

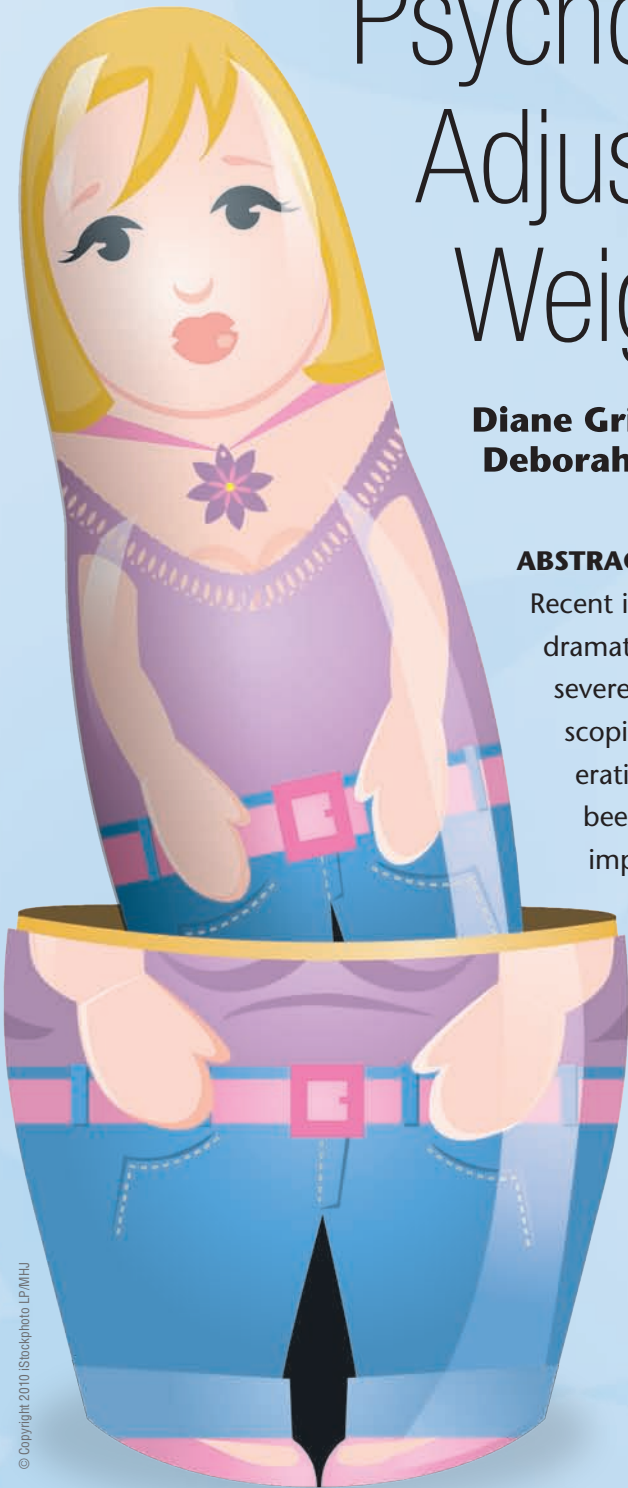
Earn  
**4.0** Contact  
Hours

# Psychosocial Adjustments Following Weight Loss Surgery

**Diane Grimaldi, PMHCNS, BC; and  
Deborah Van Etten, PMHCNS, GNP, BC**

## **ABSTRACT**

Recent interest in weight loss surgery has increased dramatically, largely due to the rising prevalence of severe obesity and the use of less invasive laparoscopic surgical procedures. Physiological postoperative outcomes are easily measured and have been well documented in the literature. The impact of weight loss surgery on psychosocial, behavioral, and psychological function is less clearly understood. Few long-term studies of postoperative weight loss surgery patients in the literature measure emotional health and quality of life. This article discusses some of the psychosocial, behavioral, and psychiatric issues and challenges patients commonly encounter following weight loss surgery.



© Copyright 2010 iStockphoto LP/MHJ

**W**ith the rising trend of weight loss surgery in the United States and the documented prevalence of abnormal eating behavior and psychiatric disorders in this population of people selecting surgery, psychiatric nurses will be integral during all phases of treatment. Outcomes are enhanced when multidisciplinary teams, that include psychiatric nurses, work collaboratively to meet patients' medical, educational, nutritional, and psychological needs. Psychiatric nurses may be responsible for providing preoperative psychological evaluations, pre- and postoperative support groups, and individual counseling and follow up. Clinicians providing these services must be knowledgeable about the issues that may influence psychosocial outcomes.

## BACKGROUND

The limitations of traditional treatments and weight loss programs for severely obese individuals have been well documented (Fisher & Schauer, 2002). Weight loss surgery is the only medically effective solution for those who have chronically struggled with morbid obesity and the related medical comorbidities. In many patients, surgery will improve hyperlipidemia and cure obstructive sleep apnea, hyperten-

sion, and type II diabetes (Buchwald et al., 2004). However, surgery is only a tool that inhibits one's ability to overeat and to eat too quickly. Long-standing triggers for emotional eating remain unaltered by surgery.

The results from outcome studies measuring weight loss following surgery vary widely. In general, patients who have malabsorptive procedures such as the Roux-en-Y gastric bypass tend to lose more weight than patients who have restrictive procedures such as gastric banding (Buchwald et al., 2004). During a 3- to 5-year period, the percentage of excess weight loss averages 60% to 70% for gastric bypass compared with 40% to 50% for gastric banding (Fisher & Schauer, 2002).

The majority of weight loss surgery patients will lose the predicted amount of weight postoperatively. However, 20% or more fail to achieve the expected amount of weight loss (Benotti & Forse, 1995), and 20% to 35% who were morbidly obese preoperatively may regain weight up to 10 years later (Christou, Look, & MacLean, 2006).

Success following weight loss surgery may be defined as the partial or complete resolution of obesity-related medical comorbidities. The achievement and maintenance of a healthier weight and lifestyle, as well as an overall improvement in self-esteem and quality of life, are important parameters for measuring outcomes.

For many patients, weight loss surgery typically represents a second chance or hope for a new beginning. The necessary psychological adjustments that patients typically encounter postoperatively must be anticipated, clearly identified as they emerge, and addressed in a conscious and constructive manner.

There are no standardized, empirically tested recommendations regarding psychological treatment for patients following weight loss surgery. In a recently published best practice update by Greenberg, Sogg, and Perna (2009), close monitoring postoperatively is recommended. They also noted the correlation between the complexity of psychosocial factors and the physical and emotional outcomes following weight loss surgery.

In our clinical experience, permanent weight loss is most often achieved and sustained when bariatric surgical procedures are followed by ongoing emotional support and psychoeducation. This is of particular importance when there is a history of presurgical psychiatric comorbidities such as depression, anxiety, post-traumatic stress from childhood sexual abuse, binge eating disorder, avoidant personality disorder, and alcohol or substance abuse/dependence. Follow up is aimed at assessing and monitoring psychosocial adjustments and psychiatric functioning, as well as adherence to recommended dietary and lifestyle changes.

## PSYCHOSOCIAL ISSUES

Psychosocial functioning and quality of interpersonal relationships often improve following bariatric surgery (Kolotkin, Crosby, Gress, Hunt, & Adams, 2009). Many surgical candidates anticipate they will experience greater fulfillment and satisfaction in interpersonal relationships with significant others, including spouses, family, friends, and coworkers. Although it is often the case that the quality of some marital relationships improves (Applegate & Friedman, 2008), it is also true that in some situations, dynamic shifts within relationships create interpersonal challenges and conflicts.



In a retrospective study of weight loss surgery patients, rapid transformation resulting from significant weight loss reportedly created some degree of tension in multiple areas of the patients' lives (Bocchieri, Meana, & Fisher, 2002). This study suggested that within the marital relationship, patients' increased autonomy and improved self-esteem was perceived as threatening by some spouses. Fear of abandonment was also experienced by a number of spouses as patients became more self-confident. These same researchers also reported that feelings of jealousy, insecurity, and role changes could affect relationship dynamics with old friends.

For example, when marital couples have a long-term habit of watching television and snacking together in the evening, a void is created when there is a postoperative disruption of this ritual, requiring a conscious and collaborative restructuring in terms of how these couples spend time together. Successful behavioral change in this example would require a commitment from both patients and their spouses.

Dining out with friends during the early postoperative period presents a different challenge for patients. When social groups have a history of enjoying meals together, some group members may be resentful or unwilling to accommodate the changed needs of weight loss surgery patients. Sensitivity and consideration are required for social groups to continue to enjoy such gatherings when the group includes someone who is adjusting to a new postoperative food regimen.

Psychiatric nurses often are in a key position to assess the support system of individuals who have undergone weight loss surgery. In some cases, there may be ambivalence about the changing

needs of individuals recovering from surgery. For example, sometimes spouses or family members who claim to be supportive regarding the needs of patients may also feel resentful about the patients' focus on self-care and their own diminished ability to spend as much time and energy as they had previously in a caregiving role.

This dynamic is often most prevalent during the early postoperative period when patients are appropriately self-absorbed with transitional issues. Establishing the commitment to self-care as a priority is essential for long-term success and the integration of permanent lifestyle changes. This may require setting limits and defining new expectations, and might include a reassignment of domestic chores and other family responsibilities. Limit setting and the identification of self-care as a priority often represents a need to become confident with a more assertive communication style.

Another psychosocial concern during the first postoperative year, which typically is characterized by rapid and significant weight loss, is related to how friends, acquaintances, and coworkers respond to the obvious change in patients' physical appearance (Bocchieri et al., 2002). Many weight loss surgery patients do not make a public announcement about undergoing weight loss surgery. In this case, some acquaintances respond with concern and may be fearful that the significant weight loss is caused by a nondisclosed catastrophic illness.

## **BEHAVIORAL ISSUES**

In a retrospective chart review performed by Elkins et al. (2005), behavioral compliance was assessed in 100 patients at 6- and 12-month intervals. As early

as 6 months after surgery, nonadherence with the recommended treatment plan was evident. For example, at the 6-month interval, the researchers reported 44% of patients were snacking, 40% were not exercising, 21% were not attending postoperative support groups, 14% were not increasing water consumption, and 7% were not taking required vitamins.

Permanent results following weight loss surgery require the habituation of new lifestyle management skills and behaviors. Presurgical abnormal eating must be replaced with alternative, healthy behaviors. It is estimated that the lifetime prevalence of binge eating disorder in weight loss surgery candidates is 27.1% (Kalarchian et al., 2007). However, abnormal eating patterns in one form or another are assumed to be causal in morbidly obese individuals, even in the absence of a formal eating disorder diagnosis ("Psychological Aspects of Bariatric Surgery," 2008).

The impact of preoperative binge eating on outcomes is inconclusive. Although bariatric surgery procedures inhibit the physical capacity to overeat, grazing, or eating at frequent intervals, has been reported as early as 6 months following surgery (Saunders, 2004). Maladaptive eating behavior, including emotional eating, that continues after surgery adversely affects weight loss goals. Emotional eating is defined as an overwhelming urge to eat in an attempt to mediate a mood state, in the absence of physiological hunger. Increased awareness and knowledge of triggers for emotional eating provide a foundation for developing a new behavioral repertoire.

The conscious decision to use new behaviors in response to feelings can be empowering for those who previously felt un-

able to control the compulsion to graze or binge. Conversely, relinquishing food is a significant challenge for those who have chronically relied on eating as a source of comfort, distraction, or avoidance of emotions.

Long-term monitoring for psychosocial triggers of unhealthy eating behaviors remains a necessary component of post-operative care (Doolen & Miller, 2005). Emphasis on the development and implementation of non-food-related strategies for managing difficult or unpleasant emotions and life circumstances is essential.

Evaluation of the efficacy of new adaptive behaviors such as a regular exercise regimen is an important component of follow-up psychological treatment. Others include reading, journaling, decluttering, making crafts, meditating, engaging in relaxation strategies, gardening, and listening to music. The implementation of adaptive behaviors is helpful in terms of filling the void and addressing the loss of one's previous reliance on food to cope with feelings such as anger, loneliness, fatigue, boredom, depression, emptiness, and anxiety. Follow-up treatment frequently focuses on monitoring and assessing efficacy of the learned establishment of these new behavioral responses to life stressors and difficult emotions.

Assessment for the potential development of maladaptive behaviors such as overspending, gambling, cigarette smoking, promiscuity, and alcohol or drug use is equally important. Although the emergence of these behaviors postoperatively has not been confirmed scientifically, all of these behaviors have been reported anecdotally in this patient population.

Patients with a history of impulse disordered behavior or

## KEY POINTS

1. For many patients, weight loss surgery typically represents a second chance or hope for a new beginning.
2. Permanent weight loss is most often achieved and sustained when bariatric surgical procedures are followed by ongoing emotional support and psychoeducation.
3. Psychiatric nurses are in a key position to assess the support system of individuals who have undergone weight loss surgery.
4. Follow up is aimed at assessing and monitoring psychosocial adjustments and psychiatric functioning, as well as adherence to recommended dietary and lifestyle changes.

**Do you agree with this article? Disagree? Have a comment or questions?  
Send an e-mail to the Journal, at [jpn@slackinc.com](mailto:jpn@slackinc.com).  
We're waiting to hear from you!**

prior substance abuse may be at higher risk for developing unhealthy or maladaptive behaviors. For example, a history of significant weight gain following smoking cessation may represent a propensity for transferring dependence from one substance to another. Behavioral responses to new dietary restrictions should therefore be explored in follow-up care.

### PSYCHIATRIC ISSUES

Psychiatric disorders are common in weight loss surgery candidates. A study that investigated the psychiatric treatment history of 90 surgical candidates found approximately 66% had a psychiatric diagnosis and almost 40% were involved in some form of psychiatric treatment (Sarwer et al., 2004). These researchers reported major depressive disorder as the most common Axis I diagnosis.

Kalarchian et al. (2007) investigated 288 weight loss surgery candidates for lifetime history of psychopathology. Their findings indicated the lifetime prevalence was 42% for depressive disorder, 37.5% for anxiety disorders, 32.6% for substance abuse disorders, 17% for avoid-

ant personality disorders, and 11% for posttraumatic stress disorder (PTSD). Interestingly, these psychiatric disorders were significantly less prevalent at the time of the preoperative surgical evaluation. The largest disparity was noted for substance abuse disorders, which were diagnosed in only 1.7% of candidates preoperatively.

Several possible explanations for these discrepancies and speculated underreporting are plausible, including shame and denial regarding addictive behavior, absence of trust and rapport with designated evaluators, or the misconception that the evaluators were the decision maker regarding authorization to proceed with surgery. It has also been speculated that substance abuse may diminish when eating behavior predominates (Kalarchian et al., 2007). Patients with a prior history of substance abuse should be assessed for addictions postoperatively and educated about possible recurrence.

PTSD secondary to childhood sexual abuse is common in the morbidly obese population. This disorder also may be underreported during the preoperative evaluation with evaluators who

are unknown by patients. In a sample of 340 weight loss surgery candidates assessed for childhood maltreatment, 32% reported sexual abuse (Grilo et al., 2005).

The data are inconsistent about sustained postsurgical weight loss in patients with sexual abuse histories. The sudden onset of PTSD symptoms after major weight loss in patients with a history of sexual abuse has been reported (Collazo-Clavell, Clark, McAlpine, & Jensen, 2006).

Treatment refractory patients who fail to lose a significant amount of weight or who are unable to sustain weight loss over time may feel vulnerable without excessive body mass and the insular function it serves. Although more research is required, it has been postulated that for some victims of abuse, obesity may serve an adaptive function (Weiderman, Sansone, & Sansone, 1999). This issue may need to be explored cautiously by clinicians trained in psychotherapeutic techniques or trauma counseling. Patients may need assistance handling a diminished personal space and help coping with the attention they receive from others about their new and changing body image.

Avoidant personality disorder is the most common Axis II condition in weight loss surgery candidates (Kalarchian et al., 2007). Postoperatively, transitional challenges for patients with avoidant personality disorder center around the loss of compulsive eating as a means of distraction from painful, uncomfortable, or unpleasant feelings and life circumstances.

Some patients have reported that a few members of their peer group seem to request frequent updates regarding the current amount of weight lost. It is understandable that this situation might be extremely uncomfort-

able for individuals who have gone to great lengths for many years to avoid drawing any attention at all to their weight or personal appearance.

Given the defensive structure of the avoidant personality and the intimate nature of content discussed, large postoperative therapy groups may be difficult for this population. Therefore, patients with avoidant personality disorder may receive greater benefit from smaller or more anonymous forums such as online and telephone resources.

Patients have also reported being confronted with the all too common notion that bariatric surgery is “the easy way out” (Sogg & Mori, 2009). Weight loss surgery patients often require support and assistance with the development of tactful strategies for responding to such uninformed and insensitive reactions. Role-playing is one technique that may be beneficial in preparing patients for such interactions.

The prospect of surgery represents the hope for a major life transformation for most patients. Although many patients experience improved mood, self-esteem, and psychosocial functioning following surgery, a minority will encounter psychological issues postoperatively (Sarwer et al., 2008). In addition, some patients may report disappointment with the results or verbalize regret about having the surgery (Gallagher, 2004).

When patients have unrealistic expectations regarding the anticipated impact of surgery and have attributed most of their depressive symptoms to obesity, they are most likely to be dissatisfied with surgical outcomes. The realization that significant weight loss does not always improve all aspects of psychosocial functioning may be disappoint-

ing. Realistic expectations about the impact of expected weight loss and a determination to match expectations with major lifestyle changes yields better results. Given the fact that depressive disorder is the most common preexisting Axis I diagnosis in weight loss surgery candidates (Kalarchian et al., 2007), postoperative monitoring for the manifestation of depressive symptoms as well as the degree of satisfaction or dissatisfaction with surgical results is necessary.

## **IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH**

Empirical research is limited regarding the emotional health, psychosocial adaptation, and quality of life issues for patients following weight loss surgery. Available literature suggests a number of patients are at risk for interpersonal challenges, disordered eating, maladaptive behaviors, nonadherence with prescribed dietary and exercise regimens, and worsening psychiatric functioning. With the high prevalence of psychiatric comorbidities in weight loss surgery patients, psychiatric nurses will continue to be a valuable resource in the provision of services to this specialty population.

Preoperatively, psychiatric nurses may facilitate referral for consultation with bariatric surgeons. They also may provide psychological evaluations, assessing patients’ insight, psychiatric functioning, obesity history, and prior attempts at weight loss. Preoperative individual and group therapy sessions aimed at emotional and cognitive preparation for bariatric surgery are other examples of services psychiatric nurses provide.

Postoperatively, psychiatric nurses working with this population are responsible for assess-

ing and monitoring treatment compliance, psychosocial transition, and mental status, with an emphasis on the possible emergence of depression, anxiety, or PTSD symptoms. Postoperative individual and group treatment is focused on the provision of support and assisting patients with specific and relevant transitional issues and challenges.

More research is required to fully understand how psychosocial issues affect outcomes following weight loss surgery. Short- and long-term studies tend to focus on the easily measured physiological outcomes and have been studied more than psychosocial outcomes. Evidence-based research that investigates postoperative psychosocial outcomes is needed to generate knowledge that will guide practice in this rapidly growing population. By identifying the specific needs of weight loss surgery patients, improvements may occur in patient satisfaction, quality of care, postoperative quality of life, and surgical outcomes.

## CONCLUSION

Weight loss surgery in the United States continues to rise parallel to the increasing obesity index. Current literature suggests psychosocial and psychological functioning influence quality of life and weight loss goals. Interventions that support patients' emotional health after surgery are lacking and need to be developed.

Psychiatric nurses are in an optimal position to conduct research and contribute to the existing body of knowledge that will improve postoperative outcomes for this population. Psychiatric nurses who remain familiar with the relevant issues, best care practices, and specialized needs of weight loss surgery patients will be in the best position to provide quality nursing care.

## REFERENCES

- Applegate, K.L., & Friedman, K.E. (2008). The impact of weight loss surgery on romantic relationships. *Bariatric Nursing and Surgical Patient Care*, 3, 135-141.
- Benotti, P.N., & Forse, R.A. (1995). The role of gastric surgery in the multidisciplinary management of severe obesity. *American Journal of Surgery*, 169, 361-367.
- Bocchieri, L.E., Meana, M., & Fisher, B.L. (2002). Perceived psychosocial outcomes of gastric bypass surgery: A qualitative study. *Obesity Surgery*, 12, 781-788.
- Buchwald, H., Avidor, Y., Braunwald, E.G., Jensen, M.D., Pories, W., Fahrbach, K., et al. (2004). Bariatric surgery: A systematic review and meta-analysis. *Journal of the American Medical Association*, 292, 1724-1737.
- Christou, N.V., Look, D., & MacLean, L.D. (2006). Weight gain after short- and long-limb gastric bypass in patients followed for longer than 10 years. *Annals of Surgery*, 244, 734-740.
- Collazo-Clavell, M.L., Clark, M.M., McAlpine, D.E., & Jensen, M.D. (2006). Assessment and preparation of patients for bariatric surgery. *Mayo Clinic Proceedings*, 81(10 Suppl.), S11-S17.
- Doolen, J.L., & Miller, S.K. (2005). Primary care management of patients following bariatric surgery. *Journal of the American Academy of Nurse Practitioners*, 17, 446-450.
- Elkins, G., Whitfield, P., Marcus, J., Symmonds, R., Rodriguez, J., & Cook, T. (2005). Noncompliance with behavioral recommendations following bariatric surgery. *Obesity Surgery*, 15, 546-551.
- Fisher, B.L., & Schauer, P.S. (2002). Medical and surgical options in the treatment of severe obesity. *American Journal of Surgery*, 184(Suppl. 2), S9-S16.
- Gallagher, S. (2004). Taking the weight off with bariatric surgery. *Nursing*, 34(3), 58-63.
- Greenberg, I., Sogg, S., & Perna, F.M. (2009). Behavioral and psychological care in weight loss surgery: Best practice update. *Obesity*, 17, 880-884. doi:10.1038/oby.2008.571
- Grilo, C.M., Masheb, R.M., Brody, M., Toth, C., Burke-Martindale, C.H., & Rothschild, B.S. (2005). Childhood maltreatment in extremely obese male and female bariatric surgery candidates. *Obesity Research*, 13, 123-130.
- Kalarchian, M.A., Marcus, M.A., Levine, M.D., Courcoulas, A.P., Pilonis, P.A., Ringham, R.M., et al. (2007). Psychiatric disorders among bariatric surgery candidates: Relationship to obesity and functional health status. *American Journal of Psychiatry*, 164, 328-334.
- Kolotkin, R.L., Crosby, R.D., Gress, R.E., Hunt, S.C., & Adams, T.D. (2009). Two-year changes in health-related quality of life in gastric bypass patients compared with severely obese controls. *Surgery for Obesity and Related Diseases*, 5, 250-256.
- Psychological aspects of bariatric surgery. (2008, January). *Harvard Mental Health Letter*, 24(7), 1-3.
- Sarwer, D.B., Cohn, N.I., Gibbons, L.M., Magee, L., Crerand, C.E., Raper, S.E., et al. (2004). Psychiatric diagnoses and psychiatric treatment among bariatric surgery candidates. *Obesity Surgery*, 14, 1148-1156.
- Sarwer, D.B., Fabricatore, A.N., Jones-Corneille, L.R., Allison, K.C., Faulconbridge, L.N., & Wadden, T.A. (2008). Psychological issues following bariatric surgery. *Primary Psychiatry*, 15(8), 50-55.
- Saunders, R. (2004). "Grazing": A high risk behavior. *Obesity Surgery*, 14, 98-102.
- Sogg, S., & Mori, D.L. (2009). Psychosocial evaluation for bariatric surgery: The Boston interview and opportunities for intervention. *Obesity Surgery*, 19, 369-377.
- Weiderman, M.W., Sansone, R.A., & Sansone, L.A. (1999). Obesity among sexually abused women: An adaptive function for some? *Women & Health*, 29(1), 89-100.

---

*Ms. Grimaldi has a private psychotherapy/psychopharmacology practice, Belmont and Gloucester, and Ms. Van Etten is a Nurse Educator, Lawrence Memorial/Regis College, Medford, Massachusetts.*

*The authors disclose co-ownership of Weight Loss Surgery Resources and the distribution of education materials (<http://www.wls911.com>). The authors disclose that they have not received research support related to this article.*

*Address correspondence to Diane Grimaldi, PMHCNS, BC, 90 Concord Avenue, Suite #2, Belmont, MA 02478; e-mail: dianegrimaldi@wls911.com.*

*Received: June 18, 2009*

*Accepted: December 9, 2009*

*Posted: February 22, 2010*

*doi:10.3928/02793695-20100202-04*