



PREVENTING MEDICAL ERRORS IN THE GLP-1 ERA

2 Continuing Education Credits

Asynchronous Distance Learning Course

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ABOUT THE INSTRUCTOR

Gabriel Benaim, LMHC, is a Licensed Mental Health Counselor based in Miami, Florida, specializing in anxiety disorders, trauma, and psychosomatic symptom presentations. He provides psychotherapy to adolescents and adults in both English and Spanish, with a clinical focus on the relationship between emotional distress and physical symptoms. His work integrates cognitive behavioral therapy, somatic approaches, mindfulness-based interventions, and culturally responsive care. Gabriel's professional interests include patient safety, interdisciplinary collaboration with medical providers, and continuing education for healthcare professionals. He is also the author of *When Anxiety Becomes Physical: A Clinical Guide to Somatic Symptom Presentations*.

Preventing Medical Errors in the GLP-1 Era

Author: Gabriel Benaim, LMHC

Continuing Education Credit: 2 contact hours

Target Audience: Licensed mental health counselors, clinical social workers, marriage and family therapists, psychologists, and other behavioral health professionals

Board Alignment: This course is designed to address the content areas required for medical errors prevention training under Florida Statutes section 456.013(7), namely root cause analysis, error reduction and prevention, and patient safety. Approval for a specific licensure requirement is determined by the approving board or provider. It is also appropriate as a general continuing education elective for behavioral health professionals in other jurisdictions.

Disclosure Statement

The author has no financial relationships with any pharmaceutical company, device manufacturer, or commercial entity related to the content of this course. No manufacturer of any glucagon-like peptide-1 (GLP-1) receptor agonist or other medication funded, reviewed, or influenced this material. Brand names are used only for clarity and recognition and do not constitute endorsement. This course is educational and does not constitute medical, legal, or clinical supervision advice. Clinical and legal decisions depend on jurisdiction, board rules, agency policy, and individual client context.

Learning Objectives

After completing this course, the participant will be able to:

1. Describe how GLP-1 receptor agonists affect behavioral health assessment and identify the presentations most likely to be affected.
2. Apply a root cause analysis framework to behavioral health errors involving clients who use GLP-1 medications.
3. Identify common diagnostic errors that occur when medical or medication-related effects are misattributed to primary psychiatric causes.
4. Explain assessment and screening errors related to eating disorders, suicide risk, and alcohol use in clients using GLP-1 medications, and select safer assessment practices.
5. Implement documentation, communication, and interprofessional collaboration strategies that reduce error and support patient safety.
6. Evaluate systems factors, scope-of-practice limits, and cultural bias that contribute to error, and integrate error-prevention practices into routine clinical work.

Introduction

A client you have treated for two years arrives looking noticeably thinner. Almost as an aside, she mentions that her primary care physician recently started her on a weekly injection. Over the next several sessions, you notice that she is more irritable, sleeping poorly, and largely uninterested in food. At that point you are already making a clinical decision, even if it does not feel like one. Is her depression returning? Could the medication be contributing? Is there information her prescriber needs to hear?

Behavioral health errors often begin in moments exactly like this. They are usually not dramatic mistakes. More often, they arise from ordinary interpretive choices made when a new piece of information does not fit the picture we already have of a client. GLP-1 receptor agonists, including semaglutide and tirzepatide, have entered routine medical care at extraordinary speed. Behavioral health clinicians are now seeing many clients who use them, often without having received much training on how these medications can complicate assessment.

This is not a course in pharmacology, nor is it a course about weight loss. It is a course about preventing medical errors in behavioral health. A medication that can substantially alter appetite, weight, reward, mood, and patterns of alcohol use can also change the meaning of symptoms that therapists assess every day. Appetite loss may be misread as depression. Restrictive eating may be mistaken for an expected treatment effect. Old warnings about suicide risk may be repeated after the evidence has changed. Important observations may never reach the prescriber. Each is a plausible, preventable pathway to error.

For that reason, the discussion repeatedly returns to three patient safety ideas required in medical errors education: root cause analysis, error reduction and prevention, and patient safety. The aim is not to teach therapists to manage GLP-1 medications. It is to help behavioral health clinicians recognize where errors can enter their own work and to build routines that make those errors less likely.

Scope of practice matters from the outset. Unless a behavioral health clinician holds an additional license that permits medication management, the clinician does not prescribe, dose, discontinue, or manage a GLP-1 medication. The therapist's safety role is different: notice clinically relevant changes, assess behavioral health risk, encourage appropriate medical follow-up, document the reasoning behind clinical decisions, and coordinate with prescribers when consent and clinical circumstances support doing so. The material that follows stays within that boundary.

The approach is the same one patient safety science has used for decades: examine the system in which an error becomes possible, look past the convenient explanation to the underlying cause, and design routines that make the safer action easier to take. Throughout the course, those principles are applied to ordinary therapy sessions and to the kinds of mistakes capable clinicians can make when clinical practice changes faster than training does.

Section 1: The GLP-1 Landscape and Why It Matters for Behavioral Health

(Supports Learning Objective 1)

What these medications are

GLP-1 receptor agonists imitate the action of a gut hormone released after eating. Among their effects, they slow gastric emptying, increase satiety, and reduce appetite. They also influence brain systems involved in reward and food-seeking, which helps explain why their effects can extend beyond hunger alone. Semaglutide is marketed as Ozempic for type 2 diabetes and Wegovy for weight management. Tirzepatide, a dual GIP and GLP-1 agonist, is marketed as Mounjaro and Zepbound. Although tirzepatide is pharmacologically distinct, behavioral health clinicians will often encounter the two together because both can produce substantial changes in appetite, weight, and reward.

Those changes can be large. In the STEP 1 trial, adults with overweight or obesity who received semaglutide 2.4 mg weekly lost an average of roughly 15 percent of body weight over 68 weeks, compared with about 2 percent among participants receiving placebo (Wilding et al., 2021). In

SURMOUNT-1, tirzepatide produced average weight reductions of roughly 16 to 22 percent depending on dose (Jastreboff et al., 2022). For an individual client, this can amount to forty or fifty pounds over a period of months. Changes of that magnitude can affect energy, routines, self-image, eating behavior, and the way other people respond to the client.

Clients also frequently describe a quieter change: the reduction of what is sometimes called "food noise," the persistent background of cravings, food thoughts, and preoccupation that can occupy a great deal of mental space. For some people taking GLP-1 medications, that preoccupation diminishes markedly. The experience is clinically relevant because the medications act on reward and craving systems, not simply on the stomach. The same biology has prompted research into possible effects on alcohol use disorder. For therapists, the immediate implication is more modest: when reward and craving change, motivation, mood, habits, and coping can change with them.

How common this is

The scale of use makes this a routine clinical issue rather than a niche one. GLP-1 prescribing has risen rapidly. Among U.S. adults with diagnosed diabetes, more than one in four used an injectable GLP-1 medication in 2024 (Vahratian & Warren, 2025), while use for weight management has also expanded. A general outpatient caseload is therefore likely to include clients taking these medications, including clients who have never thought to mention them in therapy. Treating GLP-1 use as an unusual exception increases the chance that a relevant medication change will be missed. This matters not only for prevalence but for disclosure. Clients may view these medications as diabetes treatment, weight-management treatment, or simply a weekly injection rather than as something relevant to psychotherapy. If the therapist asks only whether the client takes "psychiatric medications," GLP-1 use can remain invisible even when it is changing symptoms that are being interpreted clinically.

Why a behavioral health clinician should care

A therapist does not need to manage the medication for it to matter clinically. Appetite and weight are neurovegetative symptoms used in the assessment of depression. Rapid changes in eating or body size can resemble, conceal, or intensify eating-disorder pathology. Changes in craving may affect alcohol or other substance use. The cultural story surrounding these medications also matters: clients may view them as lifesaving, shameful, a shortcut, a last resort, or some combination of these. Those meanings influence disclosure, body image, and treatment. The overlap is especially important because therapists routinely use appetite, sleep, energy, concentration, and pleasure as indicators of psychiatric change. A medication does not have to be prescribed for a mental health condition to alter the data on which a mental health formulation is based. That is why medication awareness belongs inside behavioral health assessment even when medication management does not.

Consider how much behavioral health assessment relies on eating and weight. Poor appetite and weight loss may appropriately raise concern about depression. Intense focus on food, shape, or weight may raise concern about an eating disorder. A GLP-1 medication can alter each of those signals through a pharmacologic mechanism. If the medication is unknown or simply left out of the formulation, the clinician may build a psychiatric explanation on incomplete information. That is a straightforward route to diagnostic error.

How clients are getting these medications

How a client obtains the medication can further shape risk. Some receive GLP-1 treatment from a primary care physician or endocrinologist who knows their broader medical history. Others use direct-to-consumer or high-volume telehealth services, where behavioral health history may

be gathered more briefly. A therapist should not assume that eating-disorder history, current psychiatric risk, or therapy involvement has been fully assessed elsewhere. Other clients obtain compounded products from compounding pharmacies or medical spas, while some use gray-market or online sources with minimal clinical oversight. The FDA has cautioned that unapproved and compounded GLP-1 products do not undergo FDA review for safety, effectiveness, and quality, and it has received reports of dosing errors and other problems involving these products (U.S. Food and Drug Administration, 2026b). Suspected non-prescribed, compounded, or gray-market use should prompt medical follow-up and coordination rather than an independent medication judgment by the therapist. The route of access also affects how much continuity can reasonably be assumed. A clinician prescribing through an established medical practice may have longitudinal records and an opportunity for follow-up, while a high-volume service may see only the information collected through its own intake. Neither route guarantees good or poor care, but the therapist should verify rather than infer what screening and coordination have actually occurred.

For behavioral health practice, the important assumption is that screening may not have happened simply because prescribing happened. A client may have completed only a brief online intake before receiving a prescription, and the therapist may be the clinician with the most complete understanding of that person's psychiatric and eating history. Connecting the medical and behavioral health pictures can therefore become an important part of the therapist's safety role. This becomes particularly important when the client has a history that may not have been disclosed to the prescribing service. Eating-disorder symptoms, prior severe depression, changes in alcohol use, or current psychotherapy involvement may be highly relevant to the behavioral health formulation even when none of those factors changes the medical indication for the prescription.

The presentations most likely to be affected

Several presentations deserve closer attention once GLP-1 use is known. Mood disorders are prominent because appetite, weight, energy, and motivation are already part of mood assessment. Eating disorders require particular vigilance because medication-driven appetite suppression can interact with restriction, bingeing, and body image. Alcohol use may shift as craving changes. Anxiety may be influenced by medication side effects, by rapid physical changes, or by fear of discontinuation and weight regain. Clients with trauma involving food or the body may also experience unexpected reactions as their appearance and social visibility change.

These concerns should not be mistaken for an argument against the medications. Many people derive substantial benefit from them. The clinical issue is that GLP-1 use can make familiar behavioral health shortcuts less reliable. Once the medication enters the picture, symptoms that once seemed easy to interpret may require a slower, more deliberate differential assessment.

Case example

Marcus is a 54-year-old accountant receiving therapy for generalized anxiety. His internist starts semaglutide for prediabetes and weight management. Three months later, during tax season, Marcus reports feeling "off," more keyed up, and barely interested in eating. Given his history and the time of year, an anxiety flare is a reasonable first hypothesis. It should not be the only one. A safer formulation keeps the medication on the differential and checks the timing of symptoms, dosing changes, eating patterns, and other physical effects before settling on the familiar explanation.

Reflection questions

Think about your current caseload. Which clients do you know are taking a GLP-1 medication? How confident are you that you would learn about a new prescription or dose change? What routine, if any, do you use to keep medication and medical changes current over the course of therapy?

Key clinical takeaways

GLP-1 medications are common enough that their effects belong in routine behavioral health assessment. They can alter appetite, weight, reward, mood, and body image, all domains that therapists regularly interpret. Knowing whether a client is taking one, and incorporating that fact into clinical reasoning, is a patient safety practice rather than a specialty skill.

Section 2: Root Cause Analysis and a Framework for Behavioral Health Errors

(Supports Learning Objective 2)

What a medical error is in behavioral health

The phrase "medical error" often calls to mind a wrong-site surgery or an incorrect medication dose. Behavioral health errors are usually less visible. They may take the form of a diagnosis that is missed or delayed, a risk assessment that never occurs, clinically important information that is not communicated, a note that records a conclusion without the reasoning behind it, or a referral that should have happened but did not. Near-misses matter as well because they reveal where a system can fail before a client is harmed.

Modern patient safety work was shaped by a shift in perspective. The Institute of Medicine's landmark report *To Err Is Human* helped move healthcare away from asking only, "Who made the mistake?" and toward asking, "What conditions allowed the mistake to reach the patient?" (Institute of Medicine, 2000). That distinction is especially useful in behavioral health. A therapist who mistakes a medication effect for depression is not necessarily careless. The clinician may be working without a reliable way to track medication changes, without an easy route to reach the prescriber, and under ordinary time pressure. Changing those conditions is more dependable than relying on a promise to be more careful next time. This systems view also changes what clinicians do with near-misses. If a potentially harmful misunderstanding is caught before it reaches the client, the event still deserves attention because it identifies a weak point in the workflow. A near-miss is useful precisely because the system can be changed before the same sequence occurs again under less forgiving circumstances.

Root cause analysis in plain terms

Root cause analysis provides a structured way to move from the visible mistake to the changeable condition underneath it. One familiar approach is to ask "why" repeatedly. Each answer becomes the starting point for the next question until the analysis reaches a process, policy, communication gap, or other condition that can actually be changed.

Imagine that a therapist fails for several months to recognize a serious restrictive eating pattern in a client taking a GLP-1 medication. The reduced intake was initially interpreted as an expected medication effect and evidence that weight treatment was working. Why was it not questioned? The therapist had no routine trigger for reassessing disordered eating during rapid weight loss. Why was there no trigger? The intake form asked about eating disorders once, as a yes-or-no history item, and the practice never revisited the issue. At that point, the analysis has

moved beyond "the therapist missed it" to a concrete systems problem: nothing in the workflow prompted reassessment when the client's circumstances changed.

That shift is what makes root cause analysis useful. Self-criticism may produce a sincere intention to do better, but intentions are fragile under workload and time pressure. A system change, such as requiring a fresh mood and eating assessment after rapid weight change, remains in place on the difficult weeks as well as the easy ones.

Applying the method to a different kind of error

The same method applies to communication failures. Suppose a client reports new intrusive thoughts about not wanting to be alive shortly after a GLP-1 dose increase. The therapist conducts a careful suicide-risk assessment, documents the discussion, and temporarily increases session frequency. The prescriber, however, is never informed. Six weeks later the medication dose is increased again. Much of the behavioral health response was clinically thoughtful, yet a safety-relevant observation never reached the person managing the medication.

A root cause analysis asks how that gap happened. The prescriber did not know because no one contacted the office. The therapist expected the client to bring it up at the next medical visit. That expectation existed because the practice had no clear agreement about which provider communicates what, and no release was already on file. The release was absent because the practice obtained them at intake only for providers who were already involved, while this prescriber entered the picture several months later. None of these steps requires assuming that the therapist acted irresponsibly. Each step reveals how a reasonable decision can be shaped by the design of the practice. Once the chain is visible, the intervention becomes clearer: make provider changes easier to identify, consent easier to obtain, and responsibility for communicating safety information less ambiguous.

The resulting solution is procedural rather than moral. Practices can ask periodically about new prescribers instead of limiting the question to intake, make releases easy to complete when a new provider appears, and create a clear expectation that safety-relevant observations are actively communicated rather than left for the client to relay. Those are changes that can be repeated and audited.

Notice what this analysis avoids. It does not end with "the therapist should have remembered," and it does not make the client's failure to tell the physician the final explanation. Both may describe part of what happened, but neither reduces the likelihood of recurrence. Root cause analysis is useful only when it reaches something the clinician or system can change.

The Swiss cheese model and why single causes are rare

The Swiss cheese model offers another way to understand why harm rarely has a single cause. Picture several layers of defense between a potential problem and the client: prescriber screening, intake questions, the therapist's clinical attention, documentation systems, and the client's own report. Each layer has gaps. Usually the gaps occur in different places, so one layer catches what another misses. Harm becomes more likely when weaknesses in several layers line up and allow the same problem to pass through each one. The layers do not have to be formal departments or elaborate policies. In a solo practice, a recurring medication question, a note-template prompt, a release-of-information workflow, and a habit of checking symptom timing can function as separate defenses. Their value comes from independence: one can catch what another misses.

This model counters the instinct to search for one decisive mistake and one responsible person. A harmful outcome may require several ordinary failures: a prescriber does not ask about psychiatric history, the therapist's intake does not capture the medication, the clinician

interprets a symptom quickly during a busy day, and the client does not realize the medication change is relevant to therapy. Any single failure might have been caught by another layer. Prevention therefore depends less on perfecting one person than on strengthening several defenses so that one weak point does not become the whole system. This is why adding several modest safeguards can be more effective than trying to design one flawless safeguard. A client may forget to mention a medication at intake but remember when asked during a progress review. A therapist may miss the significance of a symptom in session but notice the timeline while documenting. Redundancy is not waste in a safety system; it is protection against ordinary human variability.

Just culture and why blame backfires

Just culture extends the same logic to how organizations respond after an error. It distinguishes an honest mistake by a competent professional from reckless disregard of a known risk. The distinction is not permission to ignore poor practice. It recognizes that a setting that punishes every mistake can teach clinicians to conceal near-misses, avoid consultation, and keep uncertainty to themselves. A just culture asks what conditions contributed to an honest error and how those conditions can be improved, while still maintaining accountability for reckless behavior. Solo practitioners can use the same mindset: a near-miss is information about the design of one's practice, not merely a verdict on one's competence. The same principle helps clinicians respond constructively to their own mistakes. Shame often narrows attention toward self-defense or self-criticism, whereas a systems question opens the possibility of learning. What information was unavailable? What cue was absent? What made the safer action inconvenient? Those questions do not remove individual responsibility; they make responsibility useful by connecting it to a change that can reduce recurrence.

The main categories of error to watch

The errors discussed in the rest of this course fall into several recurring groups. Diagnostic errors involve assigning symptoms to the wrong cause, such as interpreting medication-related appetite loss as depression. Assessment errors occur when relevant screening, such as for disordered eating or suicide risk, is not performed. Communication errors arise when clinically important information fails to move among client, therapist, and prescriber. Documentation errors leave the record without the observations or reasoning needed to understand a decision. Systems errors are built into workflows that make the safer action difficult, inconsistent, or easy to forget.

Bias can intensify every one of these pathways. Body size, gender, race, age, and other characteristics can shape what clinicians notice and what they dismiss. A physical complaint from a larger-bodied client may be too quickly attributed to weight, while serious restriction in a thin client may be recognized sooner than the same behavior in someone whose body does not match a stereotype. Bias is therefore treated here as a patient safety factor woven through diagnosis, assessment, communication, and referral.

Case example

A group practice discovered that two clinicians, in separate cases, had missed rapid weight loss caused by clients taking more of a GLP-1 medication than prescribed in an effort to lose weight faster. Instead of responding only with reprimands, the practice reviewed its process. Neither clinician had a prompt to ask about dose changes or misuse, and the intake form did not identify GLP-1 medications specifically. The practice added medication and dosing questions to intake and progress reviews and created a note prompt for rapid physical change. The lasting improvement came from changing what the system asked clinicians to notice.

Reflection questions

Think of a near-miss in your own work, a time when something important was almost overlooked. If you asked "why" four or five times, where would the explanation end? Would it stop with an individual lapse, or would it reveal a process that made the lapse easier to make?

Key clinical takeaways

In behavioral health, medical errors are often quiet omissions rather than dramatic events. Root cause analysis is useful because it moves from blame toward a changeable condition. The main pathways in this course are diagnostic, assessment, communication, documentation, and systems errors, with cultural bias capable of increasing risk within each one.

Section 3: Diagnostic Errors, When Medication Effects Look Like Psychiatric Symptoms

(Supports Learning Objective 3)

The central trap

The diagnostic problem most likely to arise in this setting is misattribution: a medication effect or medical problem is interpreted as evidence of a primary psychiatric disorder. Diagnostic error is a recognized patient safety issue across healthcare and includes failures to establish or communicate an accurate and timely explanation for a patient's problem (National Academies of Sciences, Engineering, and Medicine, 2015). GLP-1 medications create fertile ground for this kind of mistake because several of their expected effects overlap with the neurovegetative symptoms used to diagnose and monitor mood disorders.

Loss of appetite and weight loss illustrate the problem clearly. Both can support a diagnosis of major depression, yet both are also intended effects of GLP-1 treatment. A client who says, "I'm barely eating and I've lost weight," may therefore appear to be accumulating depressive symptoms when the medication explains much of the change. Fatigue creates another overlap. Reduced caloric intake, rapid weight loss, nausea, and other gastrointestinal effects can produce genuine tiredness without a primary change in mood. Physical discomfort can disturb sleep, and inadequate intake can affect concentration as well. Concentration and sleep are especially easy to overread because both are nonspecific. A client who is nauseated at night may sleep poorly, and a client eating substantially less than usual may have difficulty sustaining attention. Those symptoms are real even when they are not primarily psychiatric. The task is not to discount them but to interpret them in context.

Depression should not be ruled out simply because a GLP-1 medication is present. The mistake is reaching that conclusion without examining the medication timeline, the physical context, and competing explanations. Safer diagnostic reasoning keeps more than one hypothesis active long enough to gather information that can distinguish among them. A familiar diagnosis can remain on the differential while the clinician asks what changed medically, what changed temporally, and which symptoms are specific to the psychiatric syndrome rather than shared with the medication. This avoids the false choice between "it is depression" and "it is the drug" before enough information exists to support either conclusion.

The cognitive biases behind diagnostic error

Naming the cognitive habits behind misattribution makes them easier to interrupt. Research on diagnostic error describes several biases that recur across medical settings and are just as relevant to behavioral health practice (Croskerry et al., 2013).

Anchoring occurs when an initial impression becomes the lens through which later information is interpreted. A therapist who has long known a client as depressed may automatically read new fatigue or appetite loss as a depressive recurrence. Premature closure follows when the clinician stops searching once that explanation feels plausible enough. Confirmation bias then favors details that support the existing formulation while minimizing information that challenges it, such as a recent dose increase. Availability bias adds another pull: therapists spend their days thinking psychologically, so psychological explanations may come to mind more readily than medication or medical ones. These biases can also interact. Anchoring on depression makes confirming details easier to notice; once enough of those details accumulate, premature closure makes further questioning feel unnecessary. Availability bias then supplies a familiar psychological explanation quickly. Naming the sequence gives the clinician more than vocabulary; it identifies the exact moment at which a deliberate second look can interrupt the process.

These biases do not indicate poor judgment or lack of care. They are by-products of efficient, experience-based thinking. In fact, pattern recognition can make them more subtle as expertise grows. A practical safeguard is a deliberate cognitive pause at moments when the answer seems obvious. Asking, "What else could account for this change, and have I checked?" forces a second explanation into view before the formulation closes. The pause does not need to be lengthy. It can occur in a few seconds during session or while writing the note. The important feature is that the clinician actively generates at least one competing explanation and checks whether the available evidence distinguishes it from the first. That small step is a practical example of a cognitive forcing strategy.

How to distinguish medication effects from mood

Timing is often the most useful first discriminator. Ask when the symptom began in relation to starting the medication, increasing a dose, or entering a period of rapid weight change. A symptom that appears soon after a dose escalation does not prove causation, but it makes medication involvement more plausible and worth investigating. A direct question can be enough: "You said your appetite changed. When did you first notice that, and was it around the time your dose changed?" Clients may not have considered the connection themselves.

The character of the symptom also provides clues. Medication-related appetite reduction may feel primarily like an absence of hunger or early fullness. In depression, reduced appetite may occur alongside a broader loss of pleasure, hopelessness, withdrawal, or a sense that food has become unappealing along with everything else. A person taking semaglutide might forget to eat because hunger cues are muted yet still enjoy a meal once it begins. These distinctions are imperfect, but they help organize further assessment.

Then widen the lens. If appetite and weight have changed while mood, interest, self-worth, social engagement, and outlook remain stable, a primary depressive episode becomes less likely. If anhedonia, guilt, hopelessness, and withdrawal are also present, depression deserves attention regardless of the medication. The two explanations are not mutually exclusive; a client can experience medication effects and depression at the same time.

When the medication itself affects mood

There is also a third possibility between "the medication is merely mimicking depression" and "the client has an unrelated depressive episode." Because these medications act on neural systems involved in reward and motivation, researchers are examining whether GLP-1 treatment can influence emotional experience directly. That possibility is clinically relevant even though the evidence is not yet settled. This matters because a client may report emotional flattening that does not fit neatly into either of the more familiar categories. Appetite may be

reduced as expected, yet the client may also describe less pleasure in music, relationships, sex, work, or hobbies. When that occurs, simply labeling the change "depression" or "a side effect" can be premature.

The literature is mixed. A review spanning 374 preclinical and clinical studies found fairly consistent antidepressant-like effects in animal models, while human evidence remained conflicting and was largely observational (De Giorgi et al., 2025). Some studies suggested improvements in anxiety or mood, whereas others reported adverse mood effects. The same review described a preclinical pattern in which acute administration could increase anxiety while longer exposure appeared to normalize anxiety and improve depression-like behavior. These findings are intriguing, but they do not support simple causal conclusions in clinical practice.

One observation from that review is especially relevant to behavioral health clinicians. People with substantial baseline anhedonia may be more vulnerable to worsening of that symptom, a possibility the authors raise when considering why some studies show negative mood outcomes (De Giorgi et al., 2025). The signal remains preliminary, but it intersects directly with the population seen in psychotherapy. If reward processing is already impaired, a medication that influences reward circuitry may affect the clinical picture in ways neither the client nor the prescriber anticipated.

For assessment, this adds another line of inquiry rather than a new diagnosis. When a client reports feeling flat, unmotivated, or less interested in previously rewarding activities, ask about pleasure and motivation beyond eating. Has the change reached hobbies, relationships, intimacy, work, or other sources of enjoyment? Then place those changes on the same medication and dose timeline used for appetite, fatigue, and sleep. It can also help to ask whether the change is continuous or tied to particular points in the dosing cycle and whether it appeared after a dose change. Again, these observations do not establish causality. They create a more precise description that can be followed over time and, when relevant, communicated to the medical prescriber.

What the evidence does not justify is telling a client that the medication is definitely blunting emotion or recommending that they change or stop it. Causality remains uncertain, and medication decisions belong with the client and prescriber. The therapist's role is to describe what has changed, keep the differential broad, and communicate clinically relevant observations. It is appropriate to acknowledge uncertainty directly: the research is still developing, a change has been noticed, and the pattern can be monitored over time. A measured explanation can be clinically reassuring without pretending certainty. The therapist can say that several explanations remain possible, that the change is worth tracking, and that the prescriber may have additional medical information. Clients often tolerate an honest "we are watching this" better than a confident explanation that later has to be withdrawn.

The reverse error

Misattribution can also run in the opposite direction. A clinician may interpret a medical problem as anxiety, depression, or somatization simply because psychological explanations are familiar. Lethargy, confusion, dizziness, or significant physical illness during rapid weight loss may reflect dehydration, nutritional problems, electrolyte disturbance, or another medical issue requiring evaluation. The behavioral health task is to notice when the physical picture no longer fits comfortably inside a psychological formulation and to direct the client toward appropriate medical care. Behavioral health clinicians are particularly vulnerable to this reverse error because anxiety and somatic presentations are common in therapy. Familiarity can make a psychological explanation feel efficient. A useful threshold for referral is not diagnostic certainty

about a medical problem, but recognition that the severity, persistence, or pattern of the physical symptoms exceeds what can safely be explained within the therapy frame.

Gastrointestinal side effects and their psychological mimics

Gastrointestinal effects are common with GLP-1 medications, particularly after treatment begins or a dose is increased. Nausea, reflux, constipation, and a general sense of physical discomfort can all affect how a client feels and behaves. Because those sensations overlap with anxiety and reduced appetite, they can be misread in either direction.

Persistent nausea can make someone feel tense, restless, unable to eat, and generally unwell. In session, that presentation may resemble anxiety closely enough that both client and therapist assume a psychological cause. The reverse can happen as well: a client with a genuine anxiety disorder may attribute every uncomfortable sensation to the medication and overlook a psychiatric problem that still needs treatment. Timing, symptom quality, and the broader clinical picture remain the most useful guides. Ask whether symptoms began or intensified around dosing changes and whether they follow a recognizable pattern. Severe or persistent gastrointestinal symptoms belong with the medical prescriber rather than being explained away in psychotherapy. Nausea is a good example because it can create a distinctly "keyed-up" bodily state. A client may describe restlessness, dread, reduced intake, or difficulty settling and interpret the entire experience as anxiety. Asking whether the sensation follows dosing, whether gastrointestinal symptoms are present, and whether the pattern changes over time helps keep the formulation grounded without dismissing either possibility.

Medication interactions and the client on psychiatric medications

A less obvious concern involves oral medications. Because GLP-1 drugs slow gastric emptying, they can alter the timing of absorption of co-administered medications. A systematic review found reduced peak concentrations and delayed absorption for some oral drugs, although overall drug exposure was not clinically significant for most medications studied (Calvarysky et al., 2024). The authors advised greater caution for narrow-therapeutic-index drugs and in people with kidney problems. For therapists, the implication is limited but important: if a client reports that a psychiatric medication seems to be working differently after GLP-1 treatment begins, that observation should be passed to the prescriber rather than dismissed or managed indirectly through psychotherapy. The therapist is not adjusting medication; the therapist is identifying a possible change that deserves medical review.

Talking with clients about what the medication may be doing

Recognizing a possible medication contribution is only part of the clinical task. The conversation with the client matters as well. A therapist can raise the possibility in a way that supports curiosity and shared assessment rather than sounding as though the client's experience has been reduced to a side effect.

Begin with observation rather than certainty. For example: "I noticed that your appetite dropped around the time your dose increased. I wonder whether those changes could be related. What have you noticed?" That wording invites the client into the reasoning process and leaves room for more than one explanation. Clients often have useful observations that have never surfaced simply because no one asked them to connect the timeline.

Avoid both extremes. Explaining every symptom as medication-related can leave a depressed client feeling dismissed, while ignoring the medication can pathologize a physical process. Often the most accurate stance is provisional: several factors may be contributing, and the therapist and client can watch the pattern together while gathering more information.

Some clients will understandably resist the question. A person who is pleased with weight loss may hear any discussion of possible adverse effects as criticism of a treatment they value. Another client may prefer to explain all distress through the medication because that feels less threatening than considering a psychiatric recurrence. Neither reaction needs to become an argument. A collaborative stance acknowledges what the medication has meant to the client while keeping the assessment broad enough to consider what else may be happening. Validation is important in both directions. The therapist can acknowledge that the medication has produced benefits the client values while still asking about unwanted changes. Likewise, a client who attributes everything to the medication can be told that the timing is worth considering while the therapist also remains attentive to depression, anxiety, trauma, or other established concerns. Collaboration is easier when the discussion is not framed as proving one explanation wrong.

Case example

Priya, a 41-year-old teacher with recurrent depression, has been stable for two years on an antidepressant when she begins tirzepatide. Two months later she reports feeling flat and tired and says she is eating very little. A return of depression is an obvious possibility, but her therapist first maps the timeline. The fatigue and reduced appetite began after a dose increase. Priya continues to enjoy her hobbies, feels connected to family, and denies hopelessness and guilt. With Priya's consent, the therapist documents the differential and informs the prescriber about the timing rather than immediately assuming the antidepressant has failed. Over the next two weeks the fatigue improves as the physical symptoms settle. The case illustrates how timeline mapping and communication can prevent one uncertain symptom cluster from triggering an unnecessary cascade of treatment changes. The case also illustrates why a differential should be documented even when no immediate medical action follows. If Priya's symptoms later worsen, the record shows when the change began, what features argued against a full depressive recurrence at that moment, and what information was shared with the prescriber. That continuity makes the next decision easier and less dependent on memory.

Reflection questions

When a long-term client's appetite, sleep, energy, or concentration changes, what explanation comes to mind first? How often do you compare that change with recent medical events or medication adjustments before finalizing a psychiatric formulation? What could make that comparison more routine in your practice?

Key clinical takeaways

The central diagnostic safeguard is to keep medication and medical explanations visible when psychiatric symptoms change. Timing, symptom quality, and the rest of the clinical picture help distinguish possibilities, while recognizing that more than one can be true at once. The reverse error matters too: significant physical symptoms should not be absorbed into an anxiety or somatic formulation when medical evaluation is warranted. Possible medication interactions are observations to communicate to a prescriber, not problems for the therapist to manage.

Section 4: Assessment and Screening Errors, Eating Disorders, Suicide Risk, and Alcohol

(Supports Learning Objective 4)

Eating disorders, the highest-stakes miss

Among the assessment errors discussed in this course, failing to recognize an eating disorder may carry the greatest immediate risk. GLP-1 medications suppress appetite and facilitate weight loss, effects that can overlap directly with restrictive eating. In a vulnerable client, restriction can intensify while remaining easy to explain as an expected medication effect or even as evidence of successful treatment. The very behavior that should prompt concern can therefore be mistaken for progress.

There is no established broad clinical guidance supporting GLP-1 medications as treatment for eating disorders. A review written for eating-disorder clinicians concluded that evidence remains limited, that GLP-1 medications could exacerbate or contribute to pathology in some vulnerable patients, and that available data are insufficient to support their use for eating-disorder symptoms (Bartel et al., 2024). In anorexia or other restrictive presentations, appetite suppression can reinforce restriction and increase medical risk. In bulimia or binge-eating disorder, the picture is less uniform. Some clients describe reduced food preoccupation and fewer binge urges, while others may develop restrict-binge cycles or struggle when the medication is discontinued. The evidence remains too early for blanket reassurance or blanket condemnation. Behavioral health clinicians should assess, coordinate, and refer as indicated rather than independently recommending, endorsing, or discouraging a medication decision that belongs with the client and prescriber. The behavioral health concern is therefore not whether GLP-1 treatment is categorically "good" or "bad" for people with eating disorders. The concern is that appetite suppression can alter the presentation in ways that make pathology harder to recognize. A client may experience genuine relief from binge urges while simultaneously becoming more rigid, fearful of hunger, or dependent on continued appetite suppression. Assessment has to be able to hold that complexity.

Eating-disorder history should not remain a one-time intake item. A client who screened negative years earlier can develop disordered eating in the setting of rapid weight loss, appetite suppression, and social reinforcement for a changing body. Reassessment should include restriction, adequacy of intake, binge episodes, compensatory behaviors, and the client's reaction to the possibility of stopping the medication. Rapid or excessive weight loss can also carry medical consequences, including electrolyte problems and other complications. When restriction appears medically concerning, the response includes medical evaluation and coordination. Active or medically unstable eating disorders may require a treatment team or a higher level of care rather than management within routine outpatient therapy alone (Crone et al., 2023). Useful questions go beyond "Are you eating?" Ask how many times the client is eating, whether intake is sufficient to maintain daily functioning, whether meals are skipped intentionally, whether binge episodes or compensatory behaviors are present, and what happens emotionally when hunger appears. The client's response to the possibility of weight regain can also reveal fear and rigidity that a simple history question would miss.

Why the presentation may not look like what you expect

Part of the risk comes from stereotypes. Clinicians may still picture an eating disorder as occurring in a visibly underweight person, even though serious pathology occurs across body sizes. A client can lose a large amount of weight, remain outside an underweight range, and receive enthusiastic social or medical praise while becoming progressively more restricted. In that situation, approval can remove the very signal that might otherwise prompt closer assessment. This is why appearance is an unreliable safety screen: significant restriction and serious eating-disorder pathology can occur even when a person is not underweight by conventional standards. The course does not require therapists to make medical determinations from body size. It requires them to avoid using body size as a reason not to ask.

Medical endorsement can create another blind spot. A client may have been encouraged to eat less while taking a medication that already reduces appetite, giving restrictive behavior an apparently straightforward explanation. The relevant question is not simply whether reduced intake makes sense in context. It is whether the client is eating enough to function, whether restriction has become more rigid than the medical goal requires, and what emotions arise around the idea of eating more or eventually stopping the medication.

Men, older adults, and people in larger bodies are especially vulnerable to being overlooked because they are less likely to match common stereotypes and may be asked fewer questions about disordered eating. Screening everyone is therefore safer than relying on appearance or demographic expectations. The time cost is small; the consequence of missing a serious restrictive pattern may not be.

Listen as well to the language clients use when describing relief. Statements such as "I finally don't have to think about food" or fear about hunger returning are not diagnostic by themselves, but they can reveal how much safety, control, or self-worth has become attached to appetite suppression. Those comments deserve follow-up rather than automatic celebration. Relief can be healthy, especially for a client who previously felt overwhelmed by compulsive food thoughts. The concern arises when relief becomes inseparable from fear of normal hunger, fear of eating enough, or panic about medication discontinuation. Following the language rather than reacting to the weight change gives the clinician a better chance of distinguishing those experiences.

Using a screening tool rather than relying on impression

A brief validated screen can reduce reliance on intuition alone. The five-item SCOFF questionnaire asks about self-induced vomiting, loss of control over eating, significant recent weight loss, feeling fat despite others' perceptions, and whether food dominates life (Morgan et al., 1999). It is brief enough for routine clinical use. A systematic review and meta-analysis found it useful for screening while also noting that accuracy varies across DSM-5 eating disorders (Kutz et al., 2020). A negative result does not rule out pathology, and a positive result is not a diagnosis. It is a reason to assess more fully. A structured screen is particularly valuable because it reduces the influence of appearance and clinician intuition. It gives the same basic questions to the client who visibly worries the therapist and the client who does not. That consistency is one of the ways a simple assessment tool can function as a patient safety intervention.

Familiarity with diagnostic criteria also helps clinicians recognize when a pattern needs closer evaluation. The DSM-5-TR includes anorexia nervosa, bulimia nervosa, binge-eating disorder, avoidant/restrictive food intake disorder, and other eating disorders, each with specific features (American Psychiatric Association, 2022). Clinicians do not need to memorize every criterion to notice when restriction, fear of weight gain, or disturbance in body-weight experience is becoming clinically significant. In a GLP-1 context, those features deserve particular attention because medication effects can make them easier to normalize.

Screening has limits. Its purpose is case-finding, not the management of an established eating disorder, and a questionnaire cannot substitute for clinical assessment. The value of a structured screen is that it creates a deliberate opportunity to notice a serious problem that might otherwise be hidden inside an expected medication effect.

Suicide risk, correcting an outdated alarm

GLP-1 medications also illustrate how outdated safety information can itself create error. Early anecdotal reports raised concern about suicidal thoughts, prompting regulatory review. The

subsequent evidence has been generally reassuring, but the conclusion requires more nuance than either "these drugs cause suicidality" or "there is nothing to assess."

A large real-world cohort study found semaglutide to be associated with a lower risk of suicidal ideation than comparator medications used for obesity and diabetes (Wang et al., 2024). In January 2024, the U.S. Food and Drug Administration reported that its preliminary review had not found evidence that GLP-1 medications cause suicidal thoughts or actions, while noting that a small risk could not yet be excluded (U.S. Food and Drug Administration, 2024). The European Medicines Agency reached a similar conclusion in April 2024, finding that available evidence did not support a causal association with suicidal or self-injurious thoughts and actions (European Medicines Agency, 2024). A later systematic review and meta-analysis likewise found no statistically significant association, while emphasizing heterogeneity across studies and the need for continued monitoring in psychiatric populations (Bushi et al., 2025). In 2026, the FDA reported that its evaluation did not identify increased risk of suicidal ideation or behavior and requested removal of the related warning from GLP-1 labeling (U.S. Food and Drug Administration, 2026a).

Those findings should narrow the claim, not eliminate clinical judgment. They do not establish that GLP-1 medications prevent suicide, carry no psychiatric risk, or make suicide assessment unnecessary. The evidence instead fails to support a causal claim that these medications increase suicidality. Two errors follow from misunderstanding that distinction. One is unnecessarily alarming clients with a warning that current evidence does not support. The other is becoming so reassured by the drug-safety data that ordinary suicide-risk assessment is neglected. Risk is still assessed from the client's actual presentation, history, stressors, and protective factors. The evidence also does not settle every question for every psychiatric subgroup. A client with active major depression, a history of suicide attempts, or rapidly changing life circumstances still requires the same careful individualized assessment that would be indicated without a GLP-1 medication. The drug-safety conclusion should remove an unsupported causal assumption, not remove the clinician's attention to suicide risk.

In practical terms, the framework for suicide assessment remains familiar: current ideation, plan and intent, access to means, recent losses or stressors, history of attempts, and protective factors. GLP-1 treatment can add context that is worth exploring, such as distress over weight regain, disappointment when weight loss does not produce the life changes a client expected, financial strain related to medication access, or disruption in identity after rapid physical change. These factors are not reasons to presume suicidality, but they may matter in an individualized formulation. Collaborative safety planning remains appropriate when indicated. If a client is distressed after discontinuation or rapid body change, it can be useful to ask directly what the change means to them. Is the distress about appearance, loss of control, financial pressure, disappointment, identity, or something else? Those meanings can affect risk independently of any pharmacologic question and can be addressed within psychotherapy while medical questions remain with the prescriber.

Alcohol and substance use, an emerging and clinically useful signal

Research on alcohol use adds another clinically relevant wrinkle. In a phase 2 randomized trial, low-dose semaglutide reduced alcohol craving and some measures of drinking among adults with alcohol use disorder over nine weeks (Hendershot et al., 2025). This was a small, early trial. Semaglutide is not FDA-approved for alcohol use disorder, and the finding does not establish that GLP-1 medications reliably reduce drinking. Therapists should not recommend these medications for addiction treatment outside appropriate prescribing scope. The result is useful primarily because it reminds clinicians that substance-use patterns may change after GLP-1 treatment begins.

A client may notice that alcohol is suddenly less appealing without having intentionally pursued abstinence, which can complicate how therapeutic progress is interpreted. Conversely, a client who previously relied on alcohol for emotional regulation may need to develop other coping strategies when craving diminishes. The important clinical move is to ask about the change rather than automatically assigning it to willpower, treatment success, or medication effect. The evidence is still emerging, so curiosity should outpace certainty. A reduction in drinking can still be therapeutically meaningful even if medication contributed to the change. The error would be to assume the mechanism. If alcohol had served as a primary coping strategy, reduced craving may create an opportunity to strengthen alternative regulation skills. It may also expose emotions that had previously been avoided. Tracking function, not only quantity, keeps the assessment clinically useful.

Discontinuation, weight regain, and the mood transition

Discontinuation is another point at which behavioral health clinicians can be caught unprepared. GLP-1 effects persist while treatment continues; when treatment stops, appetite often returns and weight regain is common. In the STEP 1 extension, participants regained about two-thirds of the weight they had lost during the year after semaglutide and lifestyle intervention ended (Wilding et al., 2022). That pattern reflects the biology the medication had been influencing, not a simple failure of motivation.

The emotional consequences can be substantial. A client who has reorganized self-image, routines, and social expectations around a smaller body may experience regain as shameful or catastrophic. Treatment can also stop for reasons outside the client's control, including cost, insurance changes, supply problems, side effects, or pregnancy. Anticipating this possibility gives the therapist an opportunity to assess body image, eating behavior, depression, shame, and suicide risk before distress escalates. Weight regain should not be framed as a moral failure. Discontinuation may be planned, but it is often not. Insurance denials, cost, medication shortages, side effects, or changes in pregnancy plans can force an abrupt transition. When the client has received months of praise or has attached major hopes to the weight loss, the return of appetite can feel like loss of control before much weight has actually returned. Preparing for that emotional response can reduce shame and help the therapist identify deterioration earlier.

A decline in mood after discontinuation can also be diagnostically ambiguous. Distress may reflect the meaning of weight regain, recurrence of an underlying depressive disorder, physiological adjustment, or several processes at once. The therapist does not need to force a single explanation immediately. Instead, assess the evolving picture, validate distress without reinforcing catastrophic interpretations, and monitor for a depressive episode or changes in suicide risk. Decisions about stopping, continuing, or tapering a GLP-1 medication remain medical decisions between the client and prescriber. For behavioral health clinicians, discontinuation is best treated as a foreseeable transition that deserves preparation and active monitoring. It is also possible for several mechanisms to operate together. A client may be grieving weight regain, sleeping differently, eating differently, and experiencing a recurrence of depression at the same time. A careful formulation can remain provisional while those strands are assessed. The goal is not to name one definitive cause immediately but to avoid treating the first plausible explanation as the only one.

Body image and the psychology of rapid change

Rapid physical change is psychological as well as medical. A client who wanted to lose weight and succeeded may feel pleased, but that is not the only possible response. Large changes in appearance can be disorienting, and improved weight metrics do not necessarily translate into

improved body image, mood, or quality of life. Assuming otherwise can cause a therapist to overlook clinically important distress.

During active weight loss, attention to the body may actually intensify. Loose skin, altered facial appearance, clothing that no longer fits, and frequent comments from others can make the body feel newly conspicuous. Some clients describe a lag between their changed appearance and their internal sense of self. Others discover that weight loss did not deliver the confidence, relationship change, or happiness they had imagined. For clients with trauma linked to the body, increased visibility or attention may reactivate experiences they did not expect to revisit. Social feedback can intensify the adjustment. Comments from family, coworkers, or acquaintances may feel flattering at first and intrusive later. A client may become more aware of being watched, judged, or compared with a previous body. Those reactions can matter even when the person remains pleased with the health or functional changes associated with treatment.

Identity can shift along with appearance. Food, body size, and social treatment may have been woven into a client's self-concept for years, so rapid change can unsettle familiar ways of understanding the self. Some clients become acutely aware of how differently others treated them before and after weight loss, which can bring anger, grief, or mistrust alongside genuine satisfaction. A therapist who assumes that the smaller body must feel better may therefore miss the emotional complexity underneath the visible change. Some clients also discover that positive attention after weight loss highlights earlier experiences of stigma. Being treated more warmly can prompt the painful realization that previous treatment was conditional on body size. The resulting grief or anger is easy to overlook if therapy treats weight loss only as an achievement rather than as a change in social experience.

What to ask when the body is changing

Routine questions can protect against that assumption. Ask how the change actually feels rather than beginning with congratulations. Ask what the client expected weight loss to change and whether those expectations were met. Explore reactions from other people, changes in mirror checking or body attention, and what the client imagines would happen emotionally if some weight returned. These questions make room for experiences that a simple "you look great" may shut down.

Fear of regain is particularly informative. If self-worth, safety, or social acceptance now feels dependent on maintaining the loss, the client may be carrying significant vulnerability even before any weight returns. That vulnerability belongs in the clinical formulation.

Complimenting weight loss may feel socially warm and harmless, but in therapy it can carry more meaning than intended. It can communicate that the therapist is evaluating the client's body and that a smaller body is preferable. For a client with disordered eating, body-related trauma, or escalating fear of regain, that message may reinforce a harmful pattern. Reflecting the client's own experience is generally more clinically useful than evaluating the body itself. A neutral stance does not mean ignoring a change the client wants to discuss. It means following the client's appraisal first. "How has that change been for you?" leaves room for pride, grief, discomfort, relief, ambivalence, or all of them at once. That is usually more informative than beginning with the therapist's evaluation of the client's appearance.

This does not require treating weight loss as inherently problematic. A client may be delighted with the outcome, and the therapist can share that positive experience when it is genuinely the client's. The safeguard is to let the client's meaning lead the conversation instead of assuming the meaning in advance.

Special populations and added caution

Some populations warrant additional vigilance. Adolescents and young adults are navigating peer pressure and body-image development during years in which eating disorders commonly emerge. When a younger client is using or considering a GLP-1 medication, careful eating-disorder screening, medical coordination, and attention to who is managing the treatment become especially important.

Pregnancy, plans for pregnancy, and breastfeeding raise questions that belong with an appropriate medical provider. Behavioral health clinicians should not advise whether a client should stop, continue, or restart a GLP-1 medication in those circumstances; their role is to encourage individualized medical guidance and address the emotional impact of the decision. Older adults also merit attention because rapid weight loss may involve loss of muscle and functional decline and often occurs in the context of multiple medications. A history of bariatric surgery, eating disorders, or body-related trauma can further alter how GLP-1 treatment affects a client. Recognizing those factors does not require practicing medicine. It requires knowing when the situation calls for closer assessment and coordination. A history of bariatric surgery is another factor that can raise the stakes and make careful assessment and coordination more important. Likewise, longstanding body-related trauma can change the psychological meaning of becoming more visible or receiving attention. These histories are not automatic contraindications for therapy or medication; they are signals that the clinician should ask more rather than assume more.

Clinical Red Flags Requiring Medical Coordination or Referral

Certain findings should move the therapist beyond routine observation toward active medical coordination or referral. Behavioral health clinicians are not responsible for diagnosing or managing medical instability. Their role is to recognize warning signs, encourage timely medical evaluation, coordinate with the prescriber when appropriate and permitted, refer when the client's needs exceed the clinician's competence or setting, and document what was observed and recommended. Warning signs include:

- rapid or extreme weight loss
- persistent vomiting, or inability to keep food or fluids down
- signs of dehydration
- fainting or near-fainting
- confusion or severe weakness
- dizziness that is worsening or persistent
- eating one very small meal per day or less
- amenorrhea or cold intolerance
- purging, laxative misuse, or compulsive exercise
- active suicidal ideation, or a suicidal plan or intent
- abrupt discontinuation of the medication with severe distress
- suspected misuse, or use of non-prescribed, compounded, or gray-market medication without adequate medical oversight
- any medical symptom that appears severe, rapidly worsening, or outside the clinician's competence

When these signs appear, the response should be documented and the client should be encouraged to obtain appropriate medical evaluation. With consent, coordination with the prescriber can help connect the behavioral and medical pictures, and referral should occur when the client's needs exceed the clinician's setting or competence. Extra caution is warranted with

non-prescribed, compounded, or gray-market products because they do not undergo FDA review for safety, effectiveness, and quality (U.S. Food and Drug Administration, 2026b). Recognizing possible instability falls within behavioral health assessment; managing the underlying medical problem does not.

Case example

Denise, a 36-year-old nurse, enters therapy for stress and low mood. She is pleased to have lost thirty-five pounds over four months while taking a GLP-1 medication, and her therapist initially responds to the loss as positive news. A more structured assessment changes the picture. Denise is eating one small meal a day, has stopped menstruating, feels persistently cold, and becomes anxious when she imagines stopping the medication because she fears regaining weight. Those findings suggest a restrictive pattern with medical warning signs rather than an uncomplicated treatment success. The therapist discusses the concern directly, coordinates with Denise's prescriber, and helps arrange medical evaluation and eating-disorder specialty care. The case shows how easily praise can displace assessment when the clinician does not ask systematically.

Robert, a 67-year-old retired veteran, presents a different problem. After eleven months on tirzepatide, he loses insurance coverage and has to stop the medication abruptly. His appetite returns quickly, he regains weight, and he becomes withdrawn and irritable, describing himself as "back to square one." At first, his therapist wonders whether his longstanding depression is returning. Reviewing the timeline reveals that the change followed discontinuation. The therapist validates Robert's grief and shame without endorsing the idea that regain means total failure, reassesses depression and suicide risk, and encourages him to discuss the medication change with his prescriber. Anticipating discontinuation earlier would have allowed the therapist to prepare Robert for a foreseeable transition instead of interpreting the distress only after it emerged. Robert's case also shows why discontinuation should be discussed before it occurs whenever possible. A therapist cannot predict insurance coverage or supply, but can normalize the possibility that appetite and weight may change if treatment stops and explore how the client might interpret that change. Doing so creates a language for the transition before shame or hopelessness has taken over the conversation.

Reflection questions

Do you repeat eating-disorder assessment when a client's weight is changing, or do you rely primarily on intake history? What do you currently believe about GLP-1 medications and suicide risk, and when was that belief last updated? If a client's alcohol use changes substantially, how likely are you to explore the reason rather than simply record the improvement or worsening?

Key clinical takeaways

The highest-stakes assessment miss in this context is a developing or worsening eating disorder hidden inside expected appetite suppression and weight loss. Reassessment should therefore occur when the body and eating pattern change, not only at intake. Current evidence does not support a causal increase in suicidality from GLP-1 medications, but individualized suicide-risk assessment remains essential. Alcohol and other substance-use patterns may also shift. Medical warning signs call for coordination and referral, not independent management by the therapist.

Section 5: Communication, Documentation, and Collaboration Errors

(Supports Learning Objective 5)

The information that never travels

A large share of behavioral health error is not caused by lack of knowledge. It occurs because important information never reaches the person who needs it. A therapist notices a clinically meaningful change but the prescriber never hears about it. A medication is started or adjusted without the therapist knowing. The client gives each provider a different part of the story, and no one has enough information to assemble the whole picture. Fragmented care makes these gaps easy to create and difficult to see.

GLP-1 treatment creates several predictable communication gaps. The prescriber may be a primary care physician or a weight-management telehealth clinician rather than a psychiatrist and may know little about the client's behavioral health history. The therapist may not know when the medication started, whether the dose changed, or whether it was discontinued. The client may not think of therapy and weight-management treatment as connected enough to mention one to the other. Each separation can remove information that would otherwise change assessment or treatment.

A reliable communication routine is therefore more useful than waiting for a concern to become obvious. Ask periodically about all medications and recent changes, including weight-loss and diabetes medications that clients may not think of as psychiatrically relevant. When a clinically important observation could affect medical management, such as a mood change after a dose increase, signs of restrictive eating, or concern about another medication, obtain appropriate consent and communicate the observation to the prescriber. A concise factual message can prevent a series of downstream assumptions.

Making the handoff clear with an SBAR structure

When information is sent to a prescriber, structure matters. SBAR, a communication format used widely in healthcare, organizes a handoff into Situation, Background, Assessment, and Request. Situation identifies what is happening now. Background gives the relevant medication, diagnosis, timing, or history. Assessment summarizes what the behavioral health clinician has observed. Request states what information or response is being sought. The structure is useful because it helps a busy receiving clinician understand quickly why the message matters.

For example, a therapist might report that a client treated for depression began a GLP-1 medication two months ago, developed a marked change in mood and appetite shortly after a dose increase, and is being monitored in therapy. The therapist can then ask the prescriber to consider whether that timing is relevant to medical management. The message is brief, specific, and stays within behavioral health scope. It does not direct a dose change; it communicates observations and requests medical input. By contrast, a message that says only that the client "seems different" gives the prescriber little to work with.

Good coordination also requires asking for information that is missing. If the therapist does not know whether a dose changed, whether the prescriber knows about a psychiatric history, or whether another medical factor has been considered, the safest next step may simply be to clarify rather than infer. Many communication failures begin with a question that neither provider realized the other was waiting to hear.

Consent and confidentiality in coordination

Provider-to-provider communication also raises confidentiality obligations. In many circumstances, client consent should be obtained and documented before information is shared with a prescriber or other professional. Errors occur in both directions: clinicians may disclose too freely because everyone involved is a healthcare professional, or they may become so cautious that useful information never moves even when the client would readily authorize

coordination. A sound approach is to explain why communication may help, obtain and document the necessary consent, and share only what is clinically relevant. Jurisdiction, setting, and payer requirements differ, so clinicians should follow the rules and policies that apply to their own practice.

Documentation as an error-prevention tool

Documentation is part of clinical reasoning, not merely a record created after the reasoning is finished. Writing down the differential, the screening performed, and the rationale for a decision forces the clinician to make implicit assumptions visible. A note that records consideration of a medication effect, reassessment of eating behavior, or communication with a prescriber provides continuity for future care and creates a clearer record of how the decision was reached.

Several documentation failures are especially relevant here. Medication names and changes may be omitted, leaving later symptoms without context. A note may state "depression worsening" without showing whether medication effects, medical problems, or competing explanations were considered. Safety-related conversations, risk assessments, and referral recommendations may never make it into the record. If a client declines a referral that the clinician considered important, the recommendation, the client's decision, and the clinician's reasoning should be documented. A record that captures the thinking behind care is more useful for both patient safety and risk management than one that lists conclusions alone. Documentation also supports consultation. A colleague or supervisor reviewing a brief but well-reasoned note can see what information was available at the time and where uncertainty remained. That makes consultation more specific and reduces the chance that later knowledge will distort how the earlier decision is judged.

What good documentation looks like

A useful note does not need to be long, but it should preserve the information that will matter at the next decision point. That includes current medications and recent changes, including GLP-1 use and dose when known. If a symptom has more than one plausible explanation, the note can briefly show the differential and what evidence favored one interpretation over another. Relevant eating-disorder or suicide-risk screening should be documented along with the result. Coordination with other providers, including consent and the substance of what was communicated, should also be recorded. The same applies to referrals or recommendations that the client declines. The standard is not exhaustive narrative. A concise note can still show that the clinician noticed a medication change, considered more than one explanation, performed the relevant safety assessment, and followed through on coordination. Those elements are more important to continuity than generic statements that the client was "doing better" or "doing worse."

The following example shows how those elements can fit into a short behavioral health note without making a medication recommendation:

Client reports decreased appetite, fatigue, and approximately 18-pound weight loss over eight weeks following a recent GLP-1 dose increase. Assessed mood symptoms, eating patterns, suicidal ideation, compensatory behaviors, and medical warning signs. Client denies hopelessness, anhedonia, suicidal ideation, purging, laxative misuse, or compulsive exercise. Discussed possible medication contribution and encouraged client to contact prescribing provider regarding fatigue and reduced intake. Obtained client consent to coordinate with prescriber. Plan: monitor mood, eating patterns, and safety weekly; reassess risk next session; coordinate with prescriber as clinically indicated.

The note records the observable change, the domains that were assessed, the clinician's reasoning, the consent obtained, and the follow-up plan. It does not tell the client to change a dose or endorse or discourage the medication. Precision matters more than length. A few sentences that preserve what was noticed, what was considered, and what happened next are more clinically useful than a long narrative that never explains the decision.

When coordination does not go smoothly

Coordination becomes more difficult when the other provider does not respond or responds without resolving the concern. That situation is common enough to plan for. Without a next step, clinicians may send one message, receive no useful reply, and then allow the issue to disappear into the rest of the caseload.

When a message goes unanswered, change the channel rather than simply repeating the same attempt. A portal message can be followed by a call to the office. A call can become a request to speak with nursing staff or to place a note in the chart before the client's next medical visit. Document the date and method of each attempt. The goal is not to harass another provider; it is to create a reasonable, traceable effort to convey clinically important information.

A disagreement with the prescriber is different from no response. The prescriber may have laboratory results, medical history, or other information that changes the interpretation. Ask what they are seeing before assuming the disagreement reflects inattention. If concern remains, document the behavioral health observation, the communication that occurred, and the plan to continue monitoring. The therapist's responsibility is not to prevail in a debate but to make sure the relevant observation is communicated and followed.

The most complicated situation may be a client who does not want coordination. That preference deserves both respect and exploration. Fear that the medication will be stopped, concern about judgment, or prior experiences of providers talking about the client rather than with them may all be driving the refusal. Sometimes the solution is to narrow what will be shared or to support the client in contacting the prescriber directly. When the client declines coordination and there is no imminent safety issue, document the recommendation, the refusal, and the monitoring plan. If risk becomes imminent, ordinary safety duties and the applicable confidentiality rules govern the response.

Across all of these situations, the common safeguard is having a defined next step before the communication problem occurs. Good intentions are not a substitute for a process.

Referral, scope of practice, and telehealth safeguards

Referral is part of error prevention. Behavioral health clinicians are not responsible for the medical management of GLP-1 treatment, the diagnosis or treatment of malnutrition, or solo management of a medically unstable eating disorder. Signs of medical instability call for medical evaluation and coordination. Eating-disorder severity beyond the clinician's competence or the intensity of the current setting calls for specialty care or a higher level of care. It helps to know referral options before they are needed; the National Alliance for Eating Disorders, for example, maintains resources that can assist clinicians and clients in locating specialty treatment (National Alliance for Eating Disorders, n.d.). Professional ethics across disciplines make the same broader point. Counselors are expected to practice within the boundaries of competence and refer when client needs exceed them (American Counseling Association, 2014). Social work ethics similarly address competence, consultation, and referral (National Association of Social Workers, 2021), while psychologists are held to parallel competence standards (American Psychological Association, 2017). Referral is not a failure of the therapeutic relationship. In some cases it is the action that best protects it. Clinicians can be reluctant to refer because they

fear the client will experience the recommendation as rejection, or because an established therapeutic relationship makes transfer feel disruptive. Those concerns deserve thoughtful handling, but they do not expand scope of practice. Referral can be framed as adding the expertise or intensity the client now needs while preserving appropriate behavioral health support where possible.

Telehealth adds another layer to safety planning. A remote client may be far from the therapist when a behavioral or medical emergency occurs, which makes current location and emergency information more important. Standard telebehavioral safeguards include confirming the client's location, maintaining current emergency contacts, discussing how emergencies will be handled, and documenting those plans (U.S. Department of Health and Human Services, 2024). GLP-1 treatment does not create a separate telehealth standard, but rapid physical change or possible medical instability is a reason to ensure that ordinary emergency procedures are actually current. Specific requirements still depend on jurisdiction and setting. In remote care, practical details matter. The therapist may know the client's home address but not where the client is physically located during a particular session. Confirming location and maintaining a workable emergency plan become especially important when there is concern about fainting, dehydration, severe restriction, suicidality, or another situation in which outside help might be needed quickly.

Case example

Sam, a 29-year-old with a history of bulimia, receives a GLP-1 prescription through a telehealth weight-loss service that never identifies the eating-disorder history. Sam's therapist knows about the bulimia but does not know a new medication has been started because medication review has not occurred in several months. Restriction and bingeing begin to cycle again. No single decision created the problem. The prescriber lacked psychiatric history, the therapist lacked medication information, and no one connected the two. Once the therapist learns about the GLP-1 medication during a routine medication review, Sam consents to coordination and the providers develop a plan together. A simple recurring medication question would have exposed the communication gap much earlier.

Reflection questions

How consistently do you ask about medication changes after intake? When you have clinically important information for a prescriber, what tends to delay communication? Could any of those barriers be reduced by changing your consent or release process? If another clinician reviewed your notes, would they see how you reached your conclusions or only what you concluded?

Key clinical takeaways

Communication failures are preventable when medication review and provider coordination become routine rather than exceptional. Ask about medication changes over time, obtain the consent needed to share clinically relevant observations, and use a clear handoff structure such as SBAR. Document the reasoning behind decisions, not only the final impression. When the client's medical or eating-disorder needs exceed your competence or setting, referral is part of safe care.

Section 6: Systems Factors, Cultural Bias, and Building Error-Resistant Practice

(Supports Learning Objective 6)

Why willpower is not a safety plan

By this point, a pattern emerges: many of the errors in this course can be traced to an absent prompt, an assessment that was never repeated, information that failed to move, or reasoning that was not documented. Knowledge still matters, but knowledge alone is a weak safety system. On a busy day, memory and vigilance are exactly what become unreliable. Patient safety design works differently. Root cause analysis identifies the condition that allowed the error. Error reduction changes the workflow so the safer action is easier to perform. Patient safety improves when those changes become repeatable habits rather than individual acts of concentration. The distinction between knowledge and design is important for continuing education. A clinician can leave a course remembering every major risk and still fail six months later if nothing in the workflow prompts the knowledge at the relevant moment. A checkbox, template field, standing question, or referral pathway may look less impressive than expertise, but it is often what turns expertise into consistent behavior.

The risk factors are familiar. Time pressure encourages the fastest explanation. Fragmented care separates therapists from prescribers. Intake forms that ask about medications or eating disorders only once become outdated as the client's circumstances change. Cultural praise for weight loss can make both client and clinician celebrate before assessing. These conditions do not excuse poor care, but they explain why errors recur even among thoughtful professionals. Each also offers a place to intervene.

Practical prompts that prevent error

Small workflow changes can have disproportionate value. Add medication and dose questions to intake and periodic progress review, naming weight-loss and diabetes medications so clients recognize that they are relevant. Create an automatic reassessment trigger when a client experiences rapid physical change. Make releases of information easy to obtain when a new prescriber enters the picture. When neurovegetative symptoms change, use the note template to prompt a brief differential rather than relying on memory. None of these measures is sophisticated. Their strength is that they continue working when the clinician is tired, rushed, or focused on something else.

Cultural bias as a source of error

Bias belongs inside a patient safety discussion because it changes what clinicians notice, how they interpret it, and which questions they ask. Weight and body size carry strong cultural meanings, and those meanings can quietly shape clinical judgment.

A larger-bodied client who reports fatigue or another physical complaint may have the symptom attributed to weight before other explanations are explored. A client who is losing weight may receive praise so readily that unsafe methods go unquestioned. Eating disorders are also more likely to be overlooked in people who do not match the familiar stereotype of a thin, young, white woman; men, older adults, people in larger bodies, and people of color may therefore be underrecognized (Kutz et al., 2020). In each example, bias alters assessment in a way that can delay appropriate care.

Weight stigma has measurable consequences in healthcare. People who encounter stigma may delay or avoid care, and weight stigma has been associated with adverse psychological and physical outcomes through multiple pathways (Puhl, 2023). Clinician bias can affect communication, time spent with patients, and the tendency to attribute problems prematurely to weight. In behavioral health, this can weaken both the therapeutic relationship and diagnostic accuracy. It can also shape the client's relationship with GLP-1 treatment. Someone who has experienced years of weight stigma may approach weight loss with intense urgency or shame,

while another may experience medication use as evidence of personal failure. Those meanings are clinically relevant and should not be reinforced by the therapist. Weight bias can operate even when the clinician intends to be affirming. Assuming that weight loss must represent improved health or improved self-esteem, for example, can narrow the questions asked in session. Conversely, assuming that a larger body explains fatigue, mobility problems, or emotional distress can prematurely close the differential. The safety response is not to become "weight blind" but to treat weight as one piece of information rather than the organizing explanation for everything else.

Addressing bias does not require shaming clinicians for having automatic reactions. It requires treating those reactions as potential sources of error. A culturally responsive approach asks rather than assumes, notices the clinician's own responses to body size and weight-related choices, and approaches weight with the same nonjudgmental curiosity applied to other clinically relevant material. Reflection helps, but structure matters too: universal questions and standardized reassessment reduce the opportunity for stereotypes to decide who gets screened.

Access, equity, and the assumptions we make

Access also shapes the clinical picture. GLP-1 medications can be expensive, insurance coverage is inconsistent, and patterns of use vary across demographic groups (Vahratian & Warren, 2025). A client may stop treatment because coverage disappears rather than because the medication is ineffective or unwanted. That distinction matters when assessing distress after discontinuation. It also cautions clinicians against assuming who is or is not likely to be using these medications. Equity is not merely background context; it affects exposure, continuity, discontinuation, and the assumptions built into assessment. Access problems also create discontinuities that can be mistaken for clinical choices. A therapist who assumes a client "decided to stop" may miss the demoralization of losing insurance coverage or being unable to afford treatment. Asking what happened preserves the distinction between preference and constraint. It also helps the clinician anticipate when financial stress, shame, or fear of regain may be entering the therapy room.

Treatment planning implications

Patient safety can be written into the treatment plan rather than addressed only when a problem emerges. For a client using a GLP-1 medication, periodic reassessment of eating behavior, mood, and substance use can be tied to meaningful physical or medication changes instead of an arbitrary calendar interval. Coordination with the prescriber can be identified in advance, including what circumstances would warrant contact and what consent is needed.

Discontinuation can be discussed before it occurs so that the therapist and client already know what emotional and behavioral changes to watch for. Treatment goals should also extend beyond pounds lost; using weight alone as a marker of progress can unintentionally reinforce restrictive or shame-based dynamics. The plan can also identify what information will be revisited after a dose change, a rapid shift in weight, or a change in access. That makes reassessment predictable rather than reactive. When the client knows in advance that eating, mood, body image, and substance use will be reviewed during major changes, those questions are less likely to feel like suspicion or criticism.

Planning is also a way to make scope decisions before a crisis. If a client has a history of eating-disorder symptoms, the treatment plan can identify when a dietitian, physician, specialty therapist, or higher level of care would be needed. Predetermining those thresholds reduces the chance that referral will be delayed because the clinician is trying to decide what to do in the middle of a rapidly worsening situation.

GLP-1 Patient Safety Checklist for Behavioral Health Clinicians

The checklist below translates the course into actions that can be built into ordinary practice. None requires specialized pharmacology expertise. Their value comes from repetition, particularly when they are embedded in intake forms, progress-note templates, and review routines rather than left to memory.

- Ask specifically about weight-loss and diabetes medications, not just "medications."
- Track start date, dose changes, and discontinuation when known.
- Map symptom changes against the medication timeline before settling on a psychiatric explanation.
- Reassess eating behavior when weight changes rapidly.
- Assess suicide risk based on the individual presentation, not on the medication.
- Ask about alcohol and substance use changes.
- Watch for medical red flags, and respond by coordinating and referring.
- Coordinate with the prescriber when clinically indicated and with client consent.
- Document your reasoning, not just your conclusions.
- Refer when the client's needs exceed your scope or setting.

The most common therapist mistakes, gathered in one place

The recurring mistakes are easier to recognize when they are viewed together. A therapist may interpret a medication effect as psychiatric without checking the timeline, rely on an old eating-disorder screen while the client's body and behavior change, carry outdated information about suicide risk, avoid contacting a prescriber because the consent process is cumbersome, document the conclusion but not the differential, or continue treating beyond the limits of competence because referral feels disruptive. Bias about weight and bodies can influence every one of those decisions. These are ordinary human failure points, which is exactly why a repeatable safeguard is more dependable than a promise to remember next time. Putting the errors side by side also reveals how often they compound one another. A biased assumption can reduce screening; missing screening can lead to a wrong formulation; weak documentation can hide the uncertainty in that formulation; and poor coordination can prevent a prescriber from seeing the behavioral health concern. The purpose of a systems approach is to interrupt the chain at several points rather than hope that no link ever fails.

Putting it together, the error-resistant clinician

An error-resistant clinician in this area is not necessarily the clinician with the deepest knowledge of pharmacology. It is the clinician whose practice reliably surfaces relevant information. Medication changes are asked about, symptom timelines are checked, eating and mood are reassessed when circumstances change, current evidence guides suicide-risk discussions, prescribers receive important observations with consent, reasoning appears in the record, bias is examined, and referral occurs when the case exceeds the clinician's scope or setting. The strength lies in the system behind the clinician rather than in exceptional vigilance. The same habits also make clinical supervision and consultation more useful. When the medication timeline, relevant screening, and differential are already documented, consultation can focus on the genuinely uncertain part of the case instead of reconstructing basic facts. In group settings, shared prompts create a common safety language across clinicians with different levels of experience. In solo practice, the prompts function as a second set of eyes by forcing important questions back into view at predictable moments.

That is the central lesson of patient safety. Caring more is not a dependable error-prevention strategy because clinicians already care and still work under pressure, uncertainty, and fragmented systems. Safer practice comes from understanding how errors enter the workflow and redesigning that workflow so that the careful action requires less effort, not more.

Case example

A community mental health center serving a diverse, largely low-income population notices that clinicians are inconsistently identifying GLP-1-related concerns. Instead of relying on another training alone, the center changes its workflow. Weight-loss and diabetes medications are added explicitly to every progress-note medication prompt. Clinicians receive a one-page guide identifying when rapid change should trigger renewed eating assessment and prescriber coordination. The center also creates a direct referral pathway to a dietitian and eating-disorder resources. Over the following months, restrictive patterns are identified earlier and coordination becomes more consistent. The improvement comes from changing the environment in which clinicians make decisions.

Reflection questions

What is one prompt, template change, or routine you could add this week that would make an error less likely? Where might your own assumptions about weight or body size influence your first clinical interpretation? What change in your practice setting would make the safer response easier for every clinician, not only for the person who remembers this course?

Key clinical takeaways

Most of the errors reviewed here arise from gaps in process rather than a simple lack of knowledge. Root cause analysis identifies the condition that made an error possible, error reduction changes that condition, and patient safety improves when the new behavior becomes routine. Standardized prompts, reassessment triggers, communication pathways, documentation habits, and bias-aware screening are more durable than vigilance alone.

Conclusion

The rapid adoption of GLP-1 medications has not invented entirely new forms of behavioral health error. It has made familiar ones easier to see. When appetite, weight, reward, mood, and body image can all shift over a relatively short period, the assumptions built into ordinary assessment become more vulnerable. A symptom may be attributed to the wrong cause. An eating screen may never be repeated. Important information may stop at the boundary between therapist and prescriber. Documentation may preserve the conclusion but not the reasoning. Bias may shape what is noticed and what is normalized. Each pathway is recognizable within established patient safety principles.

The appropriate response is not to treat GLP-1 use as inherently dangerous. It is to treat the medication as a clinically relevant medical factor that can change symptoms, alter risk, complicate interpretation, and sometimes require coordination. Curiosity, accurate documentation, and communication are more useful than alarm.

The most dependable safety practices are concrete. Keep medication information current. Map new symptoms against the medication and dose timeline before closing the differential. Reassess eating behavior and mood when the body changes rapidly. Use current evidence when discussing suicide risk. Communicate important observations and document the reasoning behind clinical decisions. Examine the assumptions that body size can trigger. Refer when the client's needs exceed the clinician's competence or setting. Stay within behavioral health scope

by recognizing and communicating medication-related concerns rather than managing the medication itself. These habits can be built into ordinary clinical infrastructure: intake forms that name relevant medications, progress-note prompts that ask about change, standing questions that revisit eating and substance use, simple consent procedures for coordination, and referral pathways that are known before they are needed. Safety becomes more dependable when the workflow carries part of the cognitive load. No single safeguard has to catch every problem. A medication question may reveal a new prescription, a timeline prompt may reveal that symptoms began after a dose change, an eating screen may identify restriction, and a communication routine may carry that information to the prescriber. The strength comes from layering these ordinary steps so that a missed cue in one place can still be caught somewhere else. That is the practical translation of root cause analysis and the Swiss cheese model into everyday behavioral health work.

Clients taking GLP-1 medications are not outside ordinary behavioral health practice. They are part of the ordinary caseload, with an added medical variable that can change the meaning of familiar symptoms. Slowing the reasoning at the right moments and building systems that catch what any individual clinician may miss is the essence of patient safety. It is also sound clinical care. This approach also protects against overreaction. A safety-oriented clinician does not assume every mood shift, appetite change, or episode of distress is caused by the medication. The clinician asks enough questions to keep the medication visible without allowing it to dominate the formulation. Good patient safety is not hypervigilance. It is disciplined curiosity supported by a workflow that makes clinically relevant information difficult to overlook.

Glossary

Anhedonia: A reduced capacity to feel pleasure or interest in activities that were previously enjoyable. A core feature of depression and a domain that may be affected by medications acting on reward pathways.

GLP-1 receptor agonist: A class of medications that mimics the gut hormone glucagon-like peptide-1, slowing gastric emptying, increasing fullness, reducing appetite, and acting on reward-related brain regions. Includes semaglutide and, as a dual agonist, tirzepatide.

Semaglutide: A GLP-1 receptor agonist marketed as Ozempic for type 2 diabetes and Wegovy for weight management.

Tirzepatide: A dual GIP and GLP-1 receptor agonist marketed as Mounjaro for type 2 diabetes and Zepbound for weight management.

Medical error: A preventable act or omission that has the potential to cause harm to a patient, whether or not harm actually occurs.

Root cause analysis: A structured process for identifying the underlying, changeable conditions that allowed an error to occur, rather than stopping at the immediate or surface cause.

Swiss cheese model: A patient safety concept in which harm reaches a patient only when weaknesses in several independent layers of defense align at the same time.

Just culture: An organizational approach that responds to honest error by improving the system rather than assigning blame, while still holding people accountable for reckless conduct.

Diagnostic error: An error in which a symptom or condition is attributed to the wrong cause, such as reading a medication effect as a primary psychiatric symptom.

Anchoring bias: The tendency to lock onto an initial impression and interpret later information in its light, discounting evidence that does not fit.

Neurovegetative symptoms: Physical symptoms used in assessing mood disorders, including changes in appetite, weight, sleep, energy, and concentration.

Narrow therapeutic index: A property of certain medications for which the difference between an effective dose and a harmful dose is small, making changes in absorption more clinically significant.

SBAR: A structured communication format (Situation, Background, Assessment, Request) used to convey clinically relevant information to another provider concisely.

Scope of practice: The range of activities a clinician is qualified and licensed to perform, beyond which referral or consultation is required.

Weight bias: Negative attitudes or assumptions about people based on body size, which can distort clinical judgment and contribute to diagnostic and assessment error.

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