A Case of Clinical Anxiety Following Successful Bariatric Surgery: A Cognitive Behavior Therapy Approach

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Abstract

A case study of post-surgery anxiety about weight gain, hunger, and a desire to binge is presented. A cognitive behavioral therapy approach to resolving the patient's issues is presented, illustrating cognitive behavioral therapy techniques of challenging illogical thoughts, stimulus control, mindfulness, response substitution, and reconceptualization.

Introduction

The majority of bariatric surgery patients experience improvements in their mental health status post-surgery.[1] For example, a recent study that investigated the use of antidepressants in post-surgery bariatric patients found a decline in the use of serotonin uptake inhibitors over time.[2] Nevertheless, some patients experience an increase in psychiatric problems post-surgery.[3] The following case study represents one such case of increased symptomology post-surgery. It also exemplifies the use of cognitive behavioral therapy (CBT) as an evidence-based treatment for bariatric patients.

Clinical Case

Mr. C was a 31-year-old single man who lived with his father, younger brother, younger sister, and his younger sister’s child. Mr. C was the third oldest of 10 children. He fondly remembers helping his mother care for the younger children. While Mr. C was still a teenager, his mother died suddenly. He took over much of his mother’s role in the family; cooking, cleaning, and caring for the younger children. He has been on disability for over 10 years due to his obesity and has never worked outside of the home.
Mr. C had never sought mental health treatment. Despite his apparent success after LSG, he sought out the help of a psychologist because, as he described it, he was experiencing “mind hunger.” He explained that he thought about food more often than in the period immediately after his surgery. He also found it more difficult to resist temptation. Further, during attending support group meetings, he met bariatric patients who had significant weight regain, which caused him to fear that he could also experience weight regain.

### Problem #1.
I observed that when other people’s unhealthy eating habits were in his personal space, his own desire to deviate from his planned diet was jeopardized. He gave the following two examples to illustrate this:

1. Mr. C did not yet have his driver’s license and often traveled with Linda, another bariatric surgery patient. Linda usually had a box of crackers in the car and often encouraged Mr. C to eat “just a few” or told him that deviating from his diet “wouldn’t hurt,” while thrusting the box in his direction.
2. Mr. C kept his food on a particular shelf in the pantry at home. Often his younger siblings, after purchasing their own junk food, would leave it on his shelf, thereby enticing him to eat the food.

### Problem #2.
Since his mother’s death, Mr. C found that he became better able to manage the home, thus leaving him more free time. His personal growth outside the home did not progress with his weight loss. With spare time and not enough external stimulation, his mind wandered toward food.

### Problem #3.
As the cook in the home, he recalls memories of his mother as the cook and his role helping her. He not only remembers the taste and smell of his mother’s cooking, but finds some comfort in these sensory memories when grieving over her death. As he thinks about food more often than he did after surgery and has a harder time resisting temptation, he is at once afraid he will gain weight and simultaneously comforted by his thoughts of his mother.

### Problem #4.
As many as 30 percent of post-surgery bariatric patients experience significant weight gains. Mr. C was fearful that he could be one of those people who regained substantial amounts of weight after his first postoperative year. This apprehension became an obsessive thought every time there were food cues in his environment, including his own hunger.

Following the assessment, the next phase of treatment was the development of an individual treatment plan. For each of the previously mentioned problems, a treatment strategy was developed and a CBT approach to therapy was taken. CBT has been shown to be an efficacious approach to psychotherapy in general and in the treatment of medical conditions.

### Case Conceptualization
Within a CBT framework, we created a treatment plan that encompassed the four specific problems. Snack foods, like crackers, were conceptualized as stimuli associated with eating responses. These stimuli are effective in eliciting eating primarily when they are present. For Mr. C, an initial task was to chart the thoughts that trigger the desire to eat. His first action could be to remove this stimulus from his field of vision, by making sure that his food and his siblings’ snack food is not on the same shelf or cabinet in the kitchen. Or, if driving with Linda, he could ask her not to offer snacks to him or not eat them while driving (also a good safety precaution). Once he experienced this Pavlovian response to junk food and its accompanying desire, he believed he must or should snack. However, the thought or desire of eating does not necessarily invoke the imperative to eat. It can lead to a focus on the present, as an objective observer, using the principle of mindfulness, a technique that falls within the purview of CBT. In this way, Mr. C was able to see, think about, or desire food without eating. At present, he is working on the ability to choose to do something else or, if he wants to eat, he can choose what he wants to eat.

Regarding the second problem identified, only having a modicum of external stimulation and filling spare time with thoughts of food, Mr. C is exploring going to college. Starting with small steps, he has looked online at the local community college and is preparing to take the placement exam and complete his application. Along with these graduated, small steps, he has learned tools to keep debilitating anxiety at bay by substituting his tendency to stay home and ruminate with college attendance.

Mr. C associated food with his mother and found comfort in his grief by being in the kitchen. CBT has been used to help patients make a distinction between adaptive and maladaptive courses of grief. He was encouraged to find adaptive ways of remembering his mother and dealing with the pain of her loss. Examples include him attending local hospice bereavement group meetings and talking about his mother when he volunteers to speak at bariatric surgery support group meetings. If his mother’s death has led him to seek food out of comfort, there is a good chance that the audience in both of these groups can identify with Mr. C’s emotional eating.

Finding new, healthy responses that inhibit more dysfunctional responses, counterconditioning, is another CBT treatment approach.

When Mr. C thinks about the fact that many people who have had bariatric surgery regain significant amounts of weight, he is committing a number of cognitive errors or logical errors that can be challenged using CBT. Some authors claim that weight regain is the most common fear that bariatric surgery patients experience. Mr. C believes this is unique to him and that weight regain is not “normal.” In counseling, we addressed this fear of significant weight gain as a common one and a small weight gain classified as normal. By helping Mr. C reconceptualize normal to include a small gain, he has become less fearful of the future. Part of our discussion focused on how what he hears or sees in the mass media about weight regain after surgery is not representative of what the average patient experiences; it is often sensationalized, representing the atypical patient.

With his fear of weight regain, Mr. C was projecting himself into the future, worrying about what might but has not yet happened. This has been referred to in the bariatric surgery literature as “anticipatory anxiety.” When some of his fears were explored in more depth, it was revealed that, in fact, he was continuing to lose weight, never having gained since his surgery. Also, modest weight gains are normal after bariatric surgery, and he is not one of the 5 to 10 percent of bariatric surgery patients who experience significant weight regain. As long as he continues to lose or maintain weight, he is not in jeopardy. If he begins to gain weight, he can choose a rational solution before reaching the point of “failure” by consulting his surgeon, dietitian, or psychologist on his weight loss team. We have even worked together to set a point at which he will ask for help, a 25lb. (11.3kg) regain in weight, an amount Mr. C selected. Mr. C selected this set point with the understanding that there is no research to support the 25Lbs. as a set point and some researchers have recommended re-starting weight loss efforts with as few as 5Lbs. (2.3kg).

Moreover, part of the therapy process entails helping the patient move beyond a fixation with sheer number to consider other outcome measures, such as comorbidities and quality of life.

This cluster of anxiety-related symptoms was diagnosed as a mental disorder affecting his general medical condition (DSM-IV TR Axis I diagnosis 316). The mental disorder is anxiety disorder, not otherwise specified (NOS), and the medical condition is morbid obesity (specified on axis III). The criteria for this diagnosis include a general medical condition with psychological factors that influence the course of the medical disorder, interfere with treatment of the condition, pose additional health risks, and/or may exacerbate his medical symptoms, which, in this case, is his weight.
Discussion

The techniques used in this case fall within the scope of CBT treatment. CBT is based on a conceptual understanding of patients, including their beliefs and their behaviors, utilizing a variety of techniques to create cognitive changes that result in lasting behavioral and emotional changes.[22] CBT relies on a collaborative relationship between the patient and the therapist that is focused on present problems, with an understanding of how the past helps understand current beliefs, feelings, and behaviors.[23] In the current case, Mr. C’s relationship with his mother and his role in the family after her death help us understand some of his grief and propensity to key in on what foods are in the cupboard.

CBT is a rational approach that helps patients analyze how they think about their experiences, for it is those cognitive experiences that determine how one reacts emotionally.[24] In this way, if Mr. C believes he will gain weight, anxiety is likely to ensue. If he believes that wanting to eat will mean that he will overeat, and then will gain weight, he will be anxious. This kind of thinking is often referred to as catastrophizing, thinking that sees the worst possible outcome of one’s behavior. Another CBT approach involves identifying and then challenging faulty beliefs. In this case, Mr. C’s desire to eat leading to the belief that he must or should snack is faulty because although he may want to eat, he does not have to, must, or should eat. In CBT, patients are taught how to ask questions that elicit the extent to which their beliefs are true, can be looked at in another way, or are the consequences as bad as they believe.

Conclusion

On reflection, this case study has exemplified the kinds of post-surgery thoughts and feelings that bariatric patients might experience that can otherwise undermine successful weight loss and psychological function. CBT has been used to give examples of the kinds of techniques that can be used that are evidence based, time limited, and collaborative. This collaboration is part of the team approach supported by bariatric surgery organizations that includes psychologists and other mental health professionals.[25]

REFERENCES


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Keywords: cognitive behavioral therapy; satisfaction with therapy; symptom relief; trainee therapists.

Trainees who are enrolled part of their master's degree. Trainees who are enrolled Effectiveness of Cognitive-
behavioral Therapy in the Treatment of ... Researcher allegiance and meta-analysis: the case of cognitive therapy for Effectiveness of Cognitive-Behavioral Therapy and Amitriptyline in ... 1. Introduction Bariatric surgery may result in significant weight loss, however with large individual differences [1, 2]. In patients eligible for bariatric surgery (BS), dysfunctional eating (DE) has been found among 10–25% of obese patients considered for or completing bariatric surgery [3, 4], and DE has been reported both prior [3–6] to and after BS [7–10]. Keywords Clinical case study; cognitive behavioral; narrative; paruresis; therapeutic intervention Changing narratives patients live by The narrative approach to psychotherapy argues that, writing can be therapeutic or talking about emotional experiences, can promote and improve physical and mental health of human beings. Talk and write about something that disturbs us is revealed as organizer of the experience itself. Telling and retelling stories is an essential part of all psychotherapeutic approaches. Pennebaker and Seagal (1999) developed a very interesting study which allowed