

Weight Loss Surgery readiness...

My patients tell me, "Having bariatric surgery will take care of my weight concerns forever..."

In the past decade, hundreds of thousands of people in the United States have had bariatric surgery. Their reasons for doing so are varied. It is probably fair to say, however, that every person had substantial weight loss as one of their primary goals when making the decision to have either Gastric Bypass or Lapband surgery.

In conducting pre-surgery psychological evaluations for patients preparing to have weight loss surgery, one thing has become blatantly clear to me. The vast majority of patients are not giving nearly enough consideration to the long-term realities of a lifelong, healthy lifestyle (which includes sustained weight loss). This observation is supported by the fact that, according to numerous sources, a large percentage of persons who have bariatric surgery regain a good deal of their weight in the two to ten years following their surgery.

What is that all about!? It is about the fact that our 21st-century humans, particularly those of us in the United States, are not known for our patience with delayed gratification or the notion that we must work for what we attain. Now don't get all worked up if you happen to be in the minority of people who prides himself on not being at the front of the instant gratification line... remember, we're talking about the masses here. It is well documented that our culture is famous for the 'I gotta have it now' attitude. This pertains to the latest electronic gadgets, our drive-through meals, and the anticipated weight loss associated with bariatric surgery.

Prior to having bariatric surgery, the patient salivates (forgive the pun) when thinking about losing 100+ pounds, wearing clothes 12 – 20 sizes smaller, and being more physically attractive. They tell me in enthusiastic terms how they can't wait to buy clothes at the trendy, popular stores, how thrilling it will be to ride the roller coaster with their children, and how fantastic it will be to walk briskly through the airport. Their eyes gleam when they talk about how gorgeous they will look next year at the company Christmas party and their eyes fill with mischief when they snicker about how 'hot' they will be at their next class reunion. And then, after I gush with shared delight over the happiness that their future holds, I sadly burst their happiness bubble – with reality.

Admittedly, I hate bursting people's bubbles because I find few things more aggravating than having my own happiness bubbles burst. My job, however, in the role of psychologist, is to inform these patients what they will have to do in order to still look 'hot' at the class reunion following this upcoming one. My role is to help them prepare for what they have to do to be able to accompany their grandchildren to the theme park and to have the good health and stamina to not

only walk briskly through the airport, but be able to walk around Rome once they get there!

Here's how the bubble-bursting goes (after the joyful foreshadowing of blissful future 'thin events', of course). I ask the person considering the surgery the following questions:

- What factors have led to your success in losing weight in the past?
 - Their answers include things like "I ate smaller portions, I prepared my own food, I went to the gym, I kept a food diary, and I stopped drinking sugary sodas".
- How much time do you currently devote to physical activity on a weekly basis?
 - Their answers rarely include spoken words, but are more like grunts, shifting in their seats, and looking at the floors. Nobody wants to tell me they really hate to exercise and so they don't. I tend to rescue them at this point by saying something like, "So exercise is something we'll have to be adding to the lifestyle", which leads nicely to my next question.
- How much time do you think you will need to devote to physical activity on a weekly basis after you have the surgery?
 - Their voices return, although they remain less than enthusiastic: "Yeah, I know exercise is something I'm going to have to do... but it's hard" (you will learn that those three words, when used together in that order, start my blood heating toward a boil). At this juncture, however, I simply nod in acknowledgment of their response, and ask:
- What is it that has kept you from exercising in the past?
 - Oh, boy! Now they find their voices! "I just hate to get up early in the morning to exercise and by the time I get home at night I am just so tired!" "I don't have anybody to go to the gym with and I'm not about to go in there alone looking like this!" "You live in this state, too. You know how HOT it gets here. Who can exercise in this heat?" "I would go to the pool, but it takes so long to change my clothes and do my hair and makeup all over again". "I have a treadmill, but I'd have to dig it out from under all those clothes hanging on it". The list goes on and on – and you know you've heard them from your own mouth a time or two!
- Have you ever done any of the following: emotional eating? binge eating? middle of night eating? purging?
 - Most people readily admit to emotional eating, many admit to binge eating episodes, a few admit to eating in the middle of the night, but it is the rare brave soul who admits to having purged.

Now is where the person really feels stung. Stinging is not the intention, although making this necessary point is. "How", I ask, slowly and kindly, "will surgery

assist you in preparing your own food rather than going to the drive through? How will surgery increase your odds of going to the gym, keeping a food diary, or not drinking sugary sodas – all things you noted that you have done in the past when you successfully lost weight?” I pause here, before continuing, and then, in an extremely quiet and understanding voice, (remember, my purpose is not to shame or embarrass): “How can surgery get you to go to the gym, alone or otherwise? How can surgery get you up in the morning to exercise or keep you from being fatigued when you get home in the evening or make the weather cooler or change the fact that to go swimming you have to change clothes – twice?” And finally, in an even gentler tone, I ask, “And is it possible for surgery to prevent you from emotional eating, from bingeing, from eating in the night, or from purging?” Almost in a whisper, and leaning forward to psychologically reach out to them, I add, “Surgery cannot do any of those things. Only you can. And you *must* understand that those healthy behaviors are things you will have to do for your entire lifetime if you want what you say you want: a long, healthy life with sustained weight loss. If you are not ready to do all of those things (mentioned above) on a consistent basis, you need to rethink your decision to have bariatric surgery”.

Stunned silence. I say nothing, watching their emotions swirl. I see flashes of anger (“How dare she be so mean?”), passing sadness (“I hate the thought of having to do all of that”), moments of retaliation (“I’ll show her”), and eventually, acceptance that what I have said is true.

More silence. I let them digest this information.

Finally I hear, “So what are you saying? That I shouldn’t have this surgery?” “No”, I reply. “What I am saying is that you should have the surgery if, and only if, you are aware of what the surgery can do for you and what it can’t”.

Before they have a chance to respond, I add, “Surgery can *initially* help you in terms of appetite suppression. Surgery will *initially* keep you from eating large portions. Surgery *cannot* guarantee you long-term weight loss because surgery cannot make you exercise every day. Surgery cannot make you get enough sleep. Surgery cannot make you eat breakfast. Surgery cannot make you drink enough water. Surgery cannot make you take essential vitamins. Surgery cannot ensure that you eat protein first, followed by fruits and vegetables. Surgery cannot stop you from putting sugar and fat and unnecessary carbohydrates into your mouth. Surgery cannot limit your portion sizes. And most importantly of all, surgery cannot address the underlying emotional issues that have contributed to the unhealthy behaviors resulting in your obesity. These are the things that you must do if you are to have sustained weight loss over time.”

More silence. Thinking. Contemplating.

I continue. “I completely support bariatric surgery as a starting point to help you lose a lot of weight in a short time. The danger is that people get fooled because they do lose so much weight so quickly without necessarily doing the things noted above. They have a false sense that the weight will continue to fall off and stay off as it does in the initial months following the surgery without their having to do anything. This is the psychological danger associated with bariatric surgery”.

With that, I almost always hear that this patient is fully aware of what she needs to do and will, without a doubt, do all of those things after the surgery. She “just needs a boost to get started”. In fact, it amazes me how often I hear that one would vehemently do “ANYTHING” to lose the weight. Perhaps rather than asking what they are willing to do to lose weight, I should ask what they are willing to do to keep it off forever. Lesson to self... Either way, I suspect I would get a resounding “ANYTHING” to either question. Before surgery.

After surgery, it’s amazing how many people discover “I’m just not an exercise kind of person”. I like to tell them that I’m not really a tooth-brushing kind of person but I do it anyway. Sort of makes the point without my having to say a lot.

Also baffling is the memory loss that seems to accompany bariatric surgery. Promises made about maintaining food and exercise diaries are forgotten. The order of food intake (protein first) has been dislodged from memory. The importance of breakfast and continual intake of water are distant memories.

Remarkably, and not surprisingly, there is a miraculous ability to recall (and oh, so euphorically), the route to the favored “old stomping grounds” such as Krispy Kream, Dairy Queen and ‘hidden’ candy drawer. And the courage! No – I’m not talking about courageously attempting new forms of physical activity like taking a yoga class or signing up for a 5K walk. I’m referring the daring adventure to “try” old favorite foods... “just to see how I react to them”. A misdirected sense of adventure.

What makes it so? Why do patients who earnestly desire to lose the weight and honestly vow to follow the post-surgery regimen give in so easily to the default, negative behaviors that led to their need for weight loss surgery in the first place?

Two main reasons. First, they developed incredibly bad habits regarding food and physical activity. Way too much of the former and way too little of the latter. Secondly, they are unaware of, and unfortunately, far too often, uninterested in addressing, the emotional issues that have everything to do with their obesity.

This is because they truly don’t understand the enormous role that emotional issues have in the development of their obesity. More poignantly, many people seeking the surgery protect themselves from their emotional pain by denying it.

Prior to the formal assessment I conduct with bariatric patients, they each complete a personality inventory, the Personality Assessment Inventory (PAI). The PAI is a self-administered, objective inventory of adult personality and psychopathology containing 344 items. It provides information to assist diagnosis, treatment and screening for psychopathology which parallels DSM-IV (the book used to diagnose mental disorders) categories. A full half of the bariatric patients have results that point out their protective defensiveness about their emotional issues. The report results for 50% of the bariatric patients I interview includes the following, "With respect to positive impression management, the client's pattern of responses suggests that she tends to portray herself as being relatively free of common shortcomings to which most individuals will admit, and she appears somewhat reluctant to recognize minor faults in herself. Given this apparent tendency to repress undesirable characteristics, the interpretive hypotheses in this report should be reviewed with caution. Although there is no evidence to suggest an effort to intentionally distort the profile, the results may underrepresent the extent and degree of any significant findings in certain areas due to the client's tendency to avoid negative or unpleasant aspects of herself."

These words genuinely baffle the respondents. They insist that they "answered the questions honestly". I assure them that I believe they did and attempt to explain that along with being obese, there is a lot of self-deception, which does not mean lying. Self-deception is a way to ward off emotional pain ("I eat partly because I want to hide my femininity from the world", or "I eat because I had to hide food when I was child so my mother, who called me fat, wouldn't let me eat cookies"). Self-deception is a way to assist a person in keeping problems external ("It's not my fault that I am obese... I come from an Italian family who love to eat"). Self-deception also helps people "pretend" that they do not have "issues" ("I'm perfectly happy in my life – except for my weight", even though many of these patients have histories of physical or emotional abuse, are in bad marriages, have had several failed marriages, or have children in trouble). Their PAI profiles are indicative of how they keep their emotional pain at bay – and often times eat as a way of avoiding the pain. Denial is another word for self-deception. No one wants to hear, "Sorry. You're just in denial". The truth is that we all live in denial about some aspects of ourselves.

There are two common areas of denial I see with the bariatric population. One is in relation to how much their eating-related behaviors ("I really don't eat that much"; "I'm not an emotional eater"). The second is related to painful emotional issues they still carry from childhood. "I had a wonderful childhood", they claim. Some did; some didn't. The reality is that most adults have unresolved pain related to something from their childhood that interferes with their ability to be their emotionally healthy best adult. Most people, the bariatric population

included, are often reluctant to admit to, and even more reluctant to address these past hurts.

The hard core bottom line is, that unless a person has a specific medical condition or is on medication that truly results in their gaining weight, a person is obese because he or she eats too much (usually of the wrong things) and exercises too little. And there are almost always emotional issues associated with their eating.

These two things, eating and exercise behaviors and underlying emotional issues, if not addressed and changed after bariatric surgery, will almost invariably result in the patient's regaining the majority of his or her weight two to ten years following surgery.

Understanding the eating and exercise behaviors is easy. And there are truly only a handful of behaviors that bariatric patients must do to lose the weight and keep it off. These include: 1) get enough sleep, 2) always eat breakfast, 3) when eating, be sure to eat protein first, followed by fruits and vegetables, and then carbohydrates, 4) drink water throughout the day, 5) take vitamins and minerals, and 6) exercise for 60 minutes per day.

Carrying these things out is another story. At face value, those are straightforward, relatively simple things to do. What is it then, that prevents so many bariatric patients from following these simple guidelines, resulting in the majority of them gaining back a good percentage of the weight they lose during the first two years following surgery. It is almost always the fact that there are underlying emotional issues. These issues are so powerful that they prevent a person from diligently practicing these behaviors that would result in sustained weight loss - which they previously swore they would do "anything" to get.

What are these emotional issues I keep referring to? And what makes them so powerful that they would interfere with a rational, intelligent adult's willingness to work through them?

In a word: fear. Feelings scare people, especially unpleasant feelings. Walking head-on into the feelings that they have been avoiding by overeating, is not something these people are enthusiastic about. They fear feeling again the way they did when kids called them "fatso" or "tub-o-lard". They fear feeling the way they felt when their mom took them to Weight Watchers at the age of 10 or when their sibling wouldn't let them hang out because they were embarrassed at having a fat sister or when their father "oinked" at them as if they were a pig. They fear talking about the way they used food to comfort them when they were scared while their parents fought. They fear acknowledging that being overweight hid their femininity so males would not look at them sexually or

touch them the way Uncle Stan did. The adult person forgets that now, in their adult life, they have healthier ways of coping than they had when they initially endured what they are trying to forget and when they experienced the feelings they are trying to avoid. Food has been their means of avoidance. Other people choose alcohol or drugs or excessive spending or gambling to accomplish the same avoidance of feelings. Obese people use food.

It's understandable that people want to consciously avoid pain. Yet they create tremendous pain in their adult lives in a vain attempt to avoid past pain. Tragically, the newly created pain causes heartache to the people they love the most in their present lives.

It is impossible to deny that the spouse and children of an obese person is plentiful and heart wrenching. Pain, neglect, and often times, abuse. Spouses and children feel ignored and abandoned when the obese person spends a lot of time with food, which they treat as a treasured best friend. Obese people spend exorbitant amounts of time eating food, thinking about food, or in activities surrounding food. They may neglect family members because they are "socializing" with friends – at restaurants. Family members take a back seat to watching television shows on the Food Network because the obese parent is "learning to cook". Planning where and when they will next eat can interfere with actively listening to a spouse or child, who is aware that the obese parent is "spaced out" and not paying them attention. After a binge, the "binger" is of no use to anyone as they are often on a "sugar high", sound asleep due to the chemical reaction following the binge, or pining away in the despair of shame, having vowed to themselves that they would "never do that again".

Children are ashamed and embarrassed by morbidly obese parents. They also feel angry with *themselves* for feeling that way. Kids have trouble understanding why they have the parent who can't go on field trips or take them to the zoo. Resentments by children compound over time as obese parents become less able to be involved in their lives. Sporting activities are not attended. Family vacations are often impossible because the obese parent is unable to participate in most activities. Emotional distances increase and the child's feelings toward the parent range from anger to apathy. Or the child may feel responsible for taking care of the parent, either physically or emotionally. They may give up their own social life to spend time with the parent who cannot get around easily. This will, in time, lead to resentment on the part of the child, although the feelings may or may not be acknowledged.

Spouses, although they may love their obese partner, often experience a range of emotions related to obesity that is intertwined in their marriage. Sex can be problematic in some marriages in which there is an obese partner, perhaps due to physical inability, discomfort or lack of desire related to the extra weight.

Being responsible for activities the obese person cannot participate in can become burdensome for the non-obese spouse. In marriages where both partners are obese, any children in this family will have even more emotional issues to deal with.

Perhaps the most devastating effect for children of a parent who is obese is the increased likelihood of the child being obese. It is known that the greatest predictor of childhood obesity is maternal obesity. The behaviors of an obese mother, including her eating behaviors, greatly affect what the child learns. It is currently being debated as to whether feeding a child so that he or she is obese is a form of abuse.

Abuse? Maybe. Undoubtedly unhealthy for the child. Unhealthy in more than a physiological sense. Seriously unhealthy in an emotional sense, as well. In addition to experiencing the abuse from peers that most obese kids suffer, the child will eventually develop resentment toward the parent that "allowed" him to become obese before he had any understanding or ability to take personal responsibility for his weight and health. And so goes the pattern. Children learn what they live.

So what can be done to prevent the gastric bypass patient from regaining their weight? Professionals can, and have the ethical responsibility to inform their patients of the disastrous consequences they face if they do not do the handful of behaviors directly associated with their eating behaviors. The professionals need to inform them, as well, that if they are not following through with each of these behaviors on a consistent basis, it likely means that they have some emotional issues to deal with and need to see a therapist to work through them.

What is the connection between addressing the emotional issues and being compliant with the healthy eating behaviors?

Michelle, a single, obese woman of 42, who has worked as an accountant for the past 18 years, has been obese since the age of 15 when a male minister sexually abused her for a ten-month time span. Michelle was a "late bloomer" who emotionally associates her femininity with her abuse. She subconsciously gained weight to "hide" her sexuality. She has lost weight three times over the years, but each time when men would start to pay her attention, she gained her weight back. Susie is consciously aware that she uses her weight to keep men from paying attention to her, lest she again be hurt by a male. In preparation for bariatric surgery, we discussed the fact that unless she deals with the pain associated with her sexual abuse, a topic she readily admits she does not want to discuss, she will very likely sabotage herself and eventually regain all of the weight she loses after surgery. However, if she does work through the pain of the abuse, she will no longer need the psychological protection of the weight to

guard her against men. In therapy, she can learn that not all men will hurt her, and that she can be assertive with men and set healthy physical and emotional boundaries without the use of food.

Dan, a 29-year-old obese, married man, works as an assistant manager for a rent-to-own furniture company. Dan has been working toward a bachelor's degree "on and off" for the past ten years. Mark and Brad are Dan's two older brothers. Their opinion of Dan has been of utmost importance to Dan since he was a child when their father was tragically killed in an accident. Mark and Brad regularly teased Dan throughout his childhood and adolescence about wearing "husky" jeans and being "too fat" to play sports well. Dan is unhappy with his job, the fact that he has no college degree, and about being 335 pounds. Unless he works with a professional to deal with the feelings surrounding his lack of self-esteem, part of which is related to his obesity, he is likely to gain back any weight he loses after having bariatric surgery.

Very often, the emotional issues that stand in the way of a person achieving success, whether that be in terms of advancing in one's career or keeping weight off following surgery, are partly or fully subconscious. Denial of painful emotions allows us to carry on with life. That same denial, however, usually ends up costing more in the way of sadness, anger, regret and a wide range of other feelings.

For these reasons, professionals need to inform patients of the dangers of not addressing past hurts, fears, disappointments and a low self-esteem as they relate to sustained weight loss following bariatric surgery. The patients, themselves, however, need to make the decision to address these issues, ideally with help from a trained professional.

It is said that knowledge is power. I beg to differ. Most of the bariatric patients I have interviewed have more knowledge about weight loss, diets, nutrition and bariatric surgery than do many health care professionals. Bariatric patients know what they need to do to lose weight. The vast majority of them have done it before. Knowing what to do to lose weight also means knowing what to do to keep the weight off, as this is simply doing more of the same things that led to the weight loss in the first place. Those bariatric patients who have lost weight before, have also gained it back again. For many, it has been an up and down cycle, repeated over time. So knowledge, therefore, does not necessarily equate to power.

It is more accurate to say that knowledge in action is power. The patients have the knowledge of how to lose weight. They have put it into action and have gotten the desired effects. If they were to continue to use their knowledge and continue to engage in the behaviors that led to the weight loss, they would have

sustained weight loss over time. They stop the healthy behaviors because they are uncomfortable with the results. Surgery will not change the fact that they are emotionally distraught when they lose the weight and so they gain it back. Therapy, however, addressing and dealing with the issues, can help the patients remain consistently active in following through with those behaviors that result in weight loss and assist in sustained weight loss.

Addressing the underlying emotional issues surrounding obesity provides the bariatric patient a much greater chance of keeping the weight off that they lose during the months immediately following surgery. Now that you know... there's no excuse not to!

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