The Psychologist’s Role in Metabolic Surgery

Ríos Martínez BP, Fueyo Minutti A.
Hospital Ángeles del Pedregal, México
www.blancarios.com
psychblancarios@gmail.com

In recent years, obesity has become recognized as a real pandemic. The impact of bariatric surgery on metabolic alterations of obese patients has been performed for decades now, but recently, these studies had taken new impetus, taking into account that most obese patients diagnosed with type 2 diabetes mellitus (T2DM) stop requiring medication for this disease after undergoing a bariatric procedure. A new research field has been opened for the physiopathological events of the disease and how they are affected by the different surgical procedures to control weight [1].

Obese patients have proven to suffer from higher rates of T2DM, arterial hypertension, and dyslipidemia when compared to the population at large [1,2]. These pathologies have in common the insulin resistance and belong to metabolic syndrome, currently recognized as a predictor for early cardiovascular disease. It has as well been demonstrated that a decrease in body weight can improve or reduce the severity of mentioned pathologies, which are recognized in obese patients as metabolic comorbidities of obesity. In the morbidly obese (grade III), bariatric surgery is the only method that is capable of producing substantial weight loss in a short time [3].

Papapietra [4] reports that after gastric bypass bariatric surgery, obesity metabolic comorbidities experience early improvement or resolution. In this series, the resolution rate was 97% for T2DM, 88% for dyslipidemia and 52.6% for HBP. Excess weight and insulin resistance are important factors involved in those Co morbidities.

On the other hand, when talking about metabolic surgery management, it is important to consider a multidisciplinary approach to treat diabetes mellitus and other metabolic diseases; which have cause and affect on the emotional, family, labor, social, and economic well-being of the patient (obese or not).

Therefore it is important to psychologically evaluate patients in both preoperative and postsurgical phases, given that some of the most relevant aspects for evaluation have already been postulated [5].

I. Pre-surgical psychological interview

They recommend two to three interviews prior to undergoing any surgery, which last from 45 to 60 minutes.

One of the points of utmost importance is establishing and maintaining good rapport between both the patient and his family and the multidisciplinary team, as it is essential to a successful interview, being able to seek and obtain proper, information, and later on, proper adherence to treatment.

It is important for the patient to tell the story of their own illness (obesity, diabetes, or others), as it is a key moment in which they may become more aware of their own disease and its evolution and their current personal situation (condition) [5].

Moreover, motivation is another fundamental aspect that needs to be assessed during the initial interviews, given that most patients see bariatric surgery as a magic solution to their illness. Often times, their expectations about the procedure are very unrealistic and their commitment towards change in life-style behavior is null. Therefore, our role at this point in the process is to clarify patients’ expectations, goals and objectives concerning surgery, as well as providing clear and concise information about the type of surgery they want to submit to [5].

It is also considered very useful to know the relation between a patient and the person who accompanies or takes them to their appointment as to know who else is interested in the treatment (true), as well as possible secondary motivations behind it.

Patient gender is an important aspect because, although impossible to generalize, it has been found that men and women tend to have different goals or expectations regarding surgery. Likewise, it should be noted that most of these patients can neither identify nor perceive the quantity of what they eat, so it is necessary to know behaviors and symptoms related to eating disorders; to discard or identify them, and help the patient become more aware of their behavior [5,6].
The importance of psychological factors in the evolution and maintenance of the disease are clear; that is why the psychologist must explore patient’s psycho-emotional development, social and family environment, conscious and unconscious mental representation of their body, self-esteem and self-image [7-9].

It is therefore necessary to evaluate which type and in which ways obesity has had physical, emotional, sexual and/or social affects, since difficulties in any of these areas can sometimes lead patients to seek surgery, as a way of solving their problems. Eating habits are another necessary item that should be studied to identify how often and under which circumstances the patient eats, their degree of impulsivity and frustration tolerance, as well as family eating habits and the support net he might be able to count on to make changes in his alimentary behavior [10,11].

In addition, it is essential to have knowledge about psychopathology in order to being able to identify and make a successful diagnosis. It is necessary to find out whether the patient or his family have had psychiatric backgrounds, have been in a psychological or psychiatric treatment, as well as previous hospitalizations related to their mental health [11-13].

The psychologist must inform the patient about the surgery process and the importance of psychological accompaniment and the rest of the multidisciplinary team, as well as informing the patient of the objectives of the psychological support or psychotherapy, in order for him to understand the importance of follow-up. It has been shown that a therapeutic process prior to surgery improves prognosis in short, medium and long term. To summarize, the points that were considered necessary to investigate are:

1.-Identification card (name, age, marital status, occupation, education, etc.)
2.- History of the beginning and evolution of obesity, as well as weight variations in different stages of life.
3.- Reason for consultation
4.- Expectations, goals, and objectives
5.- Family environment (base and nuclear)
6.- Life style
7.- Willingness to change
8.- Support networks (social, work, family, etc.)
9.- Self-concept
10.- Sexuality (gender, role, and sexuality)
11.- History of dietary habits (eating disorders, binge eating disorders...)
12.- Identifying what type of food the patient prefers

Some psychological contraindications have been established to evaluate the patient before metabolic surgery with the intention that the candidate undergoes intervention being as emotionally prepared as possible by carrying out previous preparation when necessary.

II. Absolute and relative contraindications for Bariatric Surgery

Usually when speaking of relative and absolute contraindications, there is still a big controversy; however we have tried to identify some of these in order to give the patient a better handle on the situation. When necessary, postpone surgery because if these contraindications are not considered the patient and his family could have higher psychological risks. Therefore, contraindications should be taken seriously and should also be discussed with the multidisciplinary group [10-15].

(a) Absolute contraindications

• Patient in current emotional crisis (emotional break, recent duel (s), etc.).
• Psychiatric disorders (schizophrenia, mania, bipolar disorder, severe depression, recent suicide attempt, etc).
• Risk: alcohol and/or drug use, eating disorders, binge eating disorder, profound mental retardation, decision of surgery by other than the patient’s own will.
• Little or no support from their family and social environment, or they are those who want the patient to be operated [5,16,17].

b) Relative contraindications

• Un-favorable family environment (dysfunctional).
• Un-elaborated past conflicts, divorce, previous suicide attempts.
• Previous history of bulimia (at least 1 year of remission).

• Previous history of alcohol use and/or drug abuse (to assess).

• Identify the secondary gains surrounding disease[5].

• That the patient considers surgery a "magic wand" and the solution to all the problems related to their general environment [16-18]. Faced by any of these contraindications, surgery is not appropriate until the patient has been subjected to psychopharmacological and/or brief psychotherapeutic treatment [12,18,19].

III. Post-surgical assessment.

Post-surgical psychological assessment and patient monitoring. The evolution of a patient undergoing bariatric surgery exhibit the following stages, which are not necessarily restricted to a certain timeframe; however, they are described using average times to have a parameter of reference.

1) Immediate postoperative phase (hospitalization).

The bonding begins to occur in the pre-surgery assessment interviews. The hospital visit during the postoperative stay has been considered a key moment for the consolidation of the therapeutic relation. Subsequently, it has been suggested to define an average of 12 follow-up sessions, which each psychologist can distribute according to each patient's needs. Therefore, the psychologist can distribute according to the necessities of each patient, leaving open the possibility for patients requiring psychotherapy to enter treatment on a weekly basis [4,12,13,20].

(2) Intermediate postoperative phase. (15 days to 1 month, time is variable according to each patient).

Hospital syndrome, feeling of illness and anxiety that patients with co-morbidities generally experience; should be avoided, so it becomes a good and important moment to provide the patient with psychological support [5,12,20].

(3) Late postoperative phase:

(a) Change in food-related habits. (1 to 3 months)

Eating becomes annoying because of the restriction in terms of quality, quantity and schedules for food.

(b) Handling of their partner, family, work, and social relations

Patient should develop self-care skills to avoid anyone who wants to tempt and ruin him and should learn to set limits on his feeding and habits, allowing him to take responsibility for the care of his own disease and surgery.

(c) Adequate time for giving follow-up to the patient

The general consensus is that a year is sufficient time to accompany the patient, favoring new coping behaviors and emotions, independent of cases requiring prolonged psychotherapy to overcome specific conflicts and dynamics true) [5, 12].

Conclusions

We believe that, due to the existence of several psychological factors involved in both the pre-surgical period and post-surgical evolution, it is important to resolve these aspects to promote better patient adaptation to their family, social, work, and sexual environment and thus be able to learn to live a better lifestyle, changing self-aggressive and harmful behaviors that affect their health and quality of life in general. It is also important to modify eating habits and learn more about their alimentation, so it is highly recommended that within the role of the psychologist, there is psycho-education for the patient care.

References


17. NAASO, North American Association for the Study of Obesity in Obesity Society (internet) www.naaso.org


