Barriers to Trauma-Centered Cancer Care in Radiation Oncology

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INTRODUCTION

Sexual violence is a significant public health issue and can shape how patients experience healthcare, particularly intimate procedures.



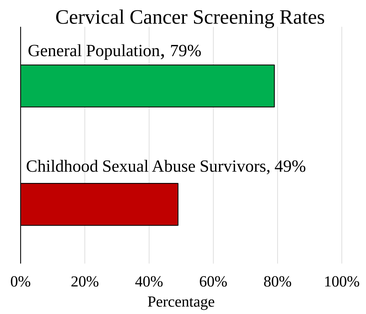
81% of women report experiencing sexual harassment and/or assault



43% of men report experiencing sexual harassment and/or assault



The lifetime prevalence of PTSD for women who have been sexually assaulted is 50%.

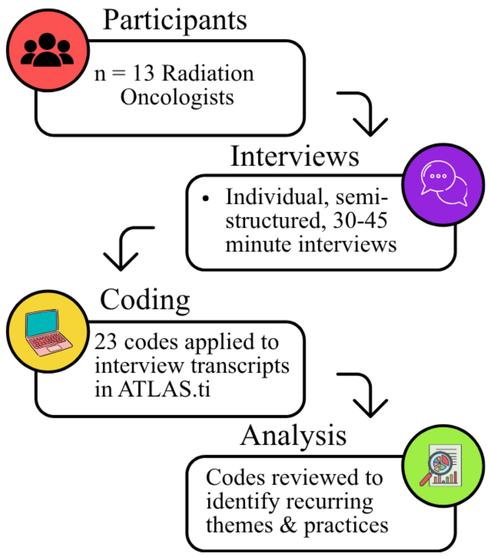


Sexual trauma is associated with lower cervical cancer screening rates.

Diagnosing and treating gynecological cancer usually involves frequent pelvic/rectal exams, pap smears, intravaginal sonograms, and pelvic irradiation.

- These treatments can cause significant distress for victims of sexual trauma due to perceived loss of control, patient-provider power disparity, and the physical sensation of the examination.
- **This highlights the need for trauma-informed approaches to delivering pelvic radiation and cancer care.**
- We investigated barriers to implementing trauma-informed care (TIC) in radiation oncology and practices that facilitate its delivery.

METHODS



RESULTS-TABLE 1. THEMATIC ANALYSIS OF INTERVIEWS

Barrier	Definition/Examples of Barrier	n/N Providers (%)	Overarching Theme	Illustrative Quote	Participant-Identified Facilitator/ Potential Solutions
Resource-Based	Lack of Time, Shortage of Available Staff (Social Workers, Psychologists), Administrative Pressure to Maximize Patient Workload, Lack of Educational Resources for Patients (Pamphlets, etc..)	9/13 (69%)	TIC implementation is constrained by limited clinician time and the complexity of coordinating institutional resources.	• "You have to have a specific room that can accommodate both brachytherapy and anesthesia, and sometimes that wasn't always the easiest. For instance, we tried to build more OR rooms that could do that. But JCo regulations are so prohibitive nowadays that it prevented us from doing that".	• Establish dedicated procedure days that consolidate anesthesia-requiring brachytherapy cases to optimize anesthesiologist availability for patients at significant risk of distress or re-traumatization
Education-Based	Lack of Trauma-Informed Care Training, Lack of Experience Treating Patients with Traumatic Histories, Uncertainty about When or How to Discuss Trauma with Patients	8/13 (62%)	Without formal TIC training, providers largely relied on individual judgment to determine whether and how to address trauma.	• "Asking outright, "Do you have a history of sexual trauma?" That's a pretty blunt and direct question for someone that you've been face-to-face with for 10 minutes, and I'm not comfortable asking that immediately."	• Presentations or lectures from speakers with expertise in trauma-informed care at ASTRO/conference sessions dedicated to teaching how to provide TIC within radiation oncology • Formal TIC education integrated into radiation oncology residency programs
Role-Based	Patients Preference to Not Discuss Trauma with Oncologists	4/13 (31%)	Providers questioned whether it was their role to initiate trauma-related conversations in the absence of patient disclosure.	• "Patients may not feel comfortable telling me and they'd rather tell the nurse, and whether it's a male or female thing, maybe [a] nurse is less intimidating to them rather than a physician. This is someone's personal business. They'll tell you if they want you to know about it".	• Allowing trauma screening/disclosure through nurses, social workers, forms, or another team member
Medication-Based	Concerns About Pain Management in Patients with Co-Occurring Substance-Use Disorders, Concerns About Pain Management Efficacy	4/13 (31%)	While sedation and anesthesia can improve procedural tolerance, providers described tradeoffs involving patient responsiveness, communication, and medication side effects.	• "We moved away from what we considered conscious sedation administered by nursing. It was kind of like twilight. The patient's reacting. Their muscle tone's the same. They would fight you because, obviously, especially some of these patients have been traumatized, if they feel someone touching them down there, that's not going to make them feel comfortable. They're trying to get away from you, even though they might not be able to talk to you."	• Guidance on non-pharmacologic ways of providing TIC to post-op implant placement patients would be useful • Discussing procedure invasiveness/duration with anesthesiology beforehand and communicating expectations to patients
Trauma-Based	Concerns about Triggering or Re-Traumatizing Patients with Traumatic Histories	4/13 (31%)	Efforts to avoid causing distress sometimes contributed to provider reluctance to initiate conversations about trauma.	• "[When] we do brachytherapy, we insert catheters into the vagina, which can obviously bring back some PTSD-like issues"	• Optimize the clinical environment to promote patient comfort and control: offer music, allow patients to adjust lighting and room temperature, conduct consultations while patients are clothed and seated, minimize time undressed, offer extra draping based on patient preference for exam visibility • Reassure the patient that you explain each step before performing it • Establish a clear "stop" signal with the patient before starting the exam or procedure

PARTICIPANT CHARACTERISTICS

	Characteristics	n (%)
Gender	Male	7 (54%)
	Female	6 (46%)
Cancers Treated	Gynecologic	10 (77%)
	Breast	6 (46%)
	Prostate	4 (31%)
	General Oncology	1 (8%)

Table 2. Participant Demographics (n = 13)
All participants were board-certified radiation oncologists with significant experience in treating pelvic malignancies.

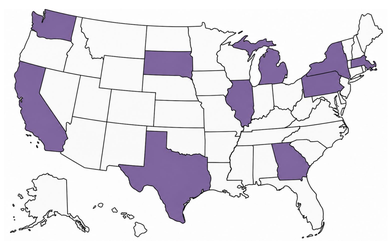


Figure 1. Radiation oncologists from 11 Institutions across 10 states were represented in our cohort.

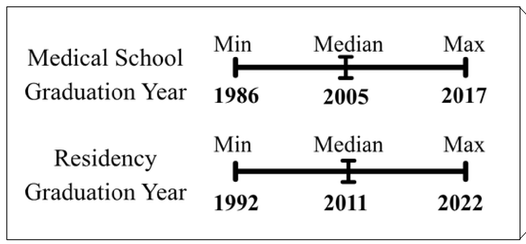


Figure 2. Median and range of medical school and residency graduation years among interviewed radiation oncologists (n= 13).

DISCUSSION

- Resource and education barriers were the most frequently reported obstacles to implementing trauma-informed care (TIC), suggesting that implementation depends on individual clinician practices, institutional support, and formal training
- **Many of the TIC facilitators/solutions are practices that would benefit all patients, regardless of whether they have disclosed a trauma history**
- **Formal TIC education was uncommon:** only 2 out of 13 interviewees (15%) reporting receiving formal trauma-informed care education, both through OB/GYN training rather than radiation oncology (one during OB/GYN residency and one during an OB/GYN clerkship)
- The absence of radiation-oncology specific TIC education highlights an opportunity to integrate trauma-informed principles into residency training to promote inclusive, patient-centered care
- **Limitations:** Small sample size (n =13) and qualitative design may limit generalizability
- **Next Steps:** Gathering feedback from trauma "experts" on identified TIC practices and assessing which practices most improve patients' engagement with care

References: National Sexual Violence Resource Center, Chivers-Wilson KA. Sexual Assault and Post-Traumatic Stress Disorder: A Review of the Biological, Psychological, and Social Factors and Treatments