The pre and post bariatric surgery profiling and support of the obese patient

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Overview of surgery outcomes

• Up to 20% of patients have suboptimal bariatric surgery results including inadequate initial weight loss or significant regain within several years postsurgery.
  • These results are often related to poor adherence to the postoperative diet and other behavioral problems.

• Additionally, while there is research that indicates general improvement in psychiatric symptoms and psychosocial issues postsurgery, there is a subset of patients for whom the opposite is true.
Comorbidities of bariatric surgery candidacy and psychiatric diagnosis

• **Depression:**
  • Lifetime prevalence for bariatric patients is 45%; general population prevalence is 20%
  • 12-month prevalence for bariatric patients is 16%; general population is 10%

• **Anxiety:**
  • Lifetime prevalence for bariatric patients is 38%; general population prevalence is 33%
  • 12-month prevalence is 24%; general population is 18%
  • Most common anxiety diagnosis for bariatric surgery candidates is Social Anxiety (9% of patients)

• **Substance/Alcohol Abuse:**
  • Lifetime prevalence is 32% for any SUD/AUD; rates at time of evaluation are 1-2%
  • Alcohol Use Disorder in general population: lifetime prevalence is 18-29%, 12-month prevalence is 4-9%
  • Substance Use Disorder in general population: lifetime prevalence 10%, 12-month prevalence is 4%

• **Binge Eating Disorder:**
  • Full disorder occurs in approximately 16% of patients seeking surgery, lifetime prevalence is 27%

• **Personality Disorder:**
  • Up to 29% of bariatric surgery candidates meet criteria for a Personality Disorder, with Avoidant PD being most common.
Suicide risk and bariatric surgery candidacy

• A post-surgical patient is anywhere from 2-4 times more likely to commit suicide than someone from the general population.

• Studies:
  • Tindle (2010) – compared suicide data from bariatric patients and general U.S. population for the same 10 year period.
    • Completed suicides in the surgical group was 5.2/10,000 for females, 13.7/10,000 for males
    • General population rates were 0.7/10,000 for females, 2.4/10,000 for males
    • 70% of the suicides took place in the first 3 years after surgery.
  • Peterhansel et al (2013)
    • Meta-analysis of 28 studies and estimated the suicide rate after surgery to be 4.1/10,000, compared to the suicide rate of the general population which is 1/10,000.
Possible reasons for increased suicide rate

• Higher pre-morbid depression/mood disorder in bariatric patients.
• Higher prevalence of suicide attempts or suicidal ideation prior to surgery.
• Higher rates of impulsivity in bariatric patients (over general population and obese people who don’t have surgery).
• Recurrence of obesity-related diseases may lead to increase in depressive symptoms.
• Metabolic changes:
  • Impaired metabolism of alcohol – easier to become intoxicated and disinhibited.
  • Antidepressant medications may be inadequately absorbed due to anatomical changes in the digestive system.
  • Decrease in peptide hormone Ghrelin, which may have an antidepressant effect.
Influence of preoperative psychological factors on weight loss after surgery

• The relationship between preoperative psychopathology and postoperative outcome remains unclear even after many studies.

• Many studies show that anxiety and mood disorders generally improve immediately following surgery (within 1 year) but the improvement deteriorates over time (within 2-4 years).

• Symptoms/correlates of psychiatric disorders have been associated with poor weight loss after surgery, such as poor adherence to diet and medical instructions, limited social support and emotional eating, even if criteria for a clinical disorder is not met.
1. To rule out surgery due to explicit psychological contraindications.
2. To lay out clear expectations for treatment in order to become a candidate for those with contraindications that could be alleviated.
3. For most candidates, the evaluation should serve planning and education functions rather than a gatekeeping function. It can be used to enhance surgical outcomes.
   - Identify pre-existing psychopathology and propose treatment.
   - Clarify expectations of surgery.
   - Identify psychosocial issues related to obesity that may require attention after surgery.
Psychological contraindications for surgery

• Diagnosis of Schizophrenia or related psychotic condition.
  • This is the only contraindication that is absolute and final.
• Active Alcohol/Substance Use Disorder.
• Active Binge Eating Disorder.
• Intellectual/cognitive disability that prevents the person from understanding surgery or their role/responsibility in the treatment process.
• Uncontrolled depression.
• *Psychiatric hospitalization within the past 1 year.
Components of psychological evaluation for surgery

1. Chart review
2. Clinical interview
3. Objective testing – MMPI and MBMD used at Ochsner
   - Allows clinicians to gather a large amount of information quickly, and offers more precise, empirically valid information than a clinical interview alone.
   - Provides clinical information on risk factors that the patient may be sensitive to disclosing during an interview.
   - Helps with differential diagnoses.
   - Provides information on the extent to which a candidate is over- or under-reporting symptoms.
Clinical interview – Domains for assessment

1. History of weight problem and prior attempts to lose weight
   • Participation in weight loss programs
   • What contributed to successes/failures

2. Eating behaviors/lifestyle issues that contribute to weight problem
   • To ensure understanding of behaviors they engage in that require change.
   • Emotional eating

3. Understanding of surgical procedure
   • Risks/benefits
   • Bariatric diet they will need to follow
   • The long-term nature of the lifestyle changes
Clinical interview – Domains for assessment

4. Expectations of surgery
   • Unrealistic expectations regarding amount of weight loss may be associated with depression post-surgery.
   • Some patients expect that surgery will alleviate problems that are not primarily weight-related (i.e. long-standing depression, bad relationships).

5. Motivation for surgery
   • While it is natural for patients to want improved physical appearance and body image post-surgery, we are looking for primary surgery goals being around health and quality of life improvement.
   • Some patients are motivated by external factors, such as pleasing or supporting someone else.
Clinical interview – Domains for assessment

6. Current psychiatric symptoms:

**Internalizing psychopathology – Depression, Anxiety**
- Evaluate if meet criteria for a Depressive Disorder versus depression/dysphoria that is attributable to their obesity with no other criteria.
- Evaluate if meet criteria for an Anxiety Disorder that might impact their treatment – Panic Disorder, Agoraphobia, Social Anxiety.
- For those with significant symptoms, treatment is recommended in order to prepare them to take on the postoperative diet and behavioral demands of surgery, to monitor/improve adherence, and to decrease suicide risk post-surgery.
Clinical interview – Domains for assessment

Externalizing psychopathology – substance/alcohol use disorders

- Multiple studies have demonstrated that risk for AUD decreases in the first year after surgery but increases (particularly with LRNY) during years 2-4 postsurgery.
- Changes in alcohol metabolism is a major concern – quicker intoxication leads to increased positive reinforcement for some.
- Significant presurgical predictors of AUD following surgery were surgery type (gastric bypass), being male, younger age, regulate cigarette and alcohol consumption (2 or more drinks per week), a presurgical diagnosis of AUD and poor interpersonal support.
- Underlying personality construct of disinhibition/disconstraint – if present presurgery, higher likelihood of non-adherence and poor eating post-surgery.
Clinical interview – Domains for assessment

7. Psychiatric history - including treatment and adherence
   • Studies have found that 20%-40% of patients report ongoing mental health treatment at the time of bariatric surgery.
     • The most common treatment is the use of antidepressant medications, most often prescribed and managed by PCP’s.
   • Also want to look at previous hospitalizations, suicide attempts.
   • Interview is the time to get contact information on their treatment providers for collateral information and collaboration purposes, as well as to suggest an increase in treatment if indicated.
8. Eating disorders
   • Binge Eating Disorder – recurrent binge episodes where eating large amounts of food when not hungry rapidly and alone, leading to feelings of guilt, depression, and shame afterwards.
   • Considered poor prognostic indicator. If actively meet criteria, 1 year of abstaining from regular bingeing plus treatment is recommended.

9. Abuse/trauma history
   • Studies have suggested that 16%-32% of surgery candidates report a history of sexual abuse, higher than general population.
   • Patients with a history of sexual abuse often struggle with a range of psychological issues after surgery, including those regarding body image, sex, and intimacy.
Clinical interview – Domains for assessment

10. Social support
   - Who lives in household and what level of support do they provide?
   - Satisfaction with marital/romantic relationships – partners could have negative feelings about weight loss.
   - Is there any weight loss sabotage taking place?

11. Current stressors

12. Coping skills
   - Particularly for those with history of emotional eating, smoking, or AUD/SUD, it is important for them to understand the role of distress tolerance skills.

13. Cognitive functioning
   - Mini-mental status exam to look for gross problems in memory, attention, reasoning.
Possible results of psychological evaluation

1. Patient not cleared for surgery due to contraindication.
2. Patient cleared for surgery with no requirements or recommendations.
3. Patient put on 3-6 month hold to complete requirements/recommendations, including:
   • Crushing psychiatric medications
   • Consultation with psychiatrist
   • Beginning psychotherapy
   • Attending support group or emotional eating group
   • Neuropsychological assessment
Need for post-surgical psychological support

• The majority of surgery patients do well for the first 1-3 years after surgery, with good weight loss and decrease in psychiatric symptoms, and do not require any postsurgical support.

• A subset of patients experience increase in psychiatric symptoms, (including suicidal ideation) or an increase in psychosocial stressors and will require treatment.

• Additionally, many patients find themselves struggling to implement behavioral changes once the surgery date is no longer a motivating goal and may benefit from specific skills to improve eating behaviors.
Support services offered at Ochsner

- Brief individual psychotherapy
- Consultation with psychiatrist
- Monthly support group
  - Not psychological in nature – patients support each other through the process and different topics are offered through various team staff members.
- Emotional eating group
Emotional eating (EE)

- EE = eating in response to negative emotions, such as sadness, fear, and anger.
- Pre-surgical emotional eating severity has been found to be significantly associated with poorer weight loss following surgery.
- A recent study (Wiedemann, 2018) of post-sleeve patients with poor weight loss found that on average, participants reported engaging in emotional eating with loss of control from 1-5 days in the past month, most commonly in response to anxiety, boredom and/or sadness.
- Highly correlated with Depression and Social Anxiety.
Psychological processes associated with EE

• **Mindfulness**: to be fully present, aware, and nonjudgmental of our internal and external experiences.
  - higher levels of mindfulness are negatively associated with EE.
  - greater difficulty identifying/descrying feelings is associated with more EE.

• **Emotion Regulation**: the ability to effectively manage and respond to an emotional experience.
  - includes emotional awareness, behavioral control, distress tolerance.
  - Deficits in goal-directedness, emotional awareness, and impulse control are associated with EE.
In a recent study (Dalrymple, 2018) surgery candidates endorsing emotional eating reported poorer mindfulness skills and emotion regulation deficits, including:

- Poor emotional awareness
- Nonacceptance of emotional responses
- Limited access to emotional coping strategies
- Difficulty controlling impulses when experiencing negative emotions
- Difficulty engaging in goal-directed behaviors when experiencing negative emotions.
Emotional eating group at Ochsner

- 8 weekly hour-long sessions focusing on topics such as mindfulness and emotion regulation skills and giving homework each week.
- Relapse prevention and harm reduction strategies are woven in as well, helping each patient identify their specific emotional triggers, high-risk situations for such triggers, and enhance skills for coping with them.
- Additionally, the social structure of the group provides support, encourages the expression of relevant emotions, and buffers patients from stress.
References


References


