reduced intake. Nutritional quality is compromised during critical developmental periods, including reduced intake of fruits, whole grains, iron, and essential fatty acids, nutrients essential for rapid brain development and cognitive, motor, and social–emotional growth.[3] Children in FI households demonstrate poorer health even after controlling for poverty; growth, cognition, academic achievement, and emotional and behavioral regulation are negatively affected.[2] These patterns contribute to elevated rates of asthma, depressive symptoms, behavioral dysregulation, iron-deficiency anemia, emergency department utilization, and early metabolic disruption.[3,4] Scarcity-driven feeding dynamics, such as restriction–overeating cycles, end-of-month intake drops tied to SNAP depletion, and pressure-based feeding practices, further destabilize eating behaviors and compound nutritional inadequacy.[2,3]

These developmental consequences parallel research on adverse childhood experiences (ACEs), defined as high-stress or traumatic events that undermine safe, stable, and nurturing environments.[5] Both ACEs and childhood FI function as chronic stress exposures that disrupt neurodevelopment, impair self-regulation, and operate as trauma-like conditions marked by fear, hypervigilance, and physiological stress activation.[6] One in four children in FI households experiences three or more ACEs, compared to one in twenty-five in food-secure homes.[6] Longitudinal data show that young adults with no ACEs face a 5.2% risk of FI, and each additional ACE increases that risk by ~40%, demonstrating a cumulative feedback loop between early adversity and later instability.[7] ACE exposure increases vulnerability to disordered eating patterns, overeating, binge eating, and unhealthy weight-control behaviors, which mirror scarcity-driven cycles in food-insecure children.[8] Environmental aspects of ACEs, including discrimination, violence, caregiver strain, and inconsistent access to medical care, co-occur with childhood FI and promote developmental harm.[2,3] Childhood FI therefore functions as an adversity acting through the same neurodevelopmental pathways as trauma, shaping long-term health and widening disparities across the life course.

These national patterns appear clearly at the local level. In King County, 8.5% of young children have experienced two or more ACEs, with substantially higher rates among Black, Hispanic, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native children (13–24%) and among households earning below $50,000 (14–24%).[9] Food hardship follows similar gradients: nearly one in four children lives in a household that has struggled to afford food, rising to 38–44% for Black, Hispanic, NHPI, and AIAN families, and to over half of households earning under $35,000.[9] These disparities reflect the same risks described on a national level, malnurishment, chronic stress, and household instability concentrated in communities facing structural inequities.

Evidence shows that long-term improvement depends on strengthening income supports, expanding SNAP and WIC benefits, feeding children through school and childcare food programs, increasing access to nutritious foods, and addressing the rising costs of housing and healthcare.[2,3,4] However, these systems rely on accurate national surveillance data and federal support. The USDA's termination of the annual Household Food Security Survey, dismissed as "redundant, costly, politicized, and extraneous," removes the core dataset historically used to track FI and justify funding for these programs.[10,11] Without transparent, publicly available data, inequities become harder to detect and program effectiveness becomes more difficult to evaluate. This mirrors the DSM-5 committee's continued rejection of developmental trauma proposals despite strong prospective evidence, reflecting institutional choices that minimize childhood adversity and restrict the public health capacity to respond.[12] These decisions foster a policy landscape unable to adapt to trauma-informed frameworks essential for reducing health disparities in the United States.

Long-term improvement depends on understanding that childhood FI is inseparable from the chronic stress and traumatic conditions that define ACEs. Families experiencing FI describe it as a daily crisis shaped by violence, discrimination, and systemic neglect, underscoring the need for trauma-informed practices that address the environments that promote ACEs.[6,13] ACE and childhood FI prevention demands coordinated, interdisciplinary responses amongst dietitians, mental and public health professional, social services, and early childhood education that allows for community development that works in tandem to stabilize families.[6,13] Families at risk for ACEs need to be identified and supported by dietitians through the integration of trauma-informed food-security screening in clinical settings paired with nutrition assistance support programs.[7] Together, this positions the future of dietetics within a public-health and trauma-informed framework that recognizes food insecurity not as an income or accessibility problem alone, but as a manifestation of adversity and structural inequity, and calls the profession to engage in advocacy, interdisciplinary collaboration, and upstream ACE-prevention strategies to prevent intergenerational transmission of harm.

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