

The role of psychiatry in bariatric care

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Like many psychiatrists, from time to time, I receive requests for evaluation regarding a patient's suitability for bariatric surgery or competency to agree to the procedure. This request poses several questions: What is my role regarding this request? How can I know whether the patient should have this surgery? I usually do not understand or know a surgeon's criteria for psychiatric clearance. They are probably arbitrary unless the patient is suicidal or psychotic. Shouldn't I also be providing some care in addition to the evaluation?

What is the role of psychiatry and psychiatrists in bariatric care? I use the word "care" rather than "surgery" because I think the management of patients who are obese should include more than just surgery.

Obesity is a serious and chronic problem that contributes to overall morbidity and mortality, both of which have been on the rise globally.¹ Obesity management has received plenty of attention with the arrival of glucagon-like peptide-1 receptor agonists (GLP-1RAs) such as liraglutide, semaglutide, and tirzepatide. Although these medications were developed for managing type 2 diabetes, clinicians and researchers noted that patients receiving weekly subcutaneous injections of these agents lost a significant amount of weight. As a result, pharmaceutical companies applied for FDA approval of the medications for treating obesity. Some have already received approval and their use has subsequently skyrocketed.

It seems these medications may have to be used indefinitely for patients to maintain the weight-loss benefits, as individuals regain some weight after discontinuing the medication. Although the long-term effects of these medications are not well-known, GLP-1RAs are clearly becoming an integral part of the medical management of obesity.

Bariatric surgery and preoperative intervention

Bariatric surgery has been considered the best evidence-based treatment for sustained weight loss and remission of obesity-related comorbidities for patients with severe obesity (body mass index [BMI] ≥ 40 kg/m²),

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individuals with a BMI 35 to 40 kg/m² and significant obesity-related comorbidities, or individuals with BMI <35 kg/m² and poorly controlled type 2 diabetes.²⁻⁴ Obesity is associated with psychiatric comorbidities such as depression, binge eating, anxiety, and suicidal ideation.² Substantial psychopathology exists, especially among those who are morbidly obese and requesting bariatric surgery, and such patients frequently meet diagnostic criteria for ≥1 personality disorders.⁵ Thus, the preoperative evaluation should focus on psychiatric comorbidities and possible contraindications to the surgery (eg, active substance abuse or suicidality).

Psychiatric interventions should include managing these comorbidities, addressing other psychiatric comorbidities, providing psychoeducation about the consequences of the surgery in terms of changes in psychiatric medications and possible emerging mental health issues, goal-setting, self-monitoring, self-care, cognitive restructuring, help with decision-making, and relapse prevention.³ It is important to recognize that preoperative psychiatric intervention may help with psychiatric comorbidities and for planning aftercare, but presurgery lifestyle intervention may not be helpful in terms of long-term postsurgery weight loss. The presence of mental illness at baseline also may not be predictive of weight loss; thus, patients with mental illness should not be routinely denied bariatric surgery⁶ apart from obvious reasons such as psychosis or suicidality.

Bariatric surgery and postoperative intervention

Overall, bariatric surgery has positive short-term outcomes, including weight loss, a decrease of obesity-related comorbidities, improved body image and sexual functioning, and improvements in other aspects of functioning. Nevertheless, Kalarchian et al⁴ point out several long-term psychosocial concerns that may emerge following surgery. These include maladaptive eating (eg, binge eating or grazing—the repetitive eating of a modest amount of food in an unplanned manner⁴), substance use, suicide, impact on interpersonal relationships (including emotional intimacy and relationship quality), and excess skin.

Various psychosocial interventions—including but not limited to cognitive-behavioral therapy, dialectical behavioral therapy, mindfulness, and acceptance and commitment therapy—have been reported to have a positive impact on psychosocial complications after

bariatric surgery, namely on disordered eating. Pre- and postsurgery psychoeducation should definitely be part of bariatric care because patients may feel unprepared for extreme psychosocial and lifestyle changes.⁷ Some of the interventions may be delivered online and/or via a mobile-device application “to promote positive outcomes in this patient population.”³ Kalarchian et al³ also noted that “Computer-assisted technologies also hold tremendous promise for intervention delivery postsurgery, when lifelong follow-up is essential for monitoring patients and supporting long-term lifestyle change.”

Psychopharmacologic intervention should also be part of postoperative bariatric care when indicated. For patients seeking bariatric surgery, psychotropic medications are the most frequently prescribed medications.² Most patients will need to continue their medication(s) following surgery. The medication regimen may require individual adjustment depending on the type of bariatric surgery and the specific medication due to decreases in the absorption of medications such as antidepressants, possible vomiting, and trouble staying hydrated, especially immediately after the surgery. Some of the mental illnesses that appear *de novo*, such as depression or severe anxiety, may require psychotropic medication.² Sockalingam et al² pointed out that lithium may require special attention to its dosing due to its narrow therapeutic window and possible toxicity. The use of antipsychotics also has to be reconsidered and restructured, because some agents are associated with serious weight gain.⁸

Conclusion

Obesity and bariatric surgery are both associated with serious physical illness comorbidity as well as serious mental illness comorbidity. Psychiatry’s involvement in bariatric care has been minimal and inadequate considering the severity of the likely lifelong comorbidity. Pre- and postbariatric surgery psychosocial and psychopharmacologic interventions have been the most examined parts of bariatric care so far. There is a clear need for integrated stepped care to provide personalized psychiatric care following bariatric surgery.² This care should not be limited to bariatric surgery and psychopharmacologic intervention. Various psychosocial interventions should also be implemented.

We do not know much about the pre- and post-interventions needed and used in the case of the new obesity medications—GLP-1RAs—for weight loss. We can assume that the approach to the care of patients

using these medications to treat overweight/obesity should be similar to that of patients who undergo bariatric surgery, as issues related to obesity treated with these medications are similar to the issues related to the treatment of obesity with bariatric surgery. These medications may have serious adverse effects (eg, nausea and vomiting), and not all long-term effects are known. This is something to consider, as the treatment of obesity with

these medications is going to be long-term, if not lifelong, which may be similar in the case of postbariatric care.

Psychiatrists do not seem to be well prepared to treat patients with obesity. It is time for the specialty to step up and prepare to provide care for patients undergoing bariatric surgery and other weight loss interventions, as the numbers of those patients and treatment approaches will likely continue to increase. ■

REFERENCES

1. Smith KB, Smith MS. Obesity statistics. *Prim Care*. 2006;43(1):121-135. doi:10.1016/j.pop.2015.10.001
2. Sockalingam S, Leung SE, Wnuk S, et al. Psychiatric management of bariatric surgery patients: a review of psychopharmacological and psychosocial treatments and their impact on postoperative mental health and weight outcomes. *Psychosomatics*. 2020;61(5):498-507. doi:10.1016/j.psym.2020.04.011
3. Kalarchian MA, Marcus MD. Psychosocial interventions pre and post bariatric surgery. *Eur Eat Disord Rev*. 2015;23(6):457-462. doi:10.1002/erv.2392
4. Kalarchian MA, Marcus MD. Psychosocial concerns following bariatric surgery: current status. *Curr Obes Rep*. 2019;8(1):1-9. doi:10.1007/s13679-019-0325-3
5. Black DW, Goldstein RB, Mason EE. Prevalence of mental disorder in 88 morbidly obese bariatric clinic patients. *Am J Psychiatry*. 1992;149(2):227-234. doi:10.1176/ajp.149.2.227
6. Black DW, Goldstein RB, Mason EE. Psychiatric diagnosis and weight loss following gastric surgery for obesity. *Obes Surg*. 2003;13(5):746-751. doi:10.1381/096089203322509327
7. Wykowski K, Krouse HJ. Self-care predictors for success post-bariatric surgery: a literature review. *Gastroenterol Nurs*. 2013;36(2):129-135. doi:10.1097/SGA.0b013e3182891295
8. Musil R, Obermeier M, Russ P, et al. Weight gain and antipsychotics: a drug safety review. *Expert Opin Drug Saf*. 2015;14(1):73-96. doi:10.1517/14740338.2015.974549