

COMMENTARY

Psychological safety in T-cell-redirecting immunotherapy**Anna Fleischer*** 

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1. Introduction

T-cell-redirecting cancer immunotherapies, including chimeric antigen receptor (CAR) T-cell therapy and bispecific antibodies, have changed the treatment landscape for hematologic malignancies. Their clinical promise is accompanied by distinctive supportive care demands: patients and caregivers must recognize symptoms such as fever, fatigue, cognitive changes, signs of infection, mood disturbance, and functional decline while coping with prognostic uncertainty, treatment delays, intensive toxicity monitoring, and fear of relapse. Distress and quality-of-life concerns are therefore not peripheral to treatment, but part of how patients interpret and manage immunotherapy-related risk.^{1,2}

This Commentary proposes psychological safety as a concise, practice-oriented dimension of supportive care in T-cell-redirecting immunotherapy. Psychological safety does not mean the absence of distress. It describes a care environment in which patients and caregivers can understand expected and concerning effects, report subtle or subjective changes promptly, and trust that concerns will be interpreted respectfully and acted upon through transparent pathways. The construct is particularly relevant when symptoms are ambiguous, rapidly evolving, or difficult to describe.

2. Why psychological safety matters

A health psychology perspective is essential because patients do not merely experience symptoms; they interpret them. Fever may be understood as a manageable adverse event, a sign of treatment activity, or a frightening signal of deterioration. Word-finding difficulty may be normalized as fatigue, feared as neurotoxicity, or withheld to avoid appearing anxious. Such interpretations shape help-seeking, symptom reporting, adherence, and caregiver escalation.

The Common-Sense Model of Self-Regulation helps explain this process: patients form cognitive and emotional representations of illness and treatment, including beliefs about identity, timeline, consequences, controllability, and emotional meaning.³ In T-cell-redirecting therapy, these representations are repeatedly revised during cell manufacturing, step-up dosing, toxicity observation, response assessment, immune recovery, and relapse surveillance. Psychological safety may therefore reduce the gap between clinical monitoring and lived symptom interpretation.

This is not only a communication issue. It is also a safety issue. If patients or caregivers hesitate to report early cognitive, infectious, emotional, or functional changes, clinically relevant deterioration may be recognized late. Conversely, if every sensation is experienced as alarming and no response pathway is clear, monitoring can amplify anxiety rather than support coping.

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3. A concise framework for practice

Psychological safety can be conceptualized through interrelated domains: informational safety, communicative safety, interpretive safety, procedural safety, and caregiver safety (Table 1). These domains overlap with supportive care, distress management, and patient-reported outcome monitoring, but are not identical to them. The key question is not only whether information is provided or symptoms are collected, but whether patients and caregivers can understand the information, voice concerns, and escalate them without fearing dismissal, blame, or that they are burdening the clinical team.

This construct is measurable at several levels: perceived permission to report, confidence in symptom interpretation, trust in clinical response pathways, caregiver confidence in escalation, and the absence of perceived penalty for speaking up. Psychological safety may also be assessed at the service level, for example through whether teams provide clear escalation instructions, respond consistently to reported symptoms, and close the feedback loop after patient-reported alerts.⁴ It should be treated as a relational and procedural property of care, not as a personality trait of the patient.

Electronic patient-reported outcome (ePRO) monitoring is especially relevant. In T-cell-redirecting therapy, ePRO systems should not function only as toxicity checklists. They should also support interpretation, escalation, and reassurance by asking about cognitive changes, fever dynamics, fatigue, sleep, oral and taste symptoms, infection anxiety, caregiver observations, perceived preparedness, and fear of treatment failure. Recent CAR T-cell-specific ePRO framework work

supports the need for symptom and impact measures adapted to this treatment context.⁵

Important limitations should be explicit. ePRO monitoring can create alert fatigue, increase anxiety, exclude patients with limited digital access or literacy, and generate false reassurance if alerts are not reviewed or acted upon. A psychologically safe ePRO system therefore requires human backup, clear thresholds, caregiver inclusion, accessible formats, and predefined clinical response pathways. Digital monitoring should make it easier to reach the team, not harder to know whether a concern matters.

Implementation should remain pragmatic. A minimal approach could combine a brief pre-treatment expectation and uncertainty assessment, written escalation guidance, caregiver orientation, short symptom and distress check-ins, and explicit normalization of early reporting. Clinicians can also invite questions proactively, name uncertainty honestly, and explain what will happen after a symptom is reported. The clinical message should be simple: reporting ambiguous symptoms is not overreacting; it is part of safe immunotherapy care.

4. Research implications

Future studies should evaluate psychological safety as both an outcome and a mechanism of care. Measurement work should test brief patient- and caregiver-reported items on permission to speak up, confidence in escalation, trust in responses, and perceived usability of information. Intervention studies could examine whether psychological safety-oriented communication, caregiver training, and ePRO workflows improve timeliness of reporting, distress, quality of life, unplanned care, and treatment

Table 1. Psychological safety as a distinct construct in T-cell-redirecting immunotherapy

Domain	What it captures	Distinction from related concepts	Example indicator
Informational safety	Whether patients understand expected, concerning, and uncertain treatment effects	Goes beyond information provision by assessing whether information is usable under uncertainty	"I know which symptoms require urgent contact."
Communicative safety	Whether patients and caregivers feel permitted to report subtle or subjective changes	Differs from general communication quality by focusing on perceived permission to speak up	"I can report cognitive or emotional changes without feeling difficult."
Interpretive safety	Whether symptoms are taken seriously without premature dismissal or psychologization	Differs from distress screening by focusing on meaning-making and clinical interpretation	"My concerns will be interpreted respectfully and medically."
Procedural safety	Whether reported concerns trigger transparent response pathways	Differs from ePRO data collection by requiring predefined action and feedback	"I know what happens after I report a symptom."
Caregiver safety	Whether caregivers feel able to observe, report, and escalate concerns	Extends supportive care to informal safety monitoring	"I know when and how to report changes I notice."

continuity. Qualitative work may clarify which moments of the treatment pathway are most vulnerable to silence, confusion, or delayed escalation.

5. Conclusion

T-cell-redirecting immunotherapies require supportive care models that address not only toxicity detection, but also how patients and caregivers interpret and report uncertain symptoms. Psychological safety offers a compact framework for making communication, monitoring, and escalation pathways more usable. It should be treated as a practical quality dimension of patient-centered immunotherapy care.

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Further disclosure

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