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Perspective

Trauma-informed and trauma-focused care across the cancer trajectory: A psycho-oncology framework

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Abstract: Although trauma-informed approaches are increasingly discussed in oncology, the point at which universal trauma-sensitive practice should be complemented by targeted trauma-focused intervention remains comparatively underexplored. This Perspective proposes a three-tier, trajectory-based framework comprising universal trauma-informed care, assessment-based early trauma-focused intervention, and trauma-focused treatment for persistent symptomatology. The framework complements distress-based stepped-care approaches by making trauma-related symptom patterns, their links to defined cancer-related stressors, and their course over time explicit considerations in assessment and referral decisions. It assumes that psychological response across the cancer trajectory reflects the interaction between illness-related stressors and individual factors, including prior trauma, attachment, coping, social support, and resilience, rather than disease severity alone. Distress, subthreshold traumatic stress, and PTSD are treated as related but non-equivalent constructs, supporting repeated assessment and proportionate intervention without requiring a categorical diagnosis before clinically significant trauma-related symptoms are addressed. EMDR is discussed as one illustrative approach alongside other trauma-focused interventions; the framework focuses on how assessment and timing may guide the selection of clinically appropriate care across the cancer trajectory. Preliminary findings in paediatric oncology and ongoing work in adult breast cancer support further investigation but do not yet establish a preventive effect. We therefore frame early trauma-focused intervention as a testable clinical hypothesis and outline a research agenda examining whether intervention timing can modify symptom trajectories and reduce persistence of trauma-related difficulties across oncology care.

Keywords: EMDR; distress screening; resilience; early psychological intervention; Adaptive Information Processing; survivorship; psychological adjustment

1. Introduction

Trauma-informed principles are increasingly discussed in oncology, yet the point at which universal trauma-sensitive practice should be complemented by a targeted trauma-focused intervention remains less clearly defined. This Perspective proposes a three-tier, trajectory-based framework comprising universal trauma-informed care, assessment-based early trauma-focused intervention, and trauma-focused treatment for persistent symptomatology. Its purpose is to distinguish levels of care according to repeated clinical assessment and symptom course while situating psychological needs across the full cancer trajectory. Drawing on clinical and research literature in psycho-oncology and EMDR, we use Eye Movement Desensitization and Reprocessing (EMDR) therapy as an illustrative clinical model—not as the exclusive intervention—to describe how processing, early intervention, and resource enhancement may be integrated within

multidisciplinary care.

2. Cancer diagnosis as a disruption of continuity

A cancer diagnosis is a major stressor and, for some patients, may be experienced as traumatic. It can disrupt a person's sense of identity, bodily integrity, and biographical continuity, creating a marked sense of discontinuity between life before and after cancer. The psychological burden of cancer is well documented: a large pooled analysis of 3,724 patients across diverse cancer diagnoses found that 52% reported clinically significant distress on the Distress Thermometer [1], indicating that substantial distress is common within the cancer experience. This estimate refers to general oncological distress and should not be interpreted as an estimate of cancer-related traumatic stress or PTSD, which are distinct constructs discussed in Section 5.

An early Italian psycho-oncological formulation described the multidimensional psychological impact of cancer under the term "psiconeoplastic syndrome" [2]. The term is used here as a historical formulation, not as a current diagnostic category. Contemporary work on personalized psycho-oncology discusses tailoring assessment and care to individual needs, but does not validate this named syndrome as a distinct construct [3].

Conceptualizing diagnosis as a potential disruption of continuity has two clinical implications. First, because psychological needs may emerge or change as patients move from diagnosis through treatment and follow-up, this perspective supports assessing them from the earliest phases of care and revisiting them at major transitions, rather than positioning them as secondary to medical treatment. Second, it avoids dismissing clinically significant distress as an unavoidable consequence of cancer or prematurely pathologizing expected emotional responses. This framing therefore supports proportionate, assessment-based care that recognizes psychological impact without assuming that every patient has been traumatized.

3. Cancer as a trajectory of potentially cumulative stressors

Unlike trauma models built primarily around a discrete, time-limited event, cancer care often unfolds through repeated and interrelated stressors: diagnostic work-up, communication of results, surgery, systemic or radiation treatment, side effects, bodily and functional changes, follow-up, survivorship, and, for some patients, recurrence or progression.

These phases may differ in psychological salience and can interact over time: a later procedure, follow-up scan, or change in prognosis may reactivate distress associated with earlier phases. A trajectory-based framework therefore requires repeated assessment from diagnosis through treatment and follow-up, rather than assuming that a single early assessment can adequately represent psychological needs across later transitions.

This cumulative structure may be better conceptualized as a sequence of potentially traumatic stressors rather than as a single index event. Within a relatively short period, a patient may need to adapt to diagnosis, invasive procedures, adverse treatment effects, changes in appearance or bodily function, and anticipatory anxiety surrounding follow-up investigations; these stressors may recur if disease status changes. The clinical implication is not that each phase is inherently traumatic, but that vulnerability, meaning, and symptom expression can change over time. A trajectory-based model of care therefore follows the person across transitions and links reassessment to changes in treatment and disease course.

4. Why does the same cancer experience affect people differently?

Two patients with a comparable diagnosis, stage, and treatment plan can

respond in markedly different ways. This variability is not explained by disease severity alone. A systematic review of distress in breast cancer survivors identified prior mental health problems, comorbidities, lower social support, physical symptoms, and modifiable health behaviors among relevant predictors, alongside disease- and treatment-related factors [4]. A more recent systematic review of longitudinal distress trajectories across adult cancer populations likewise found substantial heterogeneity in symptom course; among studies examining predictors, physical symptoms and functional impairment emerged most consistently [5]. Together, these findings support a multilevel formulation in which medical characteristics are considered alongside psychological, relational, and functional context.

Earlier breast cancer studies illustrate why psychological risk should not be inferred from cancer stage or treatment characteristics alone. Green et al. found that trauma-related symptoms were relatively common after breast cancer treatment, whereas cancer-related PTSD diagnosed by structured interview was uncommon [6]. In a related cohort, trauma history, pre-cancer psychiatric diagnosis, recent life events, and perceived social support contributed to the prediction of psychological symptoms, whereas cancer treatment variables did not [7]. These findings do not imply that disease severity is irrelevant; rather, they support assessing the person's subjective experience and pre-existing psychological context in addition to objective medical variables. A recent review also describes how trauma history may shape engagement with cancer screening, diagnosis, and treatment [8].

Attachment, prior trauma exposure, psychiatric history, and habitual coping strategies may shape how patients appraise and manage illness-related threat. A systematic review of early-stage breast cancer found insecure attachment to be associated with poorer quality of life and greater distress [9], while childhood adversity has been associated with higher anxiety, depression, and distress in women with breast cancer [10]. These associations should be interpreted probabilistically rather than deterministically: prior adversity or insecure attachment may increase vulnerability in some patients, but neither establishes a direct causal pathway to later traumatic stress.

The framework is therefore not solely a vulnerability model. Social support, effective emotion regulation, flexible coping, and previously developed personal resources may buffer psychological impact and support adaptation. Assessment should explore both risk and protective factors, because similar medical stressors can have different meanings and consequences depending on the person's relational history, current resources, and broader psychosocial context.

Resilience should likewise not be treated as a fixed trait or as the simple absence of distress. A systematic review, meta-analysis, and meta-regression of 23 randomized controlled trials involving 3,287 patients with cancer found beneficial effects of resilience-oriented interventions on resilience, post-traumatic growth, quality of life, anxiety, and depressive symptoms; interventions including cognitive flexibility, self-efficacy, self-esteem, self-regulation, and coping skills showed larger effects than interventions without these components [11]. This evidence supports viewing resilience as a potentially modifiable clinical resource, while not implying that resilience-focused work is itself a trauma treatment.

5. Distress, traumatic stress, and PTSD: related but not equivalent

Distress, trauma-related symptoms, and post-traumatic stress disorder (PTSD) overlap clinically but are not interchangeable. Conflating them can lead either to over-pathologizing expected reactions to cancer or to under-recognizing clinically significant trauma-related symptoms that fall below the diagnostic threshold for PTSD.

Only a minority of patients with cancer develop PTSD, although a larger group may experience subsyndromal trauma-related symptoms. A major review reported structured-interview estimates of approximately 6.4% for current cancer-related PTSD and 12.6% for lifetime cancer-related PTSD, with an additional 10%–20% of patients experiencing subsyndromal post-traumatic symptoms [12]. An earlier meta-analysis likewise showed that prevalence varies considerably according to assessment method and scoring approach, with lower estimates obtained using structured clinical interviews than with some self-report methods [13]. These differences make assessment method and timing essential when interpreting prevalence figures.

An additional diagnostic nuance is important. A cancer diagnosis does not, in itself, automatically satisfy Criterion A for PTSD. Under contemporary diagnostic criteria, a cancer-related experience can be considered a qualifying traumatic exposure only when the nature of that exposure meets Criterion A; substantial oncological distress or the presence of trauma-related symptoms alone is therefore not sufficient to establish criterion-level trauma or PTSD. Diagnostic assessment must establish the relevant exposure criterion together with the required symptom clusters, duration, and impairment [12]. Trauma-related symptom burden can nevertheless be considered dimensionally for clinical purposes without treating PTSD itself as a purely dimensional construct. In this Perspective, the term traumatic impact is used to describe clinically meaningful trauma-related reactions without presuming that every patient meets criteria for PTSD.

6. From trauma-informed care to early trauma-focused intervention

Recent literature has articulated trauma-informed care as a relevant framework for oncology, emphasizing recognition of trauma exposure, psychological and physical safety, patient agency, collaborative communication, and avoidance of unnecessary re-traumatization [14,15]. A sensitive-practice tool has also been implemented and evaluated in breast radiotherapy [16]. Contemporary oncology guidance also supports ongoing distress identification, assessment, and referral across the disease course rather than one-time screening [17]. Building on these principles, we ask a more specific question: when, if at all, should universal trauma-informed care be complemented by a targeted trauma-focused intervention before persistent symptomatology becomes established?

We propose a three-tier conceptual distinction: universal trauma-informed care; assessment-based, clinically indicated early trauma-focused intervention; and trauma-focused treatment for persistent clinically significant symptomatology. The model is intended as a heuristic for clinical decision-making and research, not as a validated stepped-care algorithm.

The framework extends general distress-based stepped care by making trauma-related symptoms, their relationship to specific phases of the cancer trajectory, and their persistence over time explicit considerations in decisions about assessment and referral.

The first level, trauma-informed care, is universal. It concerns how oncology services communicate information, structure procedures, support choice and predictability, and respond to distress in ways that reduce avoidable re-traumatization. It applies across disciplines and does not require that a patient be identified as traumatized or referred for specialist psychotherapy.

The second level, early trauma-focused intervention, is clinically indicated rather than universal. It refers to a time-limited intervention considered after focused assessment identifies acute trauma-related symptoms linked to a defined cancer-related stressor, together with clinically meaningful distress or functional interference, before a persistent pattern is established. Assessment

should consider the symptom pattern and course, effects on daily functioning and cancer care, current supports, patient preference, and immediate safety needs. Trauma-specific measures may support assessment where appropriate, but a positive screen or risk factor alone does not establish an indication for treatment; Section 8 describes relevant assessment domains and examples of measures. This proposal should not be confused with universal single-session psychological debriefing. Evidence from the broader trauma literature supports targeted early trauma-focused cognitive-behavioral intervention primarily for symptomatic or higher-risk individuals, while the evidence base remains limited and heterogeneous [18]. Any preventive effect in oncology must therefore be tested rather than assumed.

For example, a patient who develops recurrent intrusive images and marked avoidance after an invasive procedure, with interference in daily functioning or subsequent care, may warrant focused assessment and discussion of an early trauma-focused intervention even if PTSD criteria are not met.

Direct oncology evidence also remains limited. A recent narrative review of psychological interventions for cancer-related PTSD identified only 11 eligible studies and found marked heterogeneity in populations, interventions, and methodological quality [19]. The existing literature is consequently more informative about treatment of established symptoms than about whether intervening earlier can alter later symptom trajectories. This distinction is central to the research question proposed here.

The third level, trauma-focused treatment, concerns patients with PTSD or persistent trauma-related symptoms associated with clinically significant distress or functional impairment, whether the symptoms are directly linked to cancer-related experiences or reflect the reactivation of earlier traumatic material. At this level, intervention should follow a full clinical formulation and differential diagnosis rather than being triggered by distress screening alone.

In practice, Level 2 concerns substantial trauma-related symptoms linked to a recent or ongoing cancer-related stressor, identified through assessment before a persistent pattern is established. Level 3 concerns symptoms that persist over time, cause clinically significant distress or functional impairment, or meet criteria for PTSD, and therefore require a full clinical formulation and treatment plan. These levels are distinguished by symptom course, persistence, and impact, rather than by distress screening alone.

This three-tier distinction aims to avoid two opposite errors: withholding targeted intervention until a formal PTSD diagnosis is reached, and treating expected or transient distress as evidence that trauma-focused psychotherapy is required. Repeated screening and reassessment can identify changing needs, but screening should be followed by focused clinical assessment before treatment intensity is determined [17].

7. Trauma-focused interventions across the cancer trajectory

Trauma-focused cognitive behavioral therapy, cognitive processing therapy, prolonged exposure, and EMDR are examples of established trauma-focused approaches [20]. Their suitability in oncology should be considered in light of the patient's symptoms, preferences, medical context, and available clinical expertise. Within this three-tier framework, EMDR therapy is discussed as one illustrative clinical model rather than as the only possible intervention. Its potential role can be organized into three clinically distinct functions across the cancer trajectory: processing distressing or traumatic memories, targeted early intervention when clinically indicated, and resource-oriented preparation or stabilization. The evidentiary support for these functions is not equivalent and should be distinguished accordingly.

The first function is trauma-focused processing of specific distressing memories associated with diagnosis, invasive procedures, surgery, bodily or functional loss, treatment complications, or recurrence. A systematic review identified seven EMDR studies involving 140 patients with cancer and concluded that EMDR was promising for psychological distress, while emphasizing the small evidence base, methodological heterogeneity, and generally low study quality [21]. One multicentre clinical comparison of 57 patients reported greater improvement on several trauma and general symptom measures with EMDR than with a supportive, non-trauma-focused CBT condition; however, treatment allocation was determined by site rather than randomization, which limits causal inference [22]. Cancer-specific EMDR clinical models have also been described and updated in dedicated texts [23,24]; these sources provide clinical frameworks rather than independent evidence of efficacy.

The second function is targeted early intervention close to a potentially traumatic phase of care. In a randomized pilot study of 40 participants—20 paediatric oncology patients and 20 parents—10 patients and 9 parents received EMDR, while 10 patients and 11 parents received standard psychotherapy (SP) [25]. The reported outcomes therefore concern this mixed patient–parent sample. Both groups showed reductions in post-traumatic symptoms. The EMDR group showed greater reductions than the SP group in total Impact of Event Scale–Revised (IES-R) scores (mean change, 24 vs. 11; $p < 0.05$) and intrusion scores (1.9 vs. 1.2; $p < 0.05$); between-group differences in the other IES-R subscales were not statistically significant. Post-treatment post-traumatic growth scores were also higher in the EMDR group. The small sample and pilot design warrant replication [25]. In adult breast cancer, the B.R.E.A.S.T. protocol describes a prospective, single-blind randomized controlled trial comparing treatment as usual, treatment as usual plus psychoeducation, and treatment as usual plus EMDR Recent Traumatic Episode Protocol (R-TEP); the protocol was published in 2026 and does not yet provide outcome data [26]. A small G-TEP study in cancer survivors also reported preliminary symptom improvement, but its design and sample size limit inference and it should not be taken as evidence of a preventive effect in newly diagnosed patients [27]. These studies justify further investigation of timing and indication; they do not establish that early EMDR prevents chronic post-traumatic symptomatology.

From an AIP perspective, the clinical relevance of an oncological stressor depends not only on the event itself but also on whether the experience remains insufficiently processed or activates pre-existing maladaptive memory networks. Cancer-related experiences may become targets for early trauma-focused work when assessment identifies acute trauma-related symptoms that remain strongly linked to a defined phase of care—for example, intrusive recollections or images, marked reactivity to reminders, avoidance, persistent negative meanings, or clinically relevant interference with functioning or treatment. Prior trauma, psychiatric history, attachment patterns, limited social support, and reduced regulatory resources may increase vulnerability and inform case formulation, but they should not be treated as stand-alone indications for trauma-focused intervention. Within this framework, the AIP model guides case conceptualization and target selection rather than replacing diagnostic assessment or functioning as a triage algorithm [28,29].

The third function is resource-oriented preparation and stabilization. These procedures may be appropriate when a patient needs support with affect regulation, perceived coping capacity, or readiness for trauma processing, or when anticipated medical procedures are a focus of distress. During active treatment, they should be adapted to medical status, fatigue, pain, treatment demands, and patient preference. They are conceptually distinct from memory processing, are

not a prerequisite for every patient, and should not be presented as having an independently established cancer-specific resilience effect.

The temporal organization of EMDR is also relevant to oncology. Standard EMDR case conceptualization addresses past experiences, present triggers, and future anticipated situations [28]. In cancer care this sequence may need to be applied flexibly because the stressor is often ongoing rather than fully past: current procedures, bodily changes, and treatment demands may require attention alongside earlier experiences that are reactivated by illness and future-oriented fears such as recurrence, progression, or further invasive treatment. The model therefore does not imply that EMDR is focused only on the past.

This past-present-future organization can help structure the standard eight-phase EMDR approach within psycho-oncology [28,29], while the clinical sequence should remain responsive to safety, medical status, symptom profile, and treatment priorities. From a biopsychosocial perspective [30], the most appropriate outcomes to evaluate include trauma-related symptoms, distress, functioning, quality of life, coping, engagement with care, and adaptation to illness. Claims about effects on tumour biology, immunity, recurrence, or survival would require separate evidence and are not implied by this framework.

8. Toward an integrated model of psycho-oncological care

Figure 1 summarizes the proposed framework. The cancer trajectory interacts continuously with person-level factors—including prior trauma, attachment, coping, social support, and resilience—so that psychological response may change across diagnosis, treatment, bodily or functional changes, follow-up, and recurrence or progression. Trauma-informed care is universal, whereas early trauma-focused intervention and trauma-focused treatment are contingent on repeated assessment and clinical indication. The arrows in the figure should therefore be read as decision pathways, not as an assumption that patients necessarily progress from one level to the next.

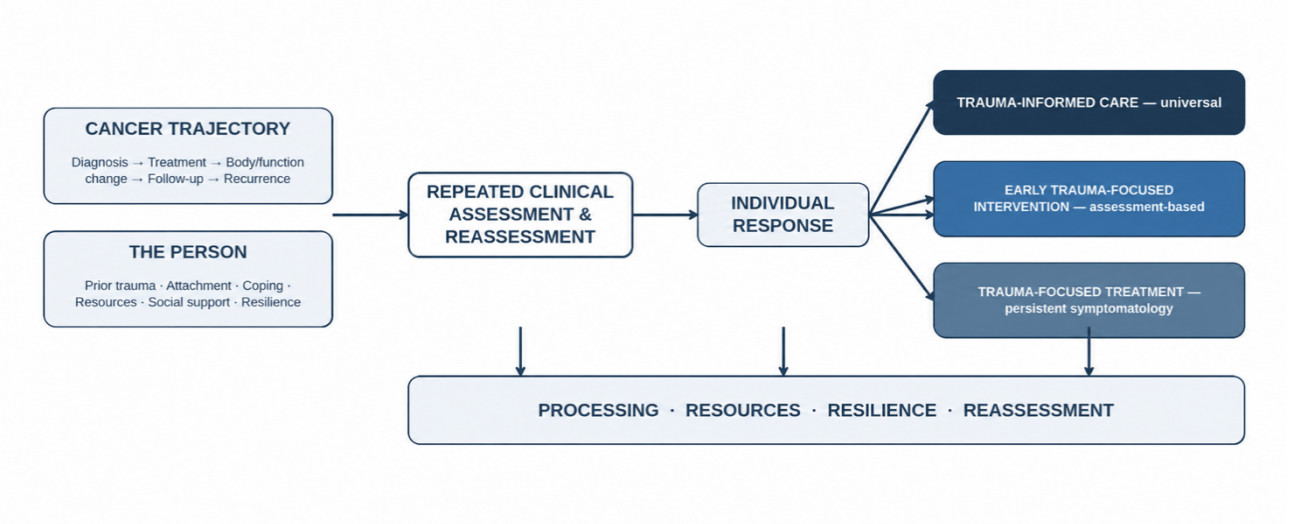

Figure 1. Heuristic trajectory-based framework for trauma-informed and trauma-focused psycho-oncological care. The framework is a conceptual and clinical heuristic and has not yet been empirically validated as an integrated model. Arrows represent possible assessment-based decision pathways and do not imply that patients necessarily progress through each level.

Implementation depends on integration with the broader oncology team. Routine distress screening can identify patients who may need further assessment, but a positive distress screen is not equivalent to a trauma diagnosis. Where clinically indicated, second-stage assessment should clarify the nature of the stressor; the pattern, intensity, and course of trauma-related symptoms; duration

and functional impact; relevant psychiatric history and prior trauma; current supports; patient preferences; immediate safety needs; and differential diagnoses [12,17]. Trauma-specific symptom measures, such as PCL-5 when appropriate to the clinical question, may support this assessment but should complement clinical interview and evaluation of functional impact. Reassessment is particularly important at major transitions—including diagnosis, initiation or completion of treatment, follow-up, recurrence, progression, and major treatment-related complications—because psychological needs can change over time [17].

Where specialist trauma-focused care is not immediately available, the oncology team can agree on a named point of contact, planned reassessment, and referral route to psycho-oncology or mental health services. Urgent risk, severe impairment, or disruption of cancer treatment should prompt timely specialist review.

9. Research agenda and conclusion

The framework generates a specific research question: among patients who show clinically significant acute trauma-related distress after a defined cancer-related stressor, does an assessment-based early trauma-focused intervention improve subsequent symptom trajectories compared with usual psychosocial care or standard stepped-care pathways? This formulation is preferable to comparing early intervention with deliberately withholding care until PTSD develops. Prospective trials should predefine eligibility thresholds, distinguish general distress from trauma-specific symptoms, include adequate follow-up, report adverse events and treatment acceptability, and assess both categorical and dimensional outcomes. Change in trauma-related symptom severity among eligible patients should be designated as a primary outcome; secondary outcomes should include general distress, anxiety and depression, functioning, quality of life, fear of recurrence, treatment engagement, and use of subsequent mental health care. Moderators such as prior trauma, psychiatric history, social support, illness phase, and baseline symptom severity should also be examined.

Several limitations should be explicit. This article is a conceptual Perspective rather than a systematic review; the cited literature was selected to develop and challenge the proposed framework rather than through a formal evidence-synthesis protocol. Evidence for early trauma-focused intervention in oncology is preliminary, particularly in adults, and the proposed three-tier model has not been empirically validated as an integrated care pathway. Evidence for EMDR in cancer populations is also limited by small samples, heterogeneous designs, and a scarcity of rigorously controlled trials [21,22]. Finally, feasibility will depend on psychosocial staffing, referral pathways, oncology workflow, and access to clinicians trained in trauma-focused treatment.

A trajectory-based approach may help psycho-oncology distinguish universal trauma-informed care from clinically indicated early trauma-focused intervention while preserving the clinical importance of repeated assessment. The framework does not assume that cancer is inherently traumatic or that every patient requires trauma-focused psychotherapy. Rather, it proposes matching the level and timing of care to the individual's assessed response across the illness trajectory. Whether targeted early trauma-focused intervention—including EMDR where appropriate—can reduce the persistence of trauma-related symptoms remains an open empirical question. The model is therefore best understood as a set of testable hypotheses for clinical research and service development.

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