Preparing for Weight Loss Surgery: Therapist Guide

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About Treatments *That Work*™

Stunning developments in health care have taken place over the last several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit but, perhaps, inducing harm. Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public. Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and health care systems and policymakers have decided that the quality of care should improve, that it should be evidence based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral health care practices and their applicability to individual patients. This new series, Treatments *That Work*™, is devoted to communicating these exciting new interventions to clinicians on the front lines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems and diagnoses. But this series also goes beyond the books and manuals by providing an-

cillary materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging health care system, the growing consensus is that evidence-based practice offers the most responsible course of action for the health professional. All behavioral health care clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

This therapist guide and companion workbook for clients addresses psychological and behavioral aspects of weight loss surgery for the morbidly obese. This approach has been shown to be highly effective as a treatment of last resort for substantially obese individuals who are subject to the dramatically increased risk factors to health associated with this condition. And indeed, the rapid growth of obesity in North America, and much of the developed world, has been referred to by most health care professionals as an "epidemic." Illnesses and conditions exacerbated by obesity cover all of the major organs and functional systems within the body, including the development of cancer in various organs. The occurrence of most of these obesity-related conditions, particularly type II diabetes, is rising dramatically. But these surgical procedures are not without risks, as has been detailed in the scientific literature as well as the popular press. Thus, most surgeons and health care professionals insist on accompanying psychological treatment to prepare patients for surgery and to assist them in complying with their post-operative routine. The patient who is not properly prepared for surgery or does not understand the surgical procedures will be bitterly disappointed and likely noncompliant following surgery. Similarly, the patient who does not comply with the recommended post-surgery regimen will fail to maintain any weight loss and will put themselves at further physical risk.

The approaches detailed in this treatment program explain the nature of morbid obesity, then go on to describe, in a very user-friendly manner, the most up-to-date procedures for dealing with attitude, emotional, and behavioral factors associated with successfully transitioning to a very different lifestyle.

David H. Barlow, Editor-in-Chief,
Treatments *That Work*™
Boston, Massachusetts

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Preparing for Weight Loss Surgery

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Chapter 1 *Introductory Information for Therapists*

Background Information and Purpose of This Program

Obesity has quickly become an American epidemic. Patients suffering from significant overweight often have to contend with a lifetime of significant co-morbidities, social stigma, and lower quality of life. Many approaches have been tried to combat obesity and its multiple co-morbid medical illnesses, including pharmacotherapy, psychotherapy, diet, exercise, and other lifestyle change. Weight loss surgery has been used as a modality for many years but has been increasingly recognized as a durable tool for weight management over the last decade. Because the success of traditional diet programs and other therapies has been sporadic and usually short term, and recent literature has shown significantly more weight loss sustained over time in patients who undergo surgery, patients have been approaching their health care teams about the option of surgery and asking to learn more.

Table 1.1 offers a detailed description of the different types of weight loss surgery procedures.

Research Support for CBT and Changing Eating Behaviors

Although systematic research has yet to be conducted on the specific utility of psychotherapy for patients undergoing weight loss surgery, there is a substantial body of research on related conditions (bulimia nervosa and binge eating disorder) that suggests cognitive behavioral therapy (CBT) may be useful.

Table 1.1 Surgical Procedures

	Name of Procedure	Description
Restrictive Procedures	Vertical Banded Gastroplasty (VBG)	In this procedure, the stomach is divided by a line of staples to produce a new gastric pouch, much smaller—only about an ounce in size. The outlet of the new pouch is similarly small, extending about 10–12 mm in diameter. This outlet empties into a section of old, larger stomach, which then empties as it used to into the small intestine. The surgeon usually reinforces the outlet with mesh or GORE-TEX to reinforce it. The VBG may be performed with an open incision or laparoscopically.
	Siliastic Ring Vertical Gastroplasty	A variant of the gastroplasty described above. Here, the stomach is again divided by a row of staples to produce a small gastric pouch. In this procedure, the new, smaller outlet of the new gastric pouch is reinforced by a silicone band to produce a narrow exit into the old section of stomach, as detailed above.
	Laparoscopic Adjustable Silicone Gastric Banding (LASGB)	This is a newer surgery, known as the LAP-BAND, approved by the U.S. Food and Drug Administration in 2001. It is only performed laparoscopically, as its name implies. Here, a new gastric pouch is formed with staples, as with the gastroplasty, but the band surrounding the outlet from the new pouch into the old part of the stomach is adjustable. This is achieved because the band is connected to a reservoir that is implanted under the skin. The surgeon can then inject saline (saltwater) into the reservoir, or remove it from the reservoir, in an outpatient office setting. This means that your surgeon can then tighten or loosen the band, adjusting the size of the gastric outlet.
Restrictive Malabsorptive	Roux-en-Y Gastric Bypass (RYGB)	The RYGB is the procedure most commonly performed and accepted. It involves creating a small (⅓–1 oz) gastric pouch by either separating or stapling the stomach. This pouch then drains via a narrow passageway to the middle part of the small intestine, the jejunum. This bypasses the duodenum, which food would normally traverse before arriving at the jejunum. The older portion of stomach then goes unused and maintains its normal connection to the duodenum and the first half of the jejunum. This end of the jejunum is then attached to a "new" small intestine created by the procedure above. This creates the Y referred to in the name of the procedure. This redirection of the small intestine creates a malabsorptive component to the procedure, in

Name of Procedure	Description
	addition to the restrictive gastric pouch. RYGB may be performed with an open incision or laparoscopically.
Biliopancreatic Diversion (BPD)	This surgery is considered more technically difficult and is less commonly performed. It involves a gastrectomy that is considered "subtotal," meaning that it leaves a much larger gastric pouch compared with the other options described above. The small intestine is divided at the level of the ileum (the third and final portion of the small intestine), and then the ileum is connected directly to this midsize gastric pouch. The remaining part of the small intestine is then attached to the ileum as well. This procedure thereby bypasses part of the stomach and the entire duodenum and jejunum, leaving only a small section of small intestine for absorption.
Biliopancreatic Diversion with Duodenal Switch (BPDDS)	BPDDS is a variation of the BPD that preserves the first portion of the duodenum, the first section of the small intestine.
Jejunoileal Bypass	This surgery bypasses large portions of the small intestine; it is no longer recommended in the United States and Europe due to an unacceptably high rate of complications and mortality.

Aaron Beck's seminal work on CBT for depression was modified by Fairburn and colleagues for use with patients with bulimia nervosa (BN) (Fairburn, 1995). CBT has been tested in numerous controlled studies and has been found to be the most effective psychotherapeutic approach to the treatment of BN. CBT has been found more effective than delayed treatment, nondirective therapy, pill placebo, manualized psychodynamic therapy (supportive-expressive), stress management, and antidepressant treatment. Beck's work has since been further modified for use with patients who compulsively overeat or binge, such as many of those who have developed obesity.

The main focus of CBT, when working with overweight or obese individuals, is to address the negative thoughts that cause and maintain the behaviors associated with being overweight. Interventions are designed