
XXVIII IFSO World Congress
9-12 September 2025 | Santiago, Chile
COMBINED THERAPIES, THE DAWN OF A NEW ERA
IFSO
SANTIAGO 2025
The Hidden Veil: How Pre- Op Psychology Affects Post-Op Quality of Life
IFSO 2025 Santiago
Combined Therapies, The Dawn of a New Era
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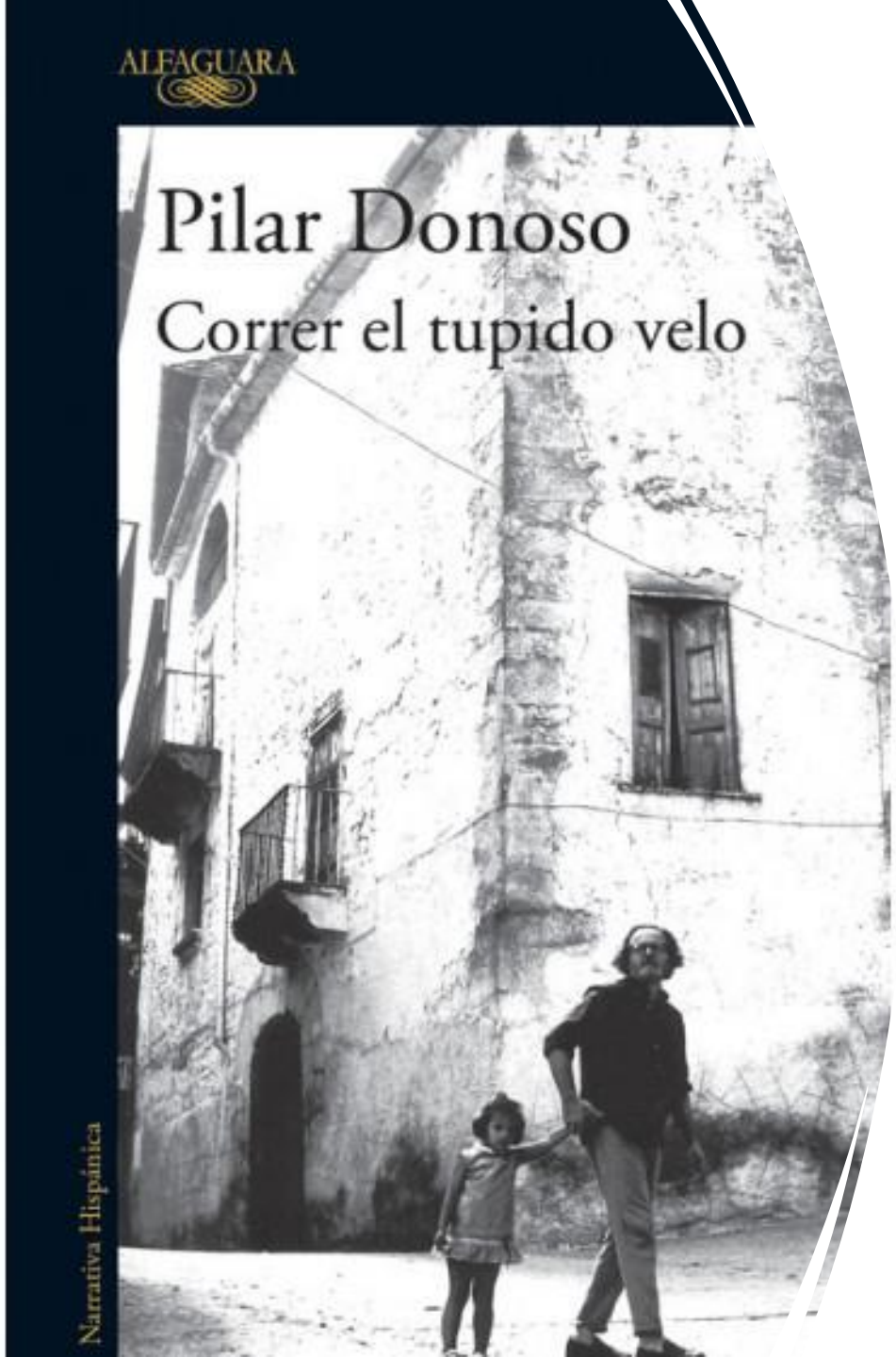
I have no disclosures related to this presentation.



Introduction

Upon receiving the invitation for this session and reading the title The Hidden Veil, I was immediately reminded of a book “Correr el tupido velo”—which loosely translates as Lifting the Veil.

The phrase evokes the act of drawing back a heavy curtain that conceals something painful or shameful—something we have collectively chosen not to confront.

It speaks to the process of unveiling what has long remained invisible, unspoken, or deliberately obscured.

The Hidden Veil

In clinical context, this metaphor resonates deeply.

It refers to the emotional and psychological dimensions of the patient's story that often remain hidden beneath the surface. These include:

- personal expectations
- difficulties with emotional regulation
- experiences of anxiety or depression
- internalized weight stigma
- shame surrounding eating behaviors

Such elements rarely emerge spontaneously in clinical interviews, yet they profoundly shape a patient's motivation, self-perception, and capacity to adapt after bariatric surgery.

Making the invisible part of standard care

In recent years, the definition of obesity has undergone a profound transformation. It is now recognized as a chronic, complex, and multifactorial disease—a shift that demands not only clinical adaptation but also a reconfiguration of our narratives and beliefs.

The Hidden Veil

This evolving definition of obesity challenges us to reconsider the role of the preoperative psychological evaluation—not only in terms of assessing the patient's mental health status and identifying potential psychological indications or contraindications for surgery.

How should psychological assessment respond to the complexity of obesity as a chronic, multifactorial disease?

Protective Psychological Factors

Evidence consistently shows that certain areas make a meaningful difference in both short- and long-term outcomes:

- **Building realistic expectations** about surgical results, lifestyle changes, and emotional adaptation
- **Enhancing emotional regulation**, particularly in relation to anxiety, impulsivity, and stress-related eating
- **Exploring the patient's relationship with food**, including patterns of emotional eating, restriction, and shame
- **Strengthening support networks**, both formal and informal, to foster resilience and postoperative adherence

These areas are not peripheral—they are central to the patient's capacity to engage with treatment, navigate change, and sustain long-term well-being.

Post-Bariatric Surgery: Psychological Challenges

On the other hand, evidence shows that there are certain challenges following bariatric surgery that clinical teams must be attentive to.

Patients who undergo bariatric surgery are at higher risk than the general population for experiencing difficulties related to mood, eating behavior, and problematic alcohol use.

- Depression and anxiety affect up to 30% of patients post-op (JAMA, 2021)
- Grazing behaviors: 16%–46%, strongly associated with weight regain (Conceição, 2022; MDPI)
- Unrealistic expectations are a strong predictor of dissatisfaction (Obesity Surgery, 2022)
- Alcohol use disorder, suicide, and self-harm increase significantly after year 3 post-op (Law et al., 2023 – Umbrella Review)

In summary:

Psychologists are responsible for assessing whether patients are in adequate mental health to undergo bariatric surgery. However, evidence shows that the most significant psychological challenges do not typically arise in the immediate postoperative period, but rather from the second or third year after surgery.

- So what should we do?
- Should we design postoperative support programs that extend over three years?
- Should we implement stricter preoperative evaluations to “ensure” that patients will not experience long-term mental health difficulties?
- Or is it time to rethink the purpose of psychological assessment altogether?

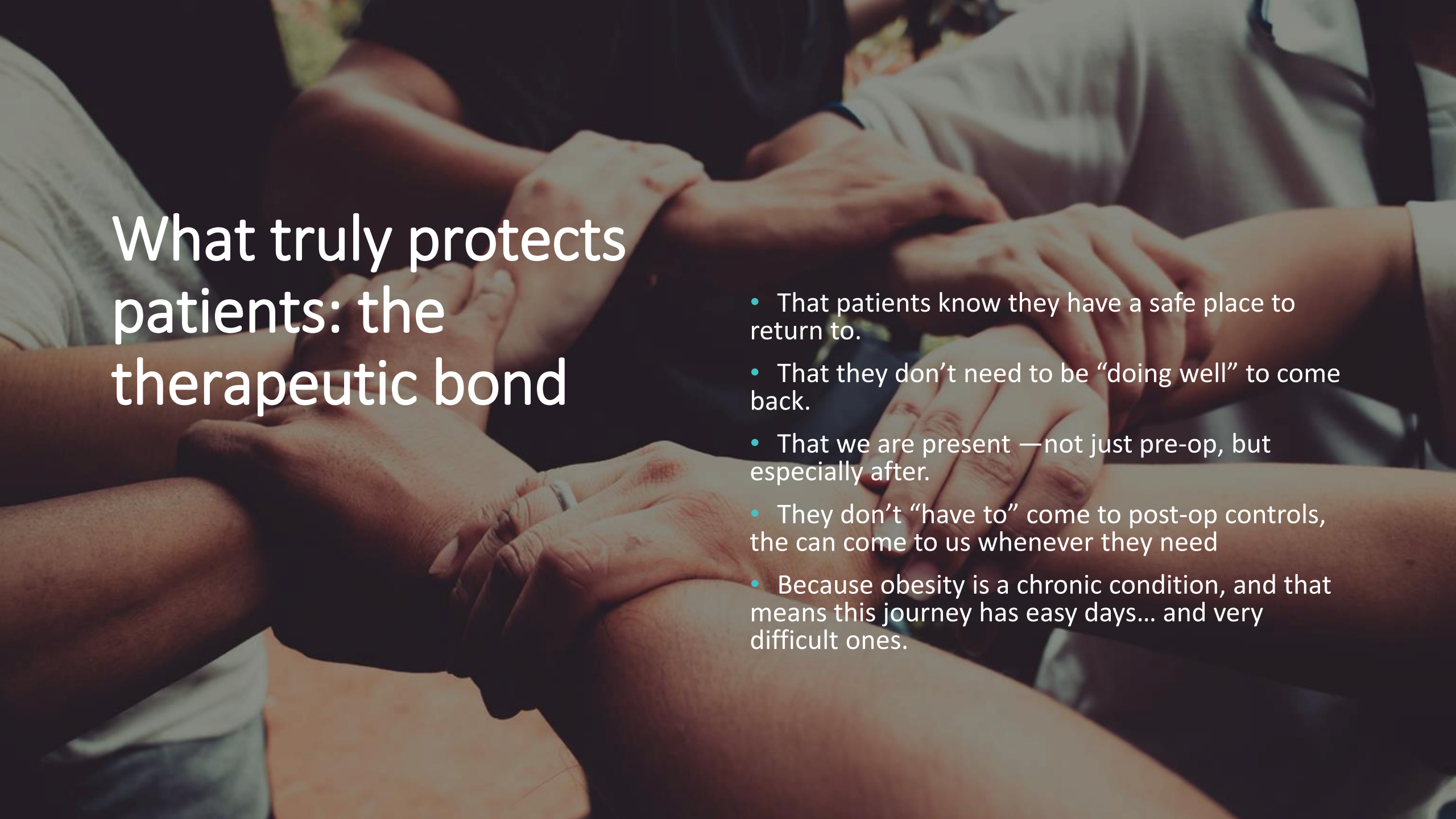
From Evaluation to Accompaniment

- It is not merely a matter of applying a psychological assessment protocol. What we need to build is a clinical space that allows us to understand the patient beyond the diagnosis—a space of trust, where what is not always spoken can be explored: emotions, beliefs, fears, and expectations.

- David Sarwer—PhD, Director of CORE at Temple University and leading expert in psychology of obesity and bariatric surgery—emphasizes that psychological evaluation should not be a barrier to surgery, but rather an opportunity to built a therapeutic alliance, identify areas of vulnerability and provide patients with the support they need to succeed long term.

- Preoperative psychology must not be reduced to an administrative requirement; it is a protective factor for long-term quality of life. This is the hidden layer we must learn to see—and to lift.

- If we limit ourselves to being “evaluators,” we risk becoming yet another barrier to treatment. The patient living with obesity has already encountered many barriers. They do not need one more.



What truly protects patients: the therapeutic bond

- That patients know they have a safe place to return to.
- That they don’t need to be “doing well” to come back.
- That we are present —not just pre-op, but especially after.
- They don’t “have to” come to post-op controls, the can come to us whenever they need
- Because obesity is a chronic condition, and that means this journey has easy days… and very difficult ones.

✨ Closing – Lifting the Clinical Veil

It’s a clinical act.

It means recognizing the emotional wounds, the stigma, the internal narratives that shape our patients’ experience.

Surgery transforms the body. The real and genuine presence of the multidisciplinary team —the bond— is what transforms the experience.