AdventHealth
Celebration Bariatric Surgery
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To: All Providers of Preoperative Psychological Evaluation

Re: Pre-operative Psychological Evaluation for Bariatric Surgery Patients

The purpose of this letter is to provide guidelines for the Pre-Operative Psychological Evaluation process as it relates to our Bariatric Surgery patients. It outlines the information we at Celebration Bariatric Surgery are looking for and how we would like your summary and any after-care plans to be handled. This will in turn allow us to achieve uniformity and consistency in processing the information provided.

The psychological evaluation is a very important part of the overall evaluation process. Therefore, we require a written report from the evaluating professional before a patient can proceed with bariatric surgery.

In this situation, we also generally leave it to the professional evaluating the patient to decide which tests [such as the MBMD® (Millon® Behavioral Medicine Diagnostic) and the MMPI-2-RF® (Minnesota Multiphasic Personality Inventory-2-Restructured Form®)] they feel are the most appropriate means of assessing each individual patient.

Given that many individuals who present for bariatric surgery also experience a range of psychosocial and behavioral concerns, pre-surgical behavioral assessment and post-surgical behavioral aftercare are designed to identify the various vulnerabilities and risk factors that may complicate bariatric surgery. The psychological evaluation should specifically identify areas where additional support (if needed) is required in order to cope with the radical psychological, physiological, and behavioral adjustments that often follow bariatric surgery.

By considering the psychological, social, and behavioral strengths as well as barriers, an extensive conceptualization of the patient may be developed with the purposes of creating an appropriately tailored pre and post-surgical plan of action for the patient. Following the pre-surgical assessment, patients should be specifically provided with recommendations that may support long-term weight management with a focus on sustainable health promoting behaviors post bariatric surgery. Patients may also be directed to engage in personal therapy, treatment for substance use/abuse concerns, or treatment for an eating disorder if indicated.

We have provided below our guidelines (based largely on recommendations of the American Society for Metabolic and Bariatric Surgery) regarding why the patient is being evaluated and specific areas we will need addressed. Please reference the link below to find the full ASMBS recommendations for pre-surgical psychosocial evaluation of bariatric surgery patients. http://asmbs.org/wp/uploads/2016/06/2016-Psych-Guidelines-published.pdf

Overview of the Pre-Surgical Psychological Assessment

Pre-Surgical Assessment Outline

1. Weight/Diet History
    a. Weight trajectory over time
    b. Types of weight interventions tried in the past
2. Eating Disorder Symptoms
    a. Binge eating symptoms/disorder
    b. Night eating syndrome
    c. Compensatory behaviors
    d. Anorexia nervosa
3. Other Eating Behaviors
    a. Eating habits likely to undermine successful weight loss after surgery

b. Frequency of meals/grazing, snacking patterns, consumption of caloric beverages
c. Meal planning and preparation, portion sizes, food choices
d. What is the patient's ability to initiate goal-directed behavior?
    i. The evaluator can provide education about the changes involved in the post-surgical eating regimen
e. Overall goal: Facilitate proactive behavioral problem solving to enhance postsurgical adherence and adjustment

4. Psychosocial History
    a. Psychiatric history
        i. Severity and impact on patient's function
        ii. How stable is patient and for how long
        iii. Is there appropriate mental health treatment in place
    b. Depression
        i. Depression symptoms truly reflecting depression verses depression due to obesity
        ii. Interventions that should be in place so that patient's mood does not interfere with post-surgical self-care and behavioral adherence or pose a risk for self-harm
    c. Current/past suicidal ideations/attempts
    d. Bipolar disorder
        i. Current function and stability
        ii. Degree to which symptoms will affect postsurgical adjustment & adherence
    e. Anxiety Disorders
        i. Agoraphobia/social phobia and the impact on post-surgical adherence to post op visits
    f. Schizophrenia
    g. Personality disorders
        i. Mood lability, attention-seeking, and self-harming behaviors
    h. Developmental and family history
        i. Significant life events: family disruption, abuse, learning difficulties
        ii. PTSD
    i. Current and past mental health history
        i. Previous mental health treatment and psychiatric hospitalizations
        ii. Substance abuse disorders
        iii. Psychotropic medication regimen (if applicable)
            1. Reinforce awareness that absorption, potency and/or effectiveness may be altered after surgery
            2. Advise patients to see prescriber if medications will need to be altered
    j. Cognitive functioning
        i. ADD – does patient have the ability to adhere to postoperative behavior regime
        ii. Comprehension skills
            1. Capacity to understand to give a truly informed consent:
                a. procedure, risks, benefits, and postoperative behavior regimen
        iii. Cognitive tests may be applicable if felt necessary
        iv. Adaptation for surgical team to compensate for patient ability to comprehend information
    k. Personality traits and temperament
5. Current Stressors
    a. Can be acute and/or chronic stressors
        i. Divorce, severe illness, recent death of a loved one, etc.
    b. Impact adherence and self-care
    c. Utilization for social support
    d. May be beneficial to delay surgery until stressor has resolved or is under better control
6. Social Support
    a. Extent and quality of social support
    b. Presence and quality of relationships with:
        i. Romantic partners
        ii. Family members
        iii. Community organizations
    c. Those with suboptimal support may require more frequent pre- and post-operative contact
7. Quality of Life
    a. Impact of weight on quality of life
    b. Expectations of surgical outcomes
8. Health Related Behaviors
    a. Substance abuse/dependence

        i. Current and past use of alcohol, nicotine, prescription medications
        ii. Reinforce awareness of potential for cross addiction
    b. Smoking
        i. Need for cessation preoperatively
        ii. Aids for cessation
    c. Adherence
        i. Motivated and willing to engage in postoperative dietary and behavioral changes
        ii. Examine past adherence behaviors to provide the best possible estimate of the likelihood that the patient will demonstrate adherence after surgery
            1. attending appointments, taking medications as prescribed, continuous positive airway pressure use etc
        iii. Identify potential barriers to adherence
        iv. Formulate interventions that can improve adherence after surgery
            1. Emphasize support group attendance
    d. Physical activity
9. Patient Motivation and Knowledge
    a. Weight loss expectations
        i. Evaluation for unrealistic expectations
            1. Weight loss
            2. Resolution of comorbidities
    b. Motivation
        i. Reasons for pursuing bariatric surgery
    c. Knowledge of surgical procedures
        i. Appreciation of anatomical changes
        ii. Appreciation of risk
        iii. Comprehension of postoperative behavior regimen

Potential Relative Contraindications to Bariatric Surgery

- Recent or multiple suicidal/homicidal thoughts or attempts
- Recent hospitalizations for mental illness
- Active symptoms of obsessive-compulsive disorder and bipolar disorder
- Problematic Borderline Personality
- Untreated active eating disorders
- Untreated active substance abuse or dependence
- Active compensatory mechanisms such as binge eating/self-induced vomiting for weight/shape
- Any active, severe, and untreated psychopathy

Written Report:

At a minimum, the evaluator's report should include a brief summary of the relevant findings of the interview and, when applicable, other sources of clinical information. Most importantly, the report will include requirements and/or recommendations based directly on the findings of the evaluation. These may include, when applicable, suggested pre- or post-surgical interventions designed to minimize barriers to optimal psychosocial and medical outcomes after surgery. For instance, rather than simply noting that the patient has severe depression, ideally the evaluator will recommend specific steps to be taken or interventions that should take place to ensure that the patient's mood symptoms do not interfere with postsurgical self-care and behavioral adherence or pose a risk for self-harm. Ideally, recommendations will be specific, with a clear delineation of what must occur before the patient will be ready to proceed with surgery.

Collaboration with the multi-disciplinary team of providers caring for the patient is widely considered a standard of care. Discussing this process directly with the patient and documenting the active collaboration among team members is recommended.